



BULGARIA HEALTH REFORM PROJECT

**Contract № PCE – I – 00 – 00 – 00014 – 00
Task Order 810**

MAY-JUNE 2003 MONTHLY REPORT

**Prepared for:
USAID Bulgaria**

Prepared by:

***BearingPoint, Inc.*
74-A Bouzloudja St.
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USAID HEALTH PROJECT SUMMARY AND REPORT
Monthly Report No. 1
May-June 30, 2003

Project Title: Bulgaria Health Reform Project (BHR)
Contractor: BearingPoint, Inc.
Contract Number: PCE-I-00-00-00014-00
Task Order: 810
Period of Performance: April 30, 2003 – April 29, 2005
Project Manager: Ibrahim Shehata
Previous Monthly Report Date: NA

Progress, Accomplishments, Issues and Events

General

- The project's COP, Ibrahim Shehata, was in the US during the first six weeks of the project to prepare for moving to Bulgaria and to attend the National Health Accounts (NHA) symposium and the International Health Economics conference with the Bulgarian delegation.
- Ibrahim Shehata made a brown bag presentation on the Bulgaria Health Reform project's activities and accomplishments to USAID bureau of Europe & Eurasia. More than 10 people representing the E&E and Global Bureau attended the presentation.
- Susan Matthies was in Bulgaria for the period between May 6-21 to provide technical assistance to the DRG working group and to assist with the analysis of the data from Lovech hospital.
- A new deputy minister of health, Dr. Petko Salchev, was named as a replacement for Dr. Tenshev who resigned earlier in May.
- Two senior Bulgarian health policy-makers, Dr. Atans Shterev, chairman of the parliamentary health commission, and Mr. Slavcho Bogoiev, deputy minister of health, attended a 2-day symposium on national health accounts (June 13-14) followed by 5-day conference of the international health economics congress (June 16- 20) in San Francisco.

Inpatient Care Financing

- The technical working group assigned with proposing specific plan for introducing case-based financing met at the Project's offices to follow up on the discussions that took place during the decision-makers working group earlier in April. Susan Matthies as well as representatives of the NHIF, Ministry of Health and Ministry of Finance attended the meeting. During the meeting Mrs. Deltsheva, from the NHIF, briefed the group on the new management organization of the NHIF, passed by the management board a week earlier and how this will impact the creation of a case-mix office. A new department of Financial Technologies and Forecasting will be created with two major divisions: inpatient and outpatient. The outpatient division may have three sections: coding/clinical data, costing and forecasting. This will likely be the core of the so-called "case-mix office".



BULGARIA HEALTH REFORM PROJECT

**Contract № PCE – I – 00 – 00 – 00014 – 00
Task Order 810**

JULY - SEPTEMBER 2003 MONTHLY REPORT

**Prepared for:
USAID Bulgaria**

Prepared by:

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USAID HEALTH PROJECT SUMMARY AND REPORT
Monthly Report No. 3
July - September 30, 2003

Project Title: Bulgaria Health Reform Project (BHR)
 Contractor: BearingPoint, Inc.
 Contract Number: PCE-I-00-00-00014-00
 Task Order: 810
 Period of Performance: April 30, 2003 – April 29, 2005
 Project Manager: Ibrahim Shehata
 Previous Monthly Report Date: NA

Progress, Accomplishments, Issues and Events

Assessing National Drug Policy

- Many of the project's local counterparts took extended time off during the months of July and August. As a result, fewer activities took place during that period and were, therefore, we combined their activities under the September monthly report.
- The Minister of health requested that the project field an expert to assess the national drug policy in preparation for the ministry's plan to announce its new positive drug list later in the year. The expected deliverable is a report summarizing existing loopholes and best options for addressing these problems and outline responsibilities and actions, which different institutions should take for successful implementation of a more transparent system.
- Names of candidates for the DRG study tour in Romania were submitted to world learning and USAID for approval.

Inpatient Care Financing

- The technical working group assigned with proposing specific plan for introducing case-based financing met at the Project's offices to follow up on the discussions that took place during the decision-makers working group earlier in April. Ibrahim Shehata as well as representatives of the NHIF, Ministry of Health and Ministry of Finance attended the meeting. During the meeting Mrs. Deltsheva, from the NHIF, briefed the group on the new management organization of the NHIF, passed by the management board a week earlier and how this will impact the creation of a case-mix office. A new department of Financial Technologies and Forecasting will be created that will be responsible for inpatient and outpatient coding/clinical data, costing and forecasting. This will likely be the core of the so-called "case-mix office".

Dr. Drenski, from NHIF updated the group on the progress made under the World Bank's training project. They said that the Bank has objected to the selection of GammaConsult, to develop hospital costing software, on the grounds that it was the highest priced tender if though it was the only one that qualified technically. There was a suggestion that the World Bank should have used a negotiated sole source process instead of a tender given the comparative advantage enjoyed by

GammaConsult. This may be the final result but will create significant delays. Meetings with the World Bank team/task manager are being scheduled by the working group to request that the process be expedited.

- Ibrahim Shehata, on three separate occasions, with met with Dr. Shterev, chairman of the parliamentary health commission, Dr. Ademov a member of the health commission, and Mr. Teodor Vassilev, the NHIF deputy director for information to discuss the DRG timeline and the steps for implementing a case based payment system based on DRGs. Also discussed were the level of readiness of Bulgaria to implement such a system and what are the technical and political decisions that will need to be taken over the coming period. Attached is the timeline for implementing the DRGs.

Hospital Restructuring and Rationalization

- A draft of the Lovech region inpatient assessment report was distributed to the MOH, and some of the hospital directors for review and comment prior to finalization. In all, the team visited 5 hospitals (Lovech, Troyan, Tetevin, Lokovit and Pulmonary hospital in Troyan. The team spent approximately 9 weeks in the field. They met with hospital management and staff as well as local health authorities. The next step is to start data analysis.
- Some of the key recommendations in the report focused on:
 1. *Change the designation of the Lovech Regional MHAT to Lovech MHAT* – this will mean that the hospital will no longer have to maintain a high number of underutilized services solely for the sake of maintaining that designation (i.e., endocrinology and gastro-intestinal disease could be consolidated under one internal medicine department rather than separate departments; ENT and Eye disease Departments could also be consolidated in one; Orthopedics and Urology could form one Specialized Surgery Department). It is clear that the hospital’s admission and discharges are overstated and that many of its departments are underutilized. In addition, the acute negative trend in the demography of Lovech and the proximity of Pleven’s University Hospital does not justify having a regional MHAT hospital in the region.
 2. *Establish a Home Care unit within each hospital* – Staffing for these home care units could be easily provided from the oversupply of physicians in the region. This should relief the burden from the hospitals and funnel unnecessary cases out of the inpatient care setting.
 3. *Relocate Physical Therapy, Dermatology, Infectious Disease, and Pneumo-phthisiatric departments to the main building in Lovech MHAT* to improve operations and contain unnecessary costs.
 4. *Convert the existing physical capacity created by the relocation into a Geriatric Center* -
 5. *Create an ambulatory care center in each of the four main towns of Lovech, Troyan, Lukovit and Teteven in order to divert unjustified traffic from the costly hospital setting to the less expensive outpatient care setting*- the lack of ambulatory one-day services leads to short-term hospitals admissions of patients who passed manipulations that need several hours of observation. *Incorporate the Emergency Center into the hospital and not as a separate administrative unit* – hospitals do not get reimbursed for lab and instrumental diagnostics of the emergency patients. Hospital management can rotate the staff providing the emergency care especially in small municipalities. This will increase the level of proficiency of the staff and the emergency care provided.

Dr. Drenski, from NHIF, and Dr. Yankova, from the World bank project updated the group on the progress made by 3M for training coders at the pilot hospitals. They said that the Bank has objected to the selection of GammaConsult, to develop hospital costing software, on the grounds that it was the highest priced tender if though it was the only one that qualified technically. There was a suggestion that the World Bank should have used a negotiated sole source process instead of a tender given the comparative advantage enjoyed by GammaConsult. This may be the final result but will create significant delays. Meetings with the World Bank team/task manager are being scheduled by the working group to request that the process be expedited.

Susan Matthies proposed that a proposed a more detailed timetable and shared a sample team organization and task lists taken from the experience in Romania. The teams proposed were Coding, Costing (relative weights), MIS, Legal & Policy Development, and Communications & Education.

- Jugna Shah, a DRG advisor arrived in Bulgaria for 2 weeks on 22 June to provide technical assistance to the NHIF and the MOH with their plan to move towards a case-based payment scheme based on DRGs. During her 2-week stay Ms. Shah met with the two deputy ministers of health to discuss steps needed to implement a case based payment system based on DRGs. Ms. Shah also answered some of the concerns that were raised by Dr. Salchev regarding the readiness of Bulgaria to implement such a system. Ms Shah also met with Dr. Pertrov, the director of the NHIF and Mr. Drenski to discuss the structure of a case mix office.

Ms. Shah left behind a timeline for implementing the DRGs (Annex 2) and a list of answers to some of the key issues raised by the various health policy makers (Annex 1). During her stay Ms Shah also met with Dr. Shterev, chairman of the parliamentary health commission, Dr. Ademov a member of the health commission, and Mr. Teodor Vassilev, the NHIF deputy director for information.

A senior level working group was also planned for July 8 at the Hilton to present the time line outlined by the project and to assign responsibilities.

Hospital Restructuring and Rationalization

- The hospital assessment team finished visiting all hospitals in the Lovech region. In all, the team visited 5 hospitals (Lovech, Troyan, Tetevin, Lokovit and Pulmonary hospital in Troyan. The team spent approximately 9 weeks in the field. They met with hospital management and staff as well as local health authorities. The next step is to start data analysis.
- The Minister of Health, Dr. Finkov, had a press conference to present the findings from the Gabrovo hospital assessment conducted by the Bulgaria Health project.

ANNEX 1

Questions and Answers Regarding Issues Related to the Development of a Case-based Payment System (DRGs) in Bulgaria

Question One: Do DRGs help solve the problems or create more problems?

This is a great question, and one that is not asked often enough. The answer really depends on what is expected from the implementation of DRGs. The DRGs are simply a tool; one that organizes hospital patients into groups based on diagnosis and procedures. We have to ask, “What problems are decision-makers expecting this tool to solve”? If a tool is implemented without a specific goal or objective in mind, then it is likely to cause more problems than it will solve. Before DRGs are selected for implementation, decision-makers should ask, “What do we expect the implementation of a case-based financing system to do for us”?

For example, a case-based financing system can create incentives so that:

- The correct amount of care is provided (i.e., appropriate length of stay)
- In the correct setting (i.e., hospital vs. ambulatory), and
- In the most appropriate “high quality” manner (i.e., data allows us to look at hospitals, departments, and physicians).

In addition, a case-based financing system can help achieve broader health system changes, including:

- Improving transparency in allocating limited resources to hospitals
- Reducing inefficiency and waste at central and hospital levels
- Providing data for creating health policies and hospital management
- Maintaining or increase the quality of services provided at hospital level
- Changing existing incentives, laws, and regulations across the health system so that all actors in the health system are efficient and treated equitably

Other questions decision-makers should ask about the implementation include:

- Why do we want to implement DRGs?
- What do we expect the DRG classification and/or financing system to help us achieve in Bulgaria?
- When do we want to implement them?
- Who will make the implementation happen?
- How will we measure our implementation success as well as the results of the implementation?

Question 2: Does Bulgaria have the data to implement DRGs?

Yes, and No. It depends on what type of data we are talking about and also on how much data decision-makers feel they need before they have enough to begin an implementation. For DRGs, two types of data are needed. The first type of data, and the one that is often considered the most important because implementation cannot begin without it, is the clinical patient level data. This data includes patient demographic information, and clinical information regarding the patient's condition as described by the diagnosis and procedure codes recorded. Collection of this type of data has been happening in Bulgaria since the mid-to-late 1990s through various DRG projects. Much of this data is too old to use now and not very representative of all types of hospitals. Currently, a project is underway that will result in clinical patient data being collected from an additional 16 hospitals, which are intended to be more representative. By the time this data is available in 6-9 months, and added together with the existing database from the past few years, there should be enough clinical data to begin a pilot DRG-based financing system implementation. For the national implementation of DRGs, it would be best to collect at least 9-12 months of this data from all Bulgarian hospitals expected to be financed under this new method.

The other type of data that is very important for the implementation of a DRG-based financing system is patient level cost data. However, this data is difficult and very time consuming to generate and most countries do not have this data. Instead, cost or accounting data from the hospital department level is used along with the clinical data grouped into DRGs along with a set of relative value units borrowed from another country for the different components that make up the cost of an individual DRG in order to estimate the cost of the DRG in Bulgaria. This is estimated for each hospital and then aggregated together for the country (all hospitals) in order to derive an overall average cost. While this is simply an estimate, it is sufficient to begin with this as long as the financial risk during the first years of the new system implementation is not placed on hospitals. Borrowing a set of relative value units allows decision-makers to begin and allows hospitals to become used to the new financing mechanism which relies on accurate coding and data reporting to the national level. During the first year of DRG implementation, while hospitals begin to adapt, the implementers can continue working to refine and improve the system. This refinement period may take several years, but it is during this time that a more accurate picture of Bulgarian costs can be collected and used to determine Bulgarian prices for the DRGs.

Decision-makers do not have to wait until the data is perfect, because that moment will never come. In most countries where DRGs have been implemented for financing, there was strong political pressure from the highest levels of government to begin with a new form of financing, therefore, those countries had no choice but to begin with some data and to improve it over time.

Question 3: How is the DRG similar to or different from the CCP methodology?

Diagnosis Related Groups (DRGs) and Clinical Care Protocols (CCPs) in Bulgaria can be said to be very similar because both use diagnosis and procedures as their basis. Both rely on essentially the same type of clinical patient data, and both rely on the reporting of cases from the hospitals. The CCP development in Bulgaria started by using DRGs as the base and then modifications were made. In Bulgaria, other adaptations were made to the CCPs, both in terms of how the groups were created and also in terms of the price assigned to each group. The actual assignment of diagnoses to a DRG group and the calculation of the price of the group in the US was based on in-depth clinical discussions and statistical analyses. The development of CCPs does not appear to have followed the same path. In fact, one CCP is not always the same

as one DRG. Some of the CCPs are made up of multiple DRGs, whereas other CCPs are exactly the same as the DRGs. The prices for the CCPs in 2001 were based on the relative values of the Medicare (HCFA) DRGs. In 2002, some costing efforts were made to generate more accurate prices, but in 2003, the prices were basically just negotiated. With DRGs, hospital data really drives the determination of prices. DRGs and CCPs also have different uses. DRGs are used as a basis for financing, but CCPs are not typically used for this reason. CCPs are useful to help guide physicians on the types of services that should be provided during a typical admission. Therefore, DRGs and the CCPs can work together, with the DRG conveying the price and the CCP conveying a recommended clinical protocol.

Question 4: Is it necessary to use the ICD-10 diagnosis coding system to implement DRGs?

No, it is not necessary to implement the ICD-10 diagnosis coding system in order to implement DRGs. The coding system being used within a country matters for DRG implementation with respect to the selection of a grouper to some extent. A grouper is a piece of software that combines different diagnosis and procedure codes into individual groups. If the grouper software is based on ICD-10 codes, but the codes being used within a country are ICD-9-CM codes, then a mapping table will need to be used in the software to convert the ICD-9-CM code to the ICD-10 code in order for the grouper to ultimately assign a DRG. This is not generally a problem, but anytime a mapping table is used, there can be some discrepancies in the final assignment of the DRG. Most countries try to achieve consistency between their coding system and the grouper software being used. Sometimes this means changing the coding system, especially if it needs to be updated anyway, and sometimes, this means purchasing a different grouper, building a country specific grouper, or working with a software vendor to modify an existing grouper to accommodate the coding systems being used in the country.

Many countries are already using ICD-10 diagnosis codes because they want to be compliant with the World Health Organization, which will require ICD-10 to be implemented in all countries for mortality reporting within the next 2-3 years. Given that the WHO has this requirement, it makes sense to move forward and implement ICD-10. Also, there are some improvements with this coding system and physicians may like it better. Of course there is always a cost involved, in terms of time and resources, to implement and learn a new system. But, if this will be required anyway, then Bulgaria may want to consider moving to this sooner rather than later.

Question 5: What are the different options for having a grouper?

As mentioned above, there are many options for having a grouper. The information below is from a larger document on “Grouper Options” available from the Bulgarian Healthcare Project team.

Things decision-makers should consider when selecting a grouper:

- What resources are available?
- For political reasons, does the grouper need to be Bulgarian, or can it be foreign?
- If the grouper is purchased from abroad, does it matter from where?
- Does the grouper need to be consistent with what other countries are using?
- Will the selected product be compatible with existing coding systems?
- Will the product be easy to use and interface to other products?
- Will customer service be included if a commercial grouper is licensed?
- You will want to be able to defend whatever grouper decision you make. That means documenting your reasons for selecting one grouper vs. another. It may be helpful to have a matrix and/or criteria upon which you make your decision.

- Will the grouper software be provided to the hospitals from the Central level or will each hospital have to purchase their own?
- What level of accuracy is required for the groupings and the relative weights?

Some options:

- Purchase the U.S. HCFA grouper
 - Pros: Low cost, readily available, public domain, many countries used this
 - Cons: Interface (i.e., code mapping) required between ICD-10 diagnosis coding system and what is in the grouper since they are not the same.
- Purchase a commercially available grouper such as various 3M groupers, including the 3M International Refined Grouper, the Australian National Grouper, and others
 - Pros: Different grouper products are available to achieve consistency you're your own coding systems therefore no interface required; vendor may work with you to develop more specific groups and/or relative weights
 - Cons: More expensive, annual contract, license fees, etc.
- Purchase ONLY the specification of a commercially available grouper in order to make a Bulgarian specific grouper
 - Pros: Cheaper than buying the actual commercial software; modification of an existing specification is easier than starting from the beginning (don't reinvent the wheel if you don't have to); grouper can be changed easily and as frequently as you like because you own the product; you get exactly what you want because the clinical and resource use in Bulgaria can be reflected in the grouping.
 - Cons: Full programming & updating responsibility lies within the country, and will require time and resources; and more time involved than buying one that is already available
- Make a Bulgarian grouper from scratch
 - Pros: You get exactly what you want because the clinical and resource use in Bulgaria will be used to determine the groups.
 - Cons: More time and resources will be required; you will essentially be reinventing the wheel; getting agreement from clinical commissions on diagnoses that belong in different groups will be difficult; detailed cost information may not be easily available to determine which diagnosis within a group having similar costs. The benefits of this may not outweigh the costs involved.

Question 6: Can you talk about the comparison of the medical and economic data regarding DRGs?

If we understand correctly, the question relates to what data is required and how DRGs were established in the first place using medical/clinical and economic/cost data. We have described the data required above in question two, and a list of the exact medical/ clinical data elements can be provided upon request. DRGs were created using clinical, statistical, and economic expertise. Physicians were invited to discuss the clinical aspects and similarities of the different DRG groups. In addition to this, economists, analysts, and statisticians used mathematical and modeling techniques to ensure that only those diagnosis codes that were both similar clinically and in costs were assigned to the same DRG group. For example, two or more clinically similar diagnoses with very different costs (i.e., beyond some statistical threshold) would not be assigned to the same group. This is a slightly simplistic explanation, but this is essentially the logic of how the DRGs were created using medical/clinical and economic/cost data.

Question 7: What is the appropriate risk distribution between the payer (i.e., the National Health Insurance Fund) and the provider (i.e., Bulgarian hospitals)?

This is another great question, and one that does not have an easy answer since it can be answered philosophically, politically, etc. However, one thing that most of us can probably agree on is that the patient's health, outcomes, and the quality of services delivered is central to the health care financing debate. Therefore, the question of balancing risk is critical. At the start of any new system, and not only a health care financing system, all participants need time to adapt. This includes the payer, the hospitals, and the patient. Under DRGs, patients may find themselves staying in the hospital for fewer days than under the previous financing system. In this case, patients may feel they are receiving lower quality of services, when in fact they probably are not. This will however be their perception because they will be facing a change. Hospitals will also face changes as they learn to code more accurately, report patients electronically to the central level, use data to manage their internal departments, and begin learning how to control their overall expenditures using a fixed budget based on DRGs. The Central authority will also need time to train all hospitals, collect and process data, and test the overall contracting and payment mechanism. All the parties involved will require some time to adapt just to this basic change. In addition, if borrowed cost relationships are used to establish DRG prices for Bulgaria, then this too should be taken into careful consideration before placing hospitals at financial risk under the new financing system. The bottom line is that the appropriate risk distribution needs to be handled very carefully and the incentive to become efficient overnight must be balanced with protecting patients and hospitals while moving ahead fast enough for the politicians (if they are in a hurry), but slow enough to ensure long-term success.

Question 8: If you implement DRGs, how do you address duplication of tests or services provided in the outpatient setting and in the hospital?

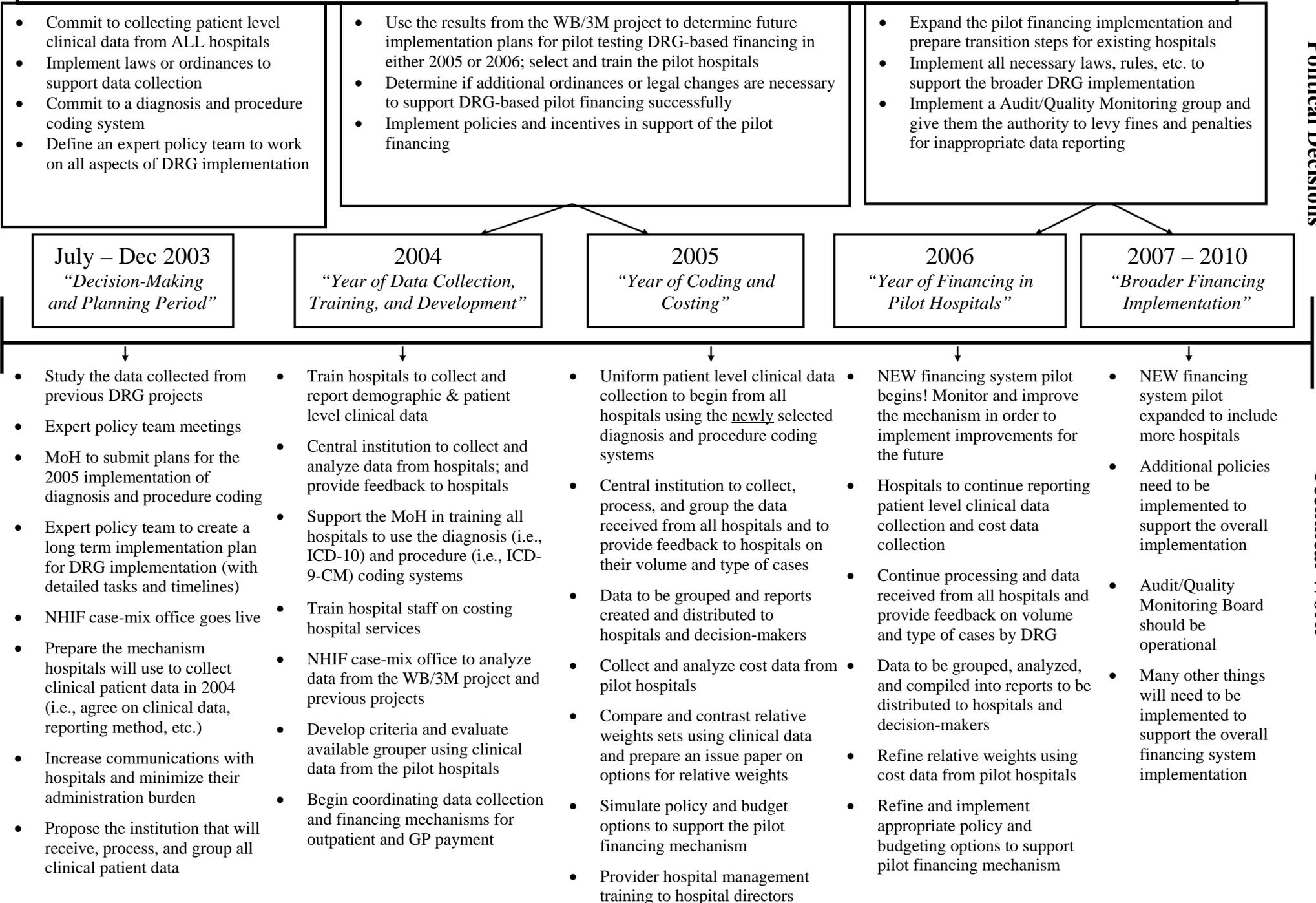
This really depends on how your overall health care system is set up, on how much data you collect from all care settings, whether patients have some unique identifier, and on your informatics capability to link patient records across multiple care settings. For example, in the U.S., if a patient is seen in an outpatient clinic of a hospital within three days of an inpatient admission, then the diagnostics received in the outpatient clinic are not paid for separately, but are instead included in the payment of the DRG since its price includes some diagnostic testing. In the U.S., the physician who provided the test in the outpatient clinic would still be paid for his or her time because the physician payment is separate from the clinic's payment for the diagnostic tests or the hospital's payment for the DRG. Also, the informatics capability exists to ensure that duplicate payment in this manner is not happening. In general, there are policy mechanisms and data processing and payment edits that can be created to monitor some of this duplication. However, duplicate payments will always exist to some extent, so each country has to decide how much they can tolerate vs. how much they want to spend their time and resources to prevent all duplication.

Question 9: How will DRGs integrate with primary care and diagnostic consulting centers (i.e., specialist care/physicians in Bulgaria)?

We should discuss this in more detail in terms of how these are currently organized in Bulgaria and how payments are made in each setting in order to better predict what type of effect DRG-based financing might have on the other types of services and caregivers in Bulgaria.

ANNEX 2

Draft Activities and Timeline for Implementing New Coding System and Preparing for Future DRG Implementation



Political Decisions

Technical Work



BULGARIA HEALTH REFORM PROJECT

**Contract № PCE – I – 00 – 00 – 00014 – 00
Task Order 810**

OCTOBER 2003 MONTHLY REPORT

**Prepared for:
USAID Bulgaria**

Prepared by:

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USAID HEALTH PROJECT SUMMARY AND REPORT
Monthly Report No. 4
October 31, 2003

Project Title: Bulgaria Health Reform Project (BHR)
 Contractor: BearingPoint, Inc.
 Contract Number: PCE-I-00-00-00014-00
 Task Order: 810
 Period of Performance: April 30, 2003 – April 29, 2005
 Project Manager: Ibrahim Shehata
 Previous Monthly Report Date: NA

Progress, Accomplishments, Issues and Events

Assessing National Drug Policy

- In response to a request by the Minister of health, the project fielded an expert to assess the national drug policy. The expert, Cheri Grace, was in Bulgaria October 19 – 31 and met with many of the stakeholders involved in formulating the national drug policy. The visit took place in a time when the Ministry was preparing to issue the first positive list in Bulgaria.

During the trip, and based on a request by the USAID, Ms. Grace attended, along with the project's COP, a meeting with the U.S. Ambassador and USAID mission director and brief them on her work and present some preliminary findings.

Ms. Grace's scope of work for the visit was to assist the MOH and the NHIF with reviewing the existing drug policy and examine different mechanisms for developing the positive and reimbursement drug lists. Cheri Grace also examined the level of transparency and controls over the purchasing of drugs. This include:

- 1) Review overall existing drug policy.
- 2) Provide different options for improving the existing policy of developing a "positive list" list by the Ministry and agreeing on principles of reimbursement through the National Framework Contract.
- 3) Assist the National Health Insurance Fund develop new principles for reimbursement and a new List of Reimbursable Drugs after the adoption of the Positive List of drugs by the MOH.
- 4) Engage policymakers to discuss different methods for controlling the rising burden of drug benefits.

The expected deliverable is a report summarizing existing loopholes and best options for addressing these problems and outline responsibilities and actions, which different institutions should take for successful implementation of a more transparent system. The initial findings from the visit that were presented to the Minister of Health during a debrief prior to leaving were:

- The total pharmaceutical market for Bulgaria in 2002 was 545,152,502 Bulgarian Leva (BGL) (about \$38 per capita, compared with an OECD¹ average of \$239.70 per capita in 1996.²) Public healthcare expenditure in 2002 was 1,320,900,000 BGL, which, at 4% of Gross Domestic Product (GDP), is low by European standards. The public pharmaceutical expenditure in 2002 was 40,120,000 BGL, 74% of the total pharmaceutical market. The pharmaceutical expenditure is 30% of the public healthcare expenditure, as compared with a 15% average for the OECD³.
- Despite what appears to be a fairly straightforward system, there are many concerns about the way benefits are distributed via the current system as well as the process through which the current policies are developed.
- There is a relatively concentrated realisation of benefits from the system, in terms of types of diseases treated and numbers of patients benefiting from reimbursement. For example, MOH expenditure is concentrated on cancer; while the NHIF's spending is concentrated on cardiovascular diseases and diabetes.
- The existing policy of adding drugs to the reimbursement list as well as determining reimbursement policies does not appear to be systematic and evidence based. Consultants make informal suggestions for drug additions to the NHIF Board of Directors on a continual basis.
- The major pharmaceutical policy that was being debated during the time of the consultant's visit was that of the country's first positive list. Up until now, there has been no national selective list in Bulgaria; rather, each institution defines its own list of brand names eligible for reimbursement with public funds. For example, there is one list for emergency care drugs, one for veterans, one for hospitals, one for the National Health Insurance Fund, and so on.
- The way that the reimbursement system has been implemented in Bulgaria appears to follow an incremental policy planning approach: i.e. implement and then see what happens and then reform the system and see what happens again, and so on. This constant 'tweaking' of the system has been done in the absence of data on the incentives embedded in the reimbursement system – data which would be needed in order to make more rational and transparent decisions based on evidence.
- There are concerns involving the transparency of the drug selection process. The Ordinance for issuing the positive list is worded in such a way that very vague criteria - quality, efficacy, safety & cost-effectiveness - can be used to include or exclude certain drugs from the list. There are also doubts about the rigour in applying the selection criteria. Although the positive list committee stated that

¹ [Organisation for Economic Co-operation and Development](#)

² S. Jacobzone. "Pharmaceutical Policies in OECD countries: reconciling social and industrial goals", Labour Market and Social Policy Occasional Papers no 40, DEELSA/ELSA/WD(2000)1, April 2000.

³ S. Jacobzone. 2000.

‘quality, efficacy, safety & cost-effectiveness⁴’ were the criteria by which drugs were being evaluated, it became obvious throughout discussions with committee members that other criteria were non-systematically considered as well, including the importance of the drug relative to disease priorities and the financial implications of adding a drug to the list.

A list of people interviewed during the trip is included in Annex-1.

Informing The Media On Health Reforms

- The Project in coordination with the Ministry of Health sponsored a two-day seminar on October 10-11 in Velingrad aimed at informing the media about health reform issues in Bulgaria and how the government is addressing them. The seminar was attended by more than 45 print and TV media representatives as well as the Minister of Health and his two deputies, the director of the NAHIF, the Chairman of the Parliamentary Health Commission and the President of the Physician Union. The Project’s COP made a presentation on the DRG principles, which along with the seminar’s agenda are included in Annex 2 & 3.

Inpatient Care Financing

- The project’s hospital financing expert, Jugna Shah, was in Bulgaria 19 September – 3 October. The purpose of the visit was to:
 1. Assist the Ministry of Health and the National Health Insurance Fund with reconciling data elements compiled and reported by the regional health centers to the MOH’s National Center for Health Informatics (NHIC) and eliminate redundancies in data collection and reporting.
 2. Assist with developing a unified data set following reviewing existing data elements with the technical working group involving members of the NHIF, NHIC and Physician Union.
 3. Ms. Shah was also scheduled to join the Bulgarian team leaving to Romania for a one-week participant training to evaluate the Romanian experiment with implementing inpatient care Diagnostic Related Groups (DRGs) as the basis for financing hospitals.
- The training in Romania was part of the preparation by the NHIF’s plan to adopt using the DRG classification scheme as the method for determining hospital funding. The participants learned how the system has been working in practice in Romania and discussed legislative and other challenges that the Romanians have confronted. The list of participants included:
 - Petko Salshev, Deputy Minister of Health
 - Polet Peychev, Head of Reporting and Analyzing of Hospital data, NHIF
 - Zheni Bumbarova-Nacheva. Director of Budget and Financial Indicators, NHIF
 - Iavor Drenski, Director of the Hospital Care Department, NHIF
 - Valeria Ivanova, Head of the Political Capinet, MOH

⁴ Or cost-minimisation, where effectiveness is considered to be equivalent

- Teodor Vasilev, Deputy Director, NHIF
- Ivaylo Vaklinov, Head of Monitoring and Grouping, NHIF
- Eugenia Delcheva, Director of Analyzing, Modeling and Pricing, NHIF
- Borislav Gaydarov, Senior Expert, MOH
- Svetla Todorova, Head of Management of Projects, MOH

In addition, the Project sent Assia Tumbanova to monitor the training with the idea that she will be the main task coordinator. Rayna Dimitrova, the project's USAID technical officer, attended the training.

- Following the training, the Minister of Health established a working group with members from the Ministry, NHIF, HCHI and the National Public Health Institute to strategize about introducing case based financing in Bulgaria. In addition 38 pilot hospitals have already started submitting clinical and cost data to the NHIF as part of the preliminary work towards a pilot financing.
- In the month ahead, the Health Project will assist the NHIF with analysis of the data compiled from the 38 pilot hospitals, work with the policy makers toward selecting morbidity coding system for clinical procedures and help with developing a national plan for training of hospitals in coding and operating hospitals under a DRG system.

Hospital Restructuring and Rationalization

- A draft of the Lovech region hospital assessment report was presented to the MOH for review and comment.

Benefit Package

- Ken Cahill visited Bulgaria from October 5 – 14 to assist the MOH with launching discussions on the need to define a basic benefit package that would eventually lead to limiting the services covered by the state to those that are considered essential and fall within the boundaries of the financial and other resources available. During his visit Mr. Cahill met with the Minister of Health, deputy Minister Salshev, The chairman of the parliamentary health commission to discuss their ideas for eventually defining a benefit package.
- It was clear from the discussions that there is confusion/misunderstanding among some of the policy makers between the desire to introduce some form of co-payment and the need to to define a clear basic benefit package compared to what is now referred to as a benefit package which in reality includes all outpatient and inpatient care services.
- Mr. Cahill discussed the need to constrain the expenditures of a national health insurance system. The benefits must be limited in one of four ways.
 - 1) Limitation on Access - access to medical services limited by covering only those services referred by an authorized medical professional.

- 2) Limitation on amount of expenditure covered by insurer - services or drugs may require a co-payment and/or a deductible. The deductible is usually either a flat amount per admission or a fraction of the total charges, not a per diem amount.
- 3) Limitation on eligibility for comprehensive coverage - only those on pensions and/or those with social vulnerability/dependence may be fully covered; others may be subject to more co-payments, deductibles, and exclusions.
- 4) Exclusion on some medical benefits for all beneficiaries or ceiling on total expenditures covered per individual or per family - prioritize all diagnosis and corresponding treatments based on their cost effectiveness in restoring health or preventing disease and disability. The idea is, given a total budget for health services, to cover all medically indigent persons and all uninsured children by reducing the benefit package to fit the size of the budget. All public and private insurance policies include some limits on the benefits, often in the form of a maximum that will be paid out in a given year or over the lifetime of the policy.

Given the above here are some possible options for the mandatory benefits package of the NHIF. Ultimately this will be a political decision based on economic realities

- NHIF covers primary care and prevention for all eligible beneficiaries (this assumes that the primary care and prevention services include only those that have been shown to be cost effective in preventing and treating disease and disability.)
- Hospitals (through MOH and municipal budget subsidies) should provide emergency services/treatments to all eligible beneficiaries/citizens.
- Referrals for specialty care, rehabilitative care and diagnostic testing could be limited as follows:
 1. Only the poor have no co-pays or deductibles.
 2. These beneficiaries may receive the above services only when referred by their primary care physician.
 3. The NHIF could provide only a defined *total annual expenditure* per beneficiary in specialty/diagnostic care even if referred by a primary care physician. If/when the cost is exceeded, the remainder would have to be paid out of pocket.
 4. NHIF should cover life saving/extending drugs based on the formulary and optimizing the use of generics. A co-payment could be required except for the poor as defined above.
- NHIF covers all beneficiaries for most inpatient medical and surgical treatments but a deductible/case payment is required per admission– (this is basic catastrophic health coverage as a hospital stay is often catastrophically expensive for the individual/family).

ANNEX-1
List of People Interviewed for the National Drug Policy Assessment

Name	Title
Almin Adzovic	Country Manager, Merck, Sharp & Dohme
Tatjana Benisheva-Dimitrova	Head of Drug Policy Department, MOH
Borislav Borissov	Executive Director, Bulgarian Drug Agency
Slavcho Bogoev	Minister of Health
Andrew Creese	Health Economist, Essential Drugs and Medicines Policy Department, World Health Organization
Deyan Denev	Executive Director, Association of the Research-Based Pharmaceutical Manufacturers in Bulgaria
Rositsa Dervisheva	Expert, National Assembly Republic of Bulgaria, Committee of Health
Rostislava Dimitrova	Head of Sector, NHIF
Robin Gray	Former Chair of the WHO Model List of Essential Drugs, World Health Organization
David Henry	Professor, University of Newcastle in Australia
Hans Hogerzeil	<i>Coordinator</i> , Essential Drugs and Medicines Policy Department, World Health Organization
Theodora Iovcheva	Eli Lilly, Government Relations
Atanas Iantchev	Bristol-Myers Squibb
Kees de Joncheere	Regional adviser Health technology and Pharmaceuticals, WHO Regional office for Europe
Vladimir Kossev	Country Manager, Wyeth
Mirela Kozareva	External Affairs Manager, Merck, Sharp & Dohme
Dr. Lukas Pfister	Director External Affairs, Central & Eastern Europe, Merck, Sharp & Dohme
The positive list committee	
Petko Salchev	Deputy Minister, Ministry of Health
Ibrahim Shehata	Senior Manager, BearingPoint Inc. and Chief of Party, Bulgaria Health Reform project
Atanas Shterev	Chairman, National Assembly of the Republic of Bulgaria, Committee of Health
Emilia Tontcheva	WHO Liaison Officer
Antony Totev	General Manager, Aventis
Jordanka Valcheva	Chief of Department 'Mediciens', National Health Insurance Fund
Maria Yunakova	Expert, National Assembly Republic of Bulgaria, Committee of Health

ANNEX-2
AGENDA FOR MEDIA SEMINAR ON
INPATIENT CARE REFORM – FINANCING AND ACTIVITIES

VELINGRAD, 10 – 11 OCTOBER 2003

Friday, October 10th

- **12.00** Lunch
- **14.00 – 14.15** **Opening** by the Minister of Health
 Speeches:
 - Mrs. Raina Dimitrova, USAID
 - Dr. D.Petrov, Director of the NHIF
 - Dr. M.Gugushev, member of the Managing Board of the Bulgarian Physicians Union
- **14.15 – 15.30** Budget 2004 – Financial parameters of the Inpatient Care Reform
 Minister Sl.Bogoev

 Discussion
- **15.30 – 16.00** Coffee-break
- **16.00 – 17.00** **A state of the hospitals – financial and medical indicators in the end of 2003**
 Mr. S.Stoyanov, Head of Financial Department, MoH

 Discussion
- **17.00 – 18.00** **Evaluation of health. Health priorities**
 Deputy Minister P.Salchev

 Discussion
- **20.00** Dinner

Saturday, October 11th

- **8.30** Breakfast
- **9.30 – 10.30** Inpatient Care 2004 – evaluation and cost per diagnosis. Implementation of the “Road Map” with the NHIF
 Deputy Minister P.Salchev and Ibrahim Shehata, COP, USAID Bulgaria Health Project



BULGARIA HEALTH REFORM PROJECT

**Contract № PCE – I – 00 – 00 – 00014 – 00
Task Order 810**

NOVEMBER 2003 MONTHLY REPORT

**Prepared for:
USAID Bulgaria**

Prepared by:

***BearingPoint, Inc.*
74-A Bouzloudja St.
Sofia, Bulgaria**

USAID HEALTH PROJECT SUMMARY AND REPORT
Monthly Report No. 5
November 30, 2003

Project Title: Bulgaria Health Reform Project (BHR)
 Contractor: BearingPoint, Inc.
 Contract Number: PCE-I-00-00-00014-00
 Task Order: 810
 Period of Performance: April 30, 2003 – April 29, 2005
 Project Manager: Ibrahim Shehata
 Previous Monthly Report Date: NA

Progress, Accomplishments, Issues and Events

Assessing National Drug Policy

- A report by the Bulgaria Health Project expert, Cheri Grace, who visited Bulgaria in October to assess the national drug policy was finalized and delivered to the Ministry of Health. A copy of the report was also sent to USAID, NHIF, and the Parliamentary health Commission.
- The need for a comprehensive national drug policy (NDP) has been recognised since 1996 but the political will and consensus have been missing.¹ What exists of a national drug policy currently takes the form of numerous uncoordinated laws, activities and policies relating to drug regulation, procurement, distribution, and reimbursement. Examples include:
 - A baseline pharmaceutical assessment completed in 1997
 - The creation of the Bulgarian Drug Agency
 - The creation of the April 2003 Ordinance on the positive list
 - The various NHIF policies relating to contracting with pharmacies and physicians and reimbursement rules²
 - The Drug Act of 1995, providing a framework for development and control of medicinal products
- These activities and policies could be considered as components of a national drug policy, but they remain uncoordinated. This results in a drug policy that, according to those interviewed in the course of this consultancy, lacks predictability, coherence and transparency. With assistance from the World Health Organisation, a working group has been formed and has just started the process of developing a more comprehensive NDP. The driver of this process appears to be a need to align with EU directives in preparation for accession to the European Union (EU). However, the written NDP document, at present, still needs a substantial amount of work. It consists of little more than a series of unprioritised bullet points for action, not linked to any kind of a situation analysis, whereas

¹ Benisheva, T. et al, 'Indicators for Monitoring National Drug Policy in Bulgaria' 1997.

² Annex to the State Gazette, No. 42 of 2000

the objective of a NDP should be to set out and prioritise the goals and the strategies for achieving access, quality and rational use of pharmaceuticals, based on a baseline study of the problems in relation to these parameters.

- The way that the reimbursement system has been implemented in Bulgaria appears to follow an incremental policy planning approach: i.e. implement and then see what happens and then reform the system and see what happens again, and so on. This constant ‘tweaking’ of the system has been done in the absence of data on the incentives embedded in the reimbursement system – data which would be needed in order to make more rational and transparent decisions based on evidence.
- Generally speaking, the reimbursement policy should be efficient, equitable, transparent, predictable for manufacturers, good for access to medicines and for health outcomes, and finally, it must correspond to the available finance. In the meantime a range of options exist for controlling drug expenditure. The option(s) most appropriate for Bulgaria will depend upon historical, cultural, economic, and political factors as well as a technical assessment of what can best address identified problems in the current system. A comprehensive pharmaceutical sector assessment will be a first step in identifying problems with the current system, and in learning where gains can be made in terms of efficiency and equity.

Private Health Insurance Supervision

- Tom Power, the Project’s insurance supervision expert was in Bulgaria October 26 – November 14. The purpose of his trip was to assist the Insurance Directorate of the Financial Supervision Commission (FSC) with drafting regulatory framework of supervision over voluntary health insurance – regulation on audit, reporting, reinsurance and registration. He also assisted with drafting instructions for the implementation of international accounting standards by voluntary health insurance companies.
- Mr. Power conducted a three-week seminar on various topics respecting supervision of voluntary health insurance companies: namely, comparisons of EU, USA and other countries’ methodologies and practices; the various frameworks employed for voluntary health insurance; the legal bases of supervision and the sufficiency of them in the Bulgarian context; the need for additional laws or ordinances in Bulgaria; internationally acceptable insurance accounting standards; importance and structure of systems of internal control/internal audit for financial institutions; dealing with intermediaries as a supervisor; theory and practice of reinsurance in the health sector; and risk-sensitive early warning indicators for insurance companies. The attendees were members of the voluntary health insurance division of the Financial Services Commission.
- There is an urgent need for drafting manuals and conducting training respecting on-site and off-site financial condition manuals, a market conduct examination manual, internal procedures manuals and some technical manuals relative to statistical sampling methods and reserving methodology.

- Regulations dealing with consumer protection (such as claims practices and unfair trade practices) should be given priority. Also needed is a regulation on dispute resolution procedures that would be more user-friendly to the public and not require engagement of private attorneys.
- A key policy issue that will affect the future of the growth of the financial institutions sector (including the health insurance sector) is the reliability of the supervisory system. Additionally, the supervisory authority must have credibility with the regulated industries, the Parliament and with the public. At present, at least for the VHIC sector, there is not sufficient broad and deep regulatory capacity. However, the staff appear eager and should respond well to additional training. The solution to this problem is clearly sustained and intense on-site technical assistance. This could take the form of on-the-job training by having experienced insurance regulators work together with local counterparts. Moreover, since financial institution regulation is vested in a unified agency (The FSC) it makes sense for this technical assistance to go beyond health insurance and encompass the entire regulatory writ of the FSC.
- The currently licensed VHICs are unsure of their market niche. This is largely due to an overly broad National Health Insurance benefit package that leaves virtually no role for the private sector in theory. In practice, of course, the likelihood of the NHI package actually delivering all that is promised is open to debate. While this is a public policy issue beyond the SOW of this project, it needs to be resolved if the private sector is to have a significant role in the health sector financing system.
- The issue of the subscription plans needs to be settled. Part of the problem is that the FSC is relying on the MOH to gather information about the actual activities of the subscription plans and determining if their services fall within the scope of the VHIC legislation and require licensing and supervision. To the extent that the subscription plans are acting as risk assumption mechanisms and intermediaries and not merely as health care providers, there must be some degree of supervision in order to protect the public interest. The Health Insurance Act needs to be revisited and the issue of the subscription plans needs to be settled unambiguously.

Inpatient Care Financing

- The technical working group assigned with proposing a consolidated data set for hospitals to provide to the NHIF's case mix office and the MOH's National Health Informatics Center met twice during the month with experts from the Parliamentary Health Commission also attending. However, it was clear that the only party that came prepared for the meetings was the NHIF team. Later it was agreed that Dr. Javor Drenski, the working group chairman, would propose the data set that was initially developed by Ms. Jugna Shah and revised by him to the deputy minister of health.
- Dr. Drenski, the chairman of the technical working group met with Dr. Salshev, Prof. Grieva, the director of the NHIC and the Health Project's COP to discuss the consolidated data set. The goal is to reach consensus about the clinical and cost data submitted by hospital for the purpose of developing a standardized database. Prof. Grieva agreed to review the data set before giving his approval. The proposed data set is attached in Annex-1.

- The data provided by hospitals shall:
 1. Enable efficient utilization and management of funds as well as improve quality of health care;
 2. Enable medical statistic reports in compliance with the requirements of the MoH and the NHIF and other relevant institutions;
 3. Improve communication with hospitals, decrease administrative burden and redundancy of reporting;
 4. Guarantee transparency of financing, performance and costs of hospitals;
 5. Enable the evaluation of hospitals' costs;
 6. Enable contrastive analysis at national and regional level and hospital accreditation based on performance and costs incurred;
 7. Enable quality assurance;
 8. Enable classification by diagnoses and procedures;
 9. Enable decision making related to hospital management;
 10. Enable the implementation of information standards in health care.

- The NHIF shall be responsible for data analysis for the needs of the hospital payment system as well as drafting proposals for amendments to classification systems as needed and developing criteria for changing the patient classification system and updating the coding system selected.

Hospital Restructuring and Rationalization

- The team conducting the hospital assessment in the Stara Zagora region continued with their hospital visits and interviews. The team visited three additional hospitals in November and were joined by Bill Lane, a Health Project consultant, who will be working with the team on assessing the region's hospitals.
- The Lovech hospital assessment report was revised based input from and the project's COP and the Ministry of Health. The final report is currently being translated into Bulgaria before dissemination.

ANNEX – 1 Consolidated Data Set

GENERAL REQUIREMENTS TO ALL HOSPITALS

I. Clinical data elements

Data on the hospital structure and the catchment area

Departments

1. Department code
2. Department title
3. Unit type /administrative, clinical, Para clinical, surgery, etc./
4. Annual standard for utilization by bed type

Beds

1. Department
2. Number or beds /by type per month /
3. Number of temporarily closed beds /per month /

Physicians by department /by payroll /

Data on patients and services

Admitted patients

1. Year
2. Patient record (history of disease) No
3. Department of discharge
4. Health Region of the patient
5. Municipality of the patient
6. Title
7. Name
8. Second name
9. Surname
10. Date of birth
11. ID No
12. Gender
13. Age
14. Age in days for children under 1
15. Weight in grams for newborns
16. Patient record year and number for mothers /of newborns/
17. Town/village
18. Address
19. Contact person
20. Phone
21. Citizenship
22. Marital status
23. Education
24. Profession

25. Social status
26. Blood type
27. Rhesus factor
28. Insurance number??
29. Insurer ??
30. Type of insurance??
31. Date and time of admission
32. Municipality/emergency catchment area/
33. Referring physician
34. Does the referring physician have a contract with the NHIF?
35. CCP as per referral
36. Diagnosis as per referral
37. Secondary diagnosis as per referral
38. Preliminary tests for diagnostics or under CCP
39. Referring hospital code
40. Referring physician code
41. Referral No ??
42. Emergency/scheduled
43. Referred on (date of issuance)
44. Reason for admission (treatment, testing, expertise, other)
45. Does the admitting hospital have a contract with the NHIF?
46. Admitting physician
47. Second admitting physician
48. Date of the first hospital visit
49. Date of scheduled admission
50. Emergency/scheduled admission
51. Emergency hours /how long after the emergency was the patient admitted/
52. Villager
53. Severity at admission
54. Allergies and counter indications
55. Treatment type – day care or regular admission
56. Informed Consent signed yes/no
57. Date and time of signing the Informed Consent
58. Planned referral to another hospital

59. Date and time of discharge /death /
60. Status at discharge /referred, discharged, deceased/
61. Refusal of treatment
62. Receiving hospital
63. Reason for referral
64. Diagnosis for referral
65. Status at discharge (healthy, improved, no change, exacerbated/
66. Incapacity for work – permanent or temporary
67. Date on the incapacity for work certificate
68. Bed days and regime
69. Treating physician /the last who finished the treatment/
70. Diagnosis at admission

71. Second Diagnosis at admission
72. CCP at admission
73. Leading diagnosis
74. CCP at discharge
75. Accompanying diseases
76. Complications
77. Histological diagnosis
78. No post mortem required
79. Cause of death
80. Pathological and anatomy diagnoses
81. Bed days by CCP out of total bed days
82. Codes of deviations from CCPs
83. Deviation 1 (yes/no)
84. Deviation 2 (yes/no)
85. Deviation 3 (yes/no)
86. Deviation 4 (yes/no)
87. Deviation 5 (yes/no)
88. Deviation 6 (yes/no)

89. Quality indicator 1 (cost)
90. Quality indicator 2 (cost)
91. Quality indicator 3 (cost)
92. Quality indicator 4 (cost)
93. Quality indicator 5 (cost)
94. Quality indicator 6 (cost)

95. Coder
96. Coding date

97. ГДК
98. GDP

Curative process by department

1. Department code
2. No as per department journal
3. Date and time of admission
4. Date and time of discharge
5. CCP /if applicable/
6. Treating physician
7. Accompanying relatives (yes/no)
8. Room
9. Bed
10. Days in status I
11. Days in status II
12. Days in status III
13. Days in status IV

Data on surgery and diagnostics

1. Department code
2. Operating suite No
3. No as per operating suite journal
4. Procedure No /by severity, by importance /
5. Patient (admitted, one-day)
6. Department
7. Operated on by unit/department/suite
8. Procedure/operation code
9. Operation or procedure
10. in the operating suite or not
11. Number of procedures/operations
12. Surgical diagnosis
13. Operation start time
14. Operation end
15. Anesthetic start time
16. Anesthetic end
17. Surgeon
18. Assistant 1
19. Assistant 2
20. Anesthesiologist
21. Surgical nurse
22. Operator apparatus lung-heart
23. Anesthesiological nurse
24. Reoperation yes/no
25. Emergency/scheduled and hours of emergency
26. Anesthetic type
27. Anesthetic scope
28. Chemical substance used
29. Post-op complications



BULGARIA HEALTH REFORM PROJECT

**Contract № PCE – I – 00 – 00 – 00014 – 00
Task Order 810**

DECEMBER 2003 MONTHLY REPORT

**Prepared for:
USAID Bulgaria**

Prepared by:

***BearingPoint, Inc.*
74-A Bouzloudja St.
Sofia, Bulgaria**

USAID HEALTH PROJECT SUMMARY AND REPORT
Monthly Report No. 6
December 31, 2003

Project Title: Bulgaria Health Reform Project (BHR)
 Contractor: BearingPoint, Inc.
 Contract Number: PCE-I-00-00-00014-00
 Task Order: 810
 Period of Performance: April 30, 2003 – April 29, 2005
 Project Manager: Ibrahim Shehata
 Previous Monthly Report Date: NA

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4. Annual standard for utilization by bed type

Beds

1. Department
2. Number or beds /by type per month /
3. Number of temporarily closed beds /per month /

Physicians by department /by payroll /

Data on patients and services

Admitted patients

1. Year
2. Patient record (history of disease) No
3. Department of discharge
4. Health Region of the patient
5. Municipality of the patient
6. Title
7. Name
8. Second name
9. Surname
10. Date of birth
11. ID No
12. Gender
13. Age
14. Age in days for children under 1
15. Weight in grams for newborns
16. Patient record year and number for mothers /of newborns/
17. Town/village
18. Address
19. Contact person
20. Phone
21. Citizenship
22. Marital status
23. Education
24. Profession

25. Social status
26. Blood type
27. Rhesus factor
28. Insurance number??
29. Insurer ??
30. Type of insurance??
31. Date and time of admission
32. Municipality/emergency catchment area/
33. Referring physician
34. Does the referring physician have a contract with the NHIF?
35. CCP as per referral
36. Diagnosis as per referral
37. Secondary diagnosis as per referral
38. Preliminary tests for diagnostics or under CCP
39. Referring hospital code
40. Referring physician code
41. Referral No ??
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45. Does the admitting hospital have a contract with the NHIF?
46. Admitting physician
47. Second admitting physician
48. Date of the first hospital visit
49. Date of scheduled admission
50. Emergency/scheduled admission
51. Emergency hours /how long after the emergency was the patient admitted/
52. Villager
53. Severity at admission
54. Allergies and counter indications
55. Treatment type – day care or regular admission
56. Informed Consent signed yes/no
57. Date and time of signing the Informed Consent
58. Planned referral to another hospital

59. Date and time of discharge /death /
60. Status at discharge /referred, discharged, deceased/
61. Refusal of treatment
62. Receiving hospital
63. Reason for referral
64. Diagnosis for referral
65. Status at discharge (healthy, improved, no change, exacerbated/
66. Incapacity for work – permanent or temporary
67. Date on the incapacity for work certificate
68. Bed days and regime
69. Treating physician /the last who finished the treatment/
70. Diagnosis at admission

71. Second Diagnosis at admission
72. CCP at admission
73. Leading diagnosis
74. CCP at discharge
75. Accompanying diseases
76. Complications
77. Histological diagnosis
78. No post mortem required
79. Cause of death
80. Pathological and anatomy diagnoses
81. Bed days by CCP out of total bed days
82. Codes of deviations from CCPs
83. Deviation 1 (yes/no)
84. Deviation 2 (yes/no)
85. Deviation 3 (yes/no)
86. Deviation 4 (yes/no)
87. Deviation 5 (yes/no)
88. Deviation 6 (yes/no)

89. Quality indicator 1 (cost)
90. Quality indicator 2 (cost)
91. Quality indicator 3 (cost)
92. Quality indicator 4 (cost)
93. Quality indicator 5 (cost)
94. Quality indicator 6 (cost)

95. Coder
96. Coding date

97. ГДК
98. GDP

Curative process by department

1. Department code
2. No as per department journal
3. Date and time of admission
4. Date and time of discharge
5. CCP /if applicable/
6. Treating physician
7. Accompanying relatives (yes/no)
8. Room
9. Bed
10. Days in status I
11. Days in status II
12. Days in status III
13. Days in status IV

Data on surgery and diagnostics

1. Department code
2. Operating suite No
3. No as per operating suite journal
4. Procedure No /by severity, by importance /
5. Patient (admitted, one-day)
6. Department
7. Operated on by unit/department/suite
8. Procedure/operation code
9. Operation or procedure
10. in the operating suite or not
11. Number of procedures/operations
12. Surgical diagnosis
13. Operation start time
14. Operation end
15. Anesthetic start time
16. Anesthetic end
17. Surgeon
18. Assistant 1
19. Assistant 2
20. Anesthesiologist
21. Surgical nurse
22. Operator apparatus lung-heart
23. Anesthesiological nurse
24. Reoperation yes/no
25. Emergency/scheduled and hours of emergency
26. Anesthetic type
27. Anesthetic scope
28. Chemical substance used
29. Post-op complications