RESOURCES LOCATION QUESTIONNAIRE

BULGARIA

California University Berkeley

This questionnaire is designed to investigate various aspects of resource allocation in mental health in your country. The questionnaire is not perfect, it may happen that a) some question is not applicable to your country, b) a question is wrongly stated or is not understandable to you, c) a question is too complex, d) a question on important issue in your country is missing. In all these cases, please contact me for further explanation or with your suggestions from which all team members will benefit.

The objective of this exercise is to obtain both qualitative as well as quantitative description of national mental health system for each participating country. This document allows structured international comparison and will be the main basis for writing papers and final report in our project.

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The theme of the post-traumatic stress turned out to be crucial both for the focus group participants - victims of organized violence and for the second and third generation. In the modern context of transition from totalitarian to democratic system the symptoms of this stress come back to life in the form of re-trauma, and the psychological mechanisms of denial and unfinished grief work are very strong. The discourse in the focus group and in the social reference group, as well as the analysis of the data imply that the interventions for people - victims of organized violence, should step out of the strict therapeutic work and support to incorporate the wider social and political context. ........................................ 20

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Country: Bulgaria

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Contact: mhproject@mbox.contact.bg

Last update: 15/07/2008
1. Basic country information (population, health, national economy)

Table 1.1: Population and Health

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (mid-year)</td>
<td>8,384,700</td>
<td>8,149,500</td>
<td>7,801,300</td>
<td>7,761,000</td>
<td>7,718,800</td>
<td>7,679,290</td>
</tr>
<tr>
<td>Life expectancy at birth - males</td>
<td>67.11</td>
<td>68.15</td>
<td>68.68</td>
<td>69.11</td>
<td>69.02</td>
<td>69.07</td>
</tr>
<tr>
<td>Life expectancy at birth - females</td>
<td>74.85</td>
<td>75.34</td>
<td>75.59</td>
<td>76.22</td>
<td>76.34</td>
<td>76.32</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>14.8</td>
<td>13.3</td>
<td>12.3</td>
<td>11.6</td>
<td>10.4</td>
<td>9.7</td>
</tr>
<tr>
<td>Physicians per 1000 inhabitants</td>
<td>3.46</td>
<td>3.37</td>
<td>3.6</td>
<td>3.52</td>
<td>3.65</td>
<td>3.66</td>
</tr>
<tr>
<td>Hospital beds per 1000 inhabitants</td>
<td>10.38</td>
<td>7.41</td>
<td>6.29</td>
<td>6.13</td>
<td>6.42</td>
<td>6.21</td>
</tr>
</tbody>
</table>


Table 1.2: Main Economic Indicators

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>%GDP</td>
<td>4.0</td>
<td>4.4</td>
<td>4.9</td>
<td>4.6</td>
<td>4.7</td>
<td>4.1</td>
<td>4.2</td>
</tr>
<tr>
<td>% Inflation (consumer price index)</td>
<td>4.8</td>
<td>3.8</td>
<td>5.3</td>
<td>4.3</td>
<td>7.4</td>
<td>6.1</td>
<td>11.6</td>
</tr>
<tr>
<td>%Unemployment</td>
<td>19.5</td>
<td>16.8</td>
<td>13.7</td>
<td>12.0</td>
<td>10.1</td>
<td>9.0</td>
<td>6.9</td>
</tr>
<tr>
<td>BGN/EUR (annual average of the daily nominal exchange rates of BGN to EUR)</td>
<td>1.96</td>
<td>1.96</td>
<td>1.96</td>
<td>1.96</td>
<td>1.96</td>
<td>1.96</td>
<td>1.96</td>
</tr>
<tr>
<td>BGN/USD (average)</td>
<td>2.19</td>
<td>2.07</td>
<td>1.72</td>
<td>1.57</td>
<td>1.58</td>
<td>1.55</td>
<td>1.42</td>
</tr>
<tr>
<td>Average gross monthly wage per full-time equivalent³</td>
<td>240</td>
<td>258</td>
<td>273</td>
<td>292</td>
<td>324</td>
<td>360</td>
<td>408</td>
</tr>
<tr>
<td>Average gross monthly wage physicians</td>
<td>182</td>
<td>258</td>
<td>323</td>
<td>367</td>
<td>441</td>
<td>454</td>
<td>513</td>
</tr>
</tbody>
</table>

2. Health Care Financing

Question 2.1 How is health care financed in your country?

The financing of the health care in Bulgaria is based on obligatory insurance model with large range of solidarity. The State has important role for financing some strategic areas as emergency care, blood-transfusion, inpatient psychiatric care and others. The state budget also contributes in the Insurance model for some categories of citizens who’s premiums are paid by the state or municipal budget. There are private funds for additional (optional) services as well as services from the defined basic package by the State and National Insurance Fund (see answers below). There is also private payments regulated for the private providers.

Please, provide data for your country

Table 2.1: Health Care Expenditures by Source of Financing

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care financed from public budgets (national, regional, municipal) as % of THE</td>
<td>87.4</td>
<td>65.2</td>
<td>61.8</td>
<td>55.2</td>
<td>46.4</td>
<td>44.7</td>
<td>37.3</td>
<td>33.9</td>
</tr>
<tr>
<td>Public health insurance as % of THE</td>
<td>12.6</td>
<td>34.8</td>
<td>38.2</td>
<td>44.8</td>
<td>53.6</td>
<td>55.3</td>
<td>65.7</td>
<td>66.1</td>
</tr>
<tr>
<td>Private expenditures as % of THE</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total health expenditures as % of GDP</td>
<td>3.7</td>
<td>4.0</td>
<td>4.4</td>
<td>4.9</td>
<td>4.6</td>
<td>4.7</td>
<td>4.1</td>
<td>4.2</td>
</tr>
</tbody>
</table>


Question 2.1.1 Is public insurance compulsory in your country? If not, what population groups are insured voluntarily or excluded from the public system?

Yes, the health insurance in Bulgaria is obligatory for all the citizens since 1999 when the Law for health insurance was adopted. The health insurance is separate from the social insurance, which is a responsibility of the National Insurance Institute established in 1995 as a successor of the State Insurance Institute since 1941. The premium for the services that are provided under the public insurance is 6% of the total income of the self-insured and divided on 70:30 employer/employee for persons working on contract.

Question 2.2.2 What is a role of private insurance in your country?

The private insurance is regulated in the same Law for health Insurance as optional for all those who want to be additionally insured along with the obligatory public insurance. There are 17 private funds but their impact on the insurance in the country is less then 1%.
Most of the funds work as simple insurance companies based on reimbursement of incident expenditures without defining and announcing package of services or some insurance scheme. The role of the funds is insignificant so far because of the specifics in the law (see Quest. 2.5.1).

**Question 2.2** Are there any separate financing mechanisms for mental health in your country or is mental health part of the general budget/public insurance? Is part of mental health services paid by the government, social insurance, municipalities or other sources? If yes, describe.

According to the Health Facilities Act since 1999 all the inpatient mental health care is financed by the state. That means all the psychiatric hospitals in the country, psychiatric wards in general hospitals and inpatient unit in the community based mental health centers (dispensaries)\(^1\). The outpatient mental health care is financed by the National Health Insurance Fund, when there is a contract between the provider and the Fund. There are also totally private practices – individual or group – without contract with the Fund.

**Question 2.3** What legal cost-sharing (copayments or charges) is paid directly by patients? Distinguish the cost-sharing as part of health insurance and direct payments for private health services. Please specify if there are some differences for mental health.

There is no co-payment in Bulgaria in the sense of cost-sharing by the patients. The only legal payment out of pocket that is stipulated in the Law is consumer tax which is 1% of the minimal salary for the country for each visit to the outpatient care and 2% for the inpatient care but no more than for 20 days after the admission. Number of social groups (including persons with some level of disability because of mental disorder), are free of this obligation. The inpatient mental health care also is free of consumer tax of 2%. Last governmental decisions are even that payment to be removed for all the consumers of health services, starting from 2009.

**Question 2.4** Do you have any information and data about existing practices of corruption in the health system in your country? Are there any specifics related to mental health?

The topic about corruption is quite popular recently in the country and health care is not exclusion. According to some surveys (Open Society Foundation Report on Informal payments in the health care in Bulgaria, 2008) the informal payments in the system do not exceed 75 ml. leva – about 40 ml. Euro. These payments are considered as illegal because of lack of document for the payment. The total out of pocket payment, by the consumers are estimated on 160 ml. – about 75 ml. Euro. These payments are only for medical services and do not include all the expenditures for drugs, consumables, medical assistance means etc. estimated on more than 800 ml. leva. The regular corruption in the health care system is not so high among the mental health care consumers and especially for those with severe mental disorders. The corruption in that field is more related with the influence of the pharmaceutical companies on central level when list of drugs subject of reimbursement by the National Health Insurance Fund is defined.

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\(^1\) The “dispensaries” for mental health are old-fashioned structures established on regional level in the country. They are financed by the municipalities, which receive ear-marked budget as contribution from the state.
Question 2.5 Describe organizational structure of the health insurance system in your country.
The Health Insurance Fund is structured following the administrative division of the country – i.e. – 28 regional branches and one central administration. It is a public institution headed by assembly of representatives of the Insured people, State, Syndicates and Employers. The Assembly selects managerial board headed by director and vice directors. There are several directorates in the central administration on different topics – financing, audit, contracts with providers, human resources etc. The 28 regional branches are headed by directors, subordinated to the central administration. The National Health Insurance Fund is reporting to the Parliament, which takes decision for the annual budget of the Fund.
The system of obligatory insurance in Bulgaria is based on contracts on every level – starting from the National framework contract that is concluded annually between the representatives of the Fund, Ministry of health and Bulgarian medical and dentist associations. Within the stipulations in the Framework contract variety of group or individual contracts are concluded in the beginning of each year. More information about the Fund could be found on its website www.nhif.bg

Question 2.5.1 If there is more than one fund in your country, do they compete for members?
According to the Law the private funds could provide the same package of services as the national fund but those who decided to insure themselves in private funds are not free of the obligation to pay premiums to the National Fund. This duplication does not create basis for competition between funds, on the contrary – it prevents citizens from choosing the private funds because of double payment for the same package. According to the last governmental decisions, after 2009 the total premium for the health insurance will increase up to 8 % of the total personal income. The additional 2% will be distributed among the private funds after defining the service packages that are subject of public or private insurance.

Question 2.6 How are insurance contributions paid? Who pays contributions for those without income?
The first stipulation in the Law from 1998 is 70:30 % sharing the premium of 6% between the employer and employee. In 2008 it is 60:40 and the tendency is this proportion gradually to be equalized to 50:50 after some period.

Question 2.7 What problems or reforms concerning financing in general and specifically mental health financing are currently discussed?
The most important problem for the moment is that according to the existing legislation the mental health hospitals cannot conclude contracts with the Insurance fund(s). There is no specific ban for that in the Law but it is implicitly stipulated that these hospitals are subject of care by the State respectively they must be financed only by the State through the Ministry of Health. The Bulgarian health care reform transformed all the medical facilities into commercial companies of different kind – share companies, limited companies, cooperatives etc. This differentiation is more or less provisional and has implications related with the registration and some financial independency – especially for the municipal hospitals where 100% of the property of the hospital is municipal although it is also supported by the state budget. The main discussion for the time being is: is there a possibility for the mental hospitals to conclude contracts with the NHIF or private fund
being 100% state property? The last question is related with definition of “a psychiatric clinical pathway” – the common instrument for payment of the inpatient care by the NHIF. There are about 300 clinical pathways that cover almost all the medical diagnoses except psychiatric ones. There is readiness to formulate psychiatric pathways for inpatient care but there is no official guarantee that it will be accepted by the government.
On the other hand – in the outpatient care there is a possibility for contracts with the Fund as well with other private funds which situation creates some inequality between these services.

**Question 2.8 Are the sickness benefits or (other any other benefits) included in health insurance or are they administered separately?**
The sickness benefits are separated from the health insurance scheme. They are paid by the National Insurance Institute to the employer except in the cases of self-employment when they are paid directly to the sick person.

### 3. Mental Health Services
*Here will be data on mental health services, their utilisation and organization.*

#### Table 3.1 Outpatient mental health services (including independent practices, outpatient departments of hospitals and alcohol and drug centres)

<table>
<thead>
<tr>
<th>Year</th>
<th>Physicians in outpatient mental health services in full time equivalents (from that psychiatrists)</th>
<th>Psychologists</th>
<th>Nurses and other personnel</th>
<th>Number of patients treated</th>
<th>Number of consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>277&lt;sup&gt;1&lt;/sup&gt;</td>
<td>N/A</td>
<td>N/A</td>
<td>234 127&lt;sup&gt;1&lt;/sup&gt;</td>
<td>955 357&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>2003</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>231 471</td>
<td>N/A</td>
</tr>
<tr>
<td>2004</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>212 694</td>
<td>N/A</td>
</tr>
<tr>
<td>2005</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>182 036</td>
<td>N/A</td>
</tr>
<tr>
<td>2006</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>175 677</td>
<td>N/A</td>
</tr>
<tr>
<td>2007</td>
<td>428&lt;sup&gt;2&lt;/sup&gt;</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**SOURCE:** National Statistical Institute (NSI) of the Republic of Bulgaria, www.nsi.bg
National Center of Health Informatics (NCHI) of the Republic of Bulgaria, www.nchi.government.bg

**Note 1:** Beshkov. N., Manual” The Psychiatric care in Bulgaria 1998”
**Note 2:** NHIF: Number of psychiatrists on contract with NHIF - 2007
### Table 3.2 Psychiatric hospitals (usually long-term care, but may include acute care)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of psychiatric hospitals in the country</th>
<th>Number of beds total and (per 10 000)</th>
<th>Number of discharges</th>
<th>ALOS in days</th>
<th>Personnel total</th>
<th>In that physicians in FTE(^1)</th>
<th>In that nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>24</td>
<td>5270</td>
<td>26 065</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2000</td>
<td>23</td>
<td>4534</td>
<td>23 365</td>
<td>48.67</td>
<td>N/A</td>
<td>750</td>
<td>N/A</td>
</tr>
<tr>
<td>2001</td>
<td>23</td>
<td>4534</td>
<td>22 759</td>
<td>47.42</td>
<td>N/A</td>
<td>646</td>
<td>N/A</td>
</tr>
<tr>
<td>2002</td>
<td>23</td>
<td>4244</td>
<td>24 121</td>
<td>44.76</td>
<td>N/A</td>
<td>625</td>
<td>N/A</td>
</tr>
<tr>
<td>2003</td>
<td>23</td>
<td>4164</td>
<td>24 203</td>
<td>45.04</td>
<td>N/A</td>
<td>646</td>
<td>N/A</td>
</tr>
<tr>
<td>2004</td>
<td>23</td>
<td>4128</td>
<td>25 555</td>
<td>41.68</td>
<td>N/A</td>
<td>610</td>
<td>N/A</td>
</tr>
<tr>
<td>2005</td>
<td>24</td>
<td>3673</td>
<td>25 521</td>
<td>38.98</td>
<td>N/A</td>
<td>608</td>
<td>N/A</td>
</tr>
<tr>
<td>2006</td>
<td>24</td>
<td>3294</td>
<td>26 438</td>
<td>38.16</td>
<td>N/A</td>
<td>611</td>
<td>N/A</td>
</tr>
<tr>
<td>2007</td>
<td>24</td>
<td>4295</td>
<td>28 053</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

National Center of Health Informatics (NCHI) of the Republic of Bulgaria, www.nchi.government.bg

**Note 1:** This is the number of all psychiatrists obtained specialty in Bulgaria

### Table 3.3 Psychiatric departments in general (acute) hospitals

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of general hospitals with psychiatric dpt.</th>
<th>Number of beds total and (per 10 000)</th>
<th>Number of discharges</th>
<th>ALOS in days</th>
<th>Physicians in FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>16</td>
<td>1600</td>
<td>10 384</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2000</td>
<td>16</td>
<td>1021</td>
<td>9281</td>
<td>31.64</td>
<td>N/A</td>
</tr>
<tr>
<td>2001</td>
<td>18</td>
<td>1005</td>
<td>9212</td>
<td>32.17</td>
<td>N/A</td>
</tr>
<tr>
<td>2002</td>
<td>18</td>
<td>865</td>
<td>9193</td>
<td>30.65</td>
<td>N/A</td>
</tr>
<tr>
<td>2003</td>
<td>18</td>
<td>818</td>
<td>9672</td>
<td>29.65</td>
<td>N/A</td>
</tr>
<tr>
<td>2004</td>
<td>19</td>
<td>823</td>
<td>12 180</td>
<td>23.21</td>
<td>N/A</td>
</tr>
<tr>
<td>2005</td>
<td>18</td>
<td>805</td>
<td>13 099</td>
<td>21.08</td>
<td>N/A</td>
</tr>
<tr>
<td>2006</td>
<td>20</td>
<td>717</td>
<td>14 990</td>
<td>15.88</td>
<td>N/A</td>
</tr>
<tr>
<td>2007</td>
<td>20</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

National Center of Health Informatics (NCHI) of the Republic of Bulgaria, www.nchi.government.bg

**Question 3.1** Outline the ownership and management arrangements that apply in provider organisations. Are there any specifics regarding the mental health services?  
The mental health hospitals in Bulgaria are 100% State ownership. The outpatient mental health facilities are private and municipal (see the answer to Quest 2.7.). There are also facilities concerned with psychosocial rehabilitation under the governance of the Ministry of
Labour and Social Policy (MLSP) – day care centers, protected houses, hospices etc. Some of these services are run by NGO’s and have public-private character. It is done through delegation of the functions to an NGO by MLSP or by private enterprise financed by donors.

**Question 3.2 Are there any problems with access to mental health services?** For example: the services are not available at all, geographical distribution of services is uneven, financial barriers exist, the catchment areas are not outlined etc.

There are problems with the access to the health care facilities especially in the remote areas in the country. It is valid as well for the mental health services especially community based mental health centers and specialised care. The restricted access is mostly because of geographical reasons than because of lack of money on behalf of the consumers. The distribution of the mental health facilities – hospitals, psychiatric wards and dispensaries is uneven across the country. This fact creates problems for admissions - sometimes away from the living area.
4. Purchasing health services

Question 4.0 Is there any separate budget for mental health services or not? If yes, in each question below describe purchasing mechanism for physical and mental health services separately. If not, describe general principles of purchasing.

There is a separate budget for inpatient mental health services as part of the budget of the ministry of Health. The outpatient budget is divided on budget by Insurance Fund and private.

Question 4.1 What organisations have the responsibility for purchasing health services? (e.g., public health insurance or sickness funds, district/regional/national government agencies, primary organisations, private organisations). Could you also indicate whether these are public sector, private not-for-profit and/or private for-profit organisations?

As described above, there is one National Health Insurance Fund with 28 branches all over the country. There are also 17 private funds, operating in parallel with the NHIF. The process of purchasing health services is based on the provisions of the National Framework Contract, which is concluded each year after negotiations between the representatives of the NHIF and Bulgarian Medical Assembly and Bulgarian Assembly of dentists. The system is criticized because of limited representation of the providers – it does not include hospitals’ associations, nurses, association of pharmacists and other organizations. There is a tendency the number of negotiating organizations to be widened with the mentioned above along with other changes of the insurance model after 2009 (see Quest. 2.5.1). After finalization of the annual negotiations (which comprise the scope of services, the number of clinical pathways, number of referrals to secondary care, price list of drugs reimbursed by the NHIF etc.), the Contract is approved by the Ministry of health as a guarantee that the negotiated level of services will be not below the basic package of services which is outlined by the Ministry of Health in the secondary legislation. Only after official announcement that the NFC is signed the individual contracts between providers – hospitals, specialized care and primary care are going to be concluded. The contracts are made between the local providers and regional branch of the NHIF, following the conditions in the framework contract, which are negotiated for the particular year. For the private funds there is no such a procedure – everybody who wants to have additional insurance with them could do that any time of the year.

Question 4.2 What are the ownership and management arrangements that apply in these organisations.

The NHIF is Public organisation, which reports to the Parliament. The last defines its budget as part of the total health care budget for the country. The management is described in the Law for health Insurance (see Quest. 2.5.)

Question 4.3 We want to obtain some idea of the relative size and importance of organisations responsible for purchasing within the overall health sector. For each

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2 The existing problem here is that basic package is quite large and includes almost all the medical services that are offered and most of them are underestimated.
category could you indicate, what proportion of the population is covered by them and their share of the overall health budget?
To the moment, NHIF is covering almost all the medical services in outpatient and hospital care with exclusion for the inpatient mental health care. The 17 private funds cover about 1% of the all the medical expenditures (the reasons for that described in Quest. 2.5.1). There is no reliable data about the private sector but by other estimations it is not considered as statistically important.

**Question 4.4 How many separate organisations are there within each category? (e.g. how many individual health insurance funds, regional governments).**

17 private funds are registered to the time being.

**Question 4.5 In comparison with the present situation, have there been any major changes in the number of purchasing organisations, their size and their organisation and management over the past 5 years that led to the present situation? Briefly describe these changes.**

The number of the private funds increases gradually through the years since 2001 when the system started to be fully operational. Their number varied from 6-8 to 14 over the period but recently it has significant increase because of expected changes in the model that will allow more opportunity for them to participate in the purchasing process.

**Question 4.6 How do purchasing organisations receive their budgets and on what basis? (e.g. allocations from a central fund on a capitation basis, direct premium payments from insurees, capitation payments etc.). Does the government undertake risk pooling or revenue sharing between purchasers**

The insurance funds are collecting premiums from the insured citizens. For the national Fund it is 6% from the total income, for the private ones – it differs according to their estimations of the risk. The government do not take risk pooling between purchasers because the NHIF takes the biggest part of the package. The revenue sharing system will be introduced from 2009 when additional 2% from the increased premium of 8% total will be shared between private funds, but only those, that meet some official requirements. Strict provisions against eventual “cream skimming” phenomena are foreseen (e.g. fines, administrative measures etc.).

**Question 4.7 Briefly describe the type of health services purchased by purchasing organisations (e.g. outpatient services, hospital services, primary health care services. Does the range of services offered by different purchaser organisations differ?**

There are definitions of the packages of services for outpatient and inpatient care published as attachments to the National Framework contract. The package for the specialized outpatient care is divided on basic (there are sub-packages for all the specialities) and highly specialized services. Medical activities within the basic package for a particular speciality are paid per visit. Highly specialised services are paid separately according to a price list. The primary care (general practitioners) is paid on a base of capitation, combined with payment for specific programs (elderly people, children, prevention etc.). The private funds
could offer different packages but only few of them – most prefer to apply the reimbursement model for insuring based on some estimated risk.

Question 4.8 Are there any plans for changes in purchasing process? Or are there any major criticisms of the present purchasing mechanisms?

See answers to Quest. 2.3, 2.5.1, 4.6

Question 4.9 Can the consumers choose the purchaser organisation that purchases services on their behalf? Is there competition between purchaser organisations for consumers / insurees?

For the time being there is no real competition between funds – the public one and private (see Quest 3.5.1). The consumers could choose private fund but there is no interest for them to do that.

Question 4.10 Are there any mechanism in place by which consumers can influence the purchasing decision by political or administrative means – i.e. use “voice” - collectively (e.g. representation in decision-making bodies; election of board of purchaser organisations, surveys on public views) and or individually (e.g. private appealing to court)?

There is a quota for representatives of patients’ organisations in the Assembly of the Representatives of the NHIF. For the moment it is only one seat. The quota for representatives of the syndicates is bigger. The syndicates also present in the supervisory board of the NHIF. Private funds do not include explicitly representatives of the consumers – their presentation is possible through possession of shares for those, which are registered as share companies.

Question 4.11 Describe present reimbursement mechanisms.

For the medical services NHIF covers the services of the described above packages. Officially it does not presume payments out of pocket, which actually happens because of the underestimated services (especially hospital services). There is debate in the Parliament if these co-payments to be recognised officially as an additional share by the consumers to the system. So far the tendency is opposite – as much as possible to free the user from direct payments in the medical facility. The drugs are reimbursed also by the NHIF but there is official co-payment for some positions, which is defined in the positive reimbursement list of drugs issued annually by the NHIF along with the National Framework contract. Most of the psychotropic drugs are reimbursed fully on 100%.

Question 4.12 Describe the process through which purchasers and providers interact. How are contracts developed, how are contracts put into place and how purchaser organisations monitor these contracts?

See Quest 4.1.

The monitoring of the execution of the contracts by the contract partners is done by specialised units in the Regional Branches of the NHIF. There is medical and financial control done by the purchasers. The system is based also on the referrals from primary to secondary level – the General practitioners are “gate keepers” and regularly a limited
number of referrals is given to them by the regional branches of NHIF. There are variations in this process but the control still is not satisfying, as many abuses are detected.
5. Mental Health Policy

NOTE: The questions in this section do not relate to allocation process directly. But they are very important as they tell us about broad policy context of resource allocation (policy questions), about the capacities for evidence-base mental health policy (research), and about the role of civic society.

POLICY

Question 5.1 Is there specific law on mental health or any other mental health legislation?

Between 1973 and 2004 a law, called Act for the Health of the Population, was in force but did not provide adequately for the observance of rights. This was the reason why new health legislation has been developed by Parliament. In 2004 a new Health Law with a separate Mental Health Chapter was adopted by the Bulgarian government. The Chapter describes mainly the groups of people targeting by this Law, the rights of mentally ill, respective institutions and services which are responsible for their treatment and procedures for compulsory treatment. By drafting this Chapter as an element of the Health Law the most urgent needs for changes in the existing mental health regulation were met.

However, the Mental Health Chapter does not address all cases and problems emerging from the everyday practice of treatment of mentally ill. This calls for a separate Mental Health Law that will guarantee and extend the range of priorities of community mental health care, the human rights of patients in the institutions and respective regulations regarding involuntary treatment and coercive actions.

This was the reason for the Bulgarian Ministry of Health to develop a proposal for the project “Strengthening the Legal and Administrative Capacity for Mental Health Reform” under the premises of the accession process of Bulgaria in the European Union. On of the major goals of this one year project, which will start in 2008, is the preparation a separate Mental Health Law to ensure that all activities needed to support the implementation of the community-based mental health care have the legislative basis including e.g. promotion/prevention, psychosocial rehabilitation, establishment of catchment areas and proper funding.

Question 5.2 Is there any national strategy in mental health? If yes, who approved that. Is it a proclamation or implementation plan? In case of implementation plan, who is responsible for its implementation?


The Mental Health Policy has been developed by experts with different profile. The group has been aware of the importance of involving as many stakeholders as possible already at the stage of conceiving the policy. To that end at meetings and on public occasions information has been released. Drafts of the text have been disseminated for comments. Representatives of all stakeholders have been approached for their opinion. The agencies and groups, which have responded and stayed in touch, were: Ministry of Health, Bulgarian Medical Association, Bulgarian Psychiatric Association, National Health Insurance Fund, Ministry of Labor and Social Policy, National Centre of Public Health Protection, Regional Municipalities and administrative structures, Medical universities, Regional Health Centres, National Centre for Health Information etc.

**Question 5.3 What are current issues, problems discussed concerning mental health policy?**

The basic elements of the current Mental Health Policy are as follows:

1. Community services. Deinstitutionalization
2. Human rights
3. Quality of services
4. Integration of users in the process of treatment and rehabilitation. Generation of informal users’ groups
5. Integral approach
6. Evidence-based policy
7. Prevention and promotion
8. Stigma and discrimination due to mental illness

The long term goals of the current Mental Health Policy of Bulgaria has been formulated and officially approved in 2001 with the development of the National Programme for the Mental Health of the Citizens of Bulgaria 2001 - 2004. The document focuses on major mental illness and common mental illness; whereas suicide, drug and alcohol addiction and learning disability are subject to other policy documents.

The specific goals of the Mental Health Policy are to humanize care and to introduce community mental health. It explicitly addresses the fact that mental illness is underreported and underdiagnosed, that the burden of mental illness is seriously underrated, that psychiatric stigma misinforms both the public and the government on the challenging aspects of illness behavior and on the opportunities for treatment and recovery from psychosis.

The MHP seeks to **reengineer** the current mental health system in accordance with the vision of community based care. It describes the network of hospital, day and rehabilitation services for serious mental illness on the one hand, and the aligning of psychiatry with general practice in providing for common mental illness, on the other. **Primary care** is shown to play a key role in handling specifically **common mental illness**. Under the program diagnosis and treatment by general practitioners backed up by consultant psychiatrists is being discussed.

**Specialist psychiatric** care is assigned two broad tasks. In the first place it is called to reinforce general practice in handling common mental illness. In the second place it is entrusted to organize and run community and hospital care in the case of **serious mental illness**. To that end the Program envisages specialist psychiatric outpatient services (group
practices), day center-based psychosocial rehabilitation with case management, and acute inpatient care in general hospital psychiatric wards. Protected housing of various kind, social services and preventive action in challenging illness behavior are envisaged, too.

The importance of the links between primary and secondary care is debated and affirmed. The poor current state of the collaboration between the two systems in Bulgaria is demonstrated to be a major shortcoming left behind from the recent past. The role of cross-sector collaboration for the effectiveness of mental health care is clearly recognized as a corner stone to community care. The current links are shown to be inadequate, particularly at community level.

The Program demonstrates that there is not reliable statistics to support the clinical impression that mental illness is associated with significantly higher mortality rates in Bulgaria. It suggests that nursing and general medical care for the mentally sick need to be significantly improved. This can come along with an overall shift away from the present frame of mind, which betrays negligence of and contempt for the mentally ill.

Care for special groups, e.g., children, the elderly, prisoners, and disadvantaged minorities, has not been specifically considered by the current policy. The Mental Health Policy notes the lack of reliable data that can permit valid planning, the underdeveloped managerial culture and the under-skilled professional staff, which does not allow for specific care protocols. Efforts to balance these deficits have resulted in planning to organize high quality surveys and training in the first years of the program. Provided that data and human resources are made available later in the course of the reform specific action to develop care for special groups will be taken.

The MHP critically notes that the hospitals statistics, which is currently collected, answer none of the questions that face management when transition to community care is in progress and when involvement of general practice in the treatment of common mental illness is unfolding. A working party on updating information systems is envisaged to address the issue.

**Question 5.4 What main mental health care reforms has been realized or at least suggested since 2000?**

In 2001 the government of Union of Democratic Forces endorsed the "National Mental Health Policy for the Citizens of the Republic of Bulgaria 2001-2005" (MHP). It comes as close to a policy formulation as ever was one in Bulgaria. In December the same year the next government put the program in operation. The MHP was an early attempt to adopt the general principles of the community-based an evidence-based policy approach in the field of mental health. The implementation of the program became possible in 2002 with a small budget from the Government and grants from external sponsors approached by NGOs from the field. Specifically, a fully operational mental health day care center was established in Sofia with funds from MATRA and other Dutch Funds, which set the pattern for a Bulgarian tradition in community psychiatry. Similarly, attempts with less spectacular results were made with acute psychiatric care in general hospitals, with risk assessment and management, and with starting an information system. Notably, the program funded the participation of the country in a representative epidemiological morbidity study (International Survey on Health and Stress, ISHS, 2002) coordinated by World Mental Health Initiative 2000 of the World Health Organization. The survey comprehends more than 5000 interviews all over the country and is coming to the end in the first quarter of
2007. A serious insufficiency of the Program that was pointed out by the inspecting agency at the end of the implementing period was the lack of regional development, hence – poor achievement of the initial goals. In practice the MH Program had only demonstrative character because number of reasons - among which, poor governance, lack of coordination, lack of authorization of the coordinative body to exercise control functions. All those were linked with the insufficient financing – far below the original proposal when the Program started.

RESEARCH BASE

Question 5.5 What is a role of research in mental health policy making? Are policy documents based on research, ideology, interests of providers?

The Mental Health Policy address the research policy in mental health and stress that it is important policy to be informed by research, referring in particular to mental health service evaluation research. It describes that in the sense of the Evidence-based policy, the mental health care facilities distribution in the community would be based on systemic research of mental health status of the population. Mental health system profile would be defined on the basis of identified needs of mentally ill. They will have the freedom to choose among different services.

As described above, the recent epidemiological study (EPIBUL, in a WHO initiative) of a random population sample provides a detailed picture of the mental health situation in Bulgaria especially regarding the common mental disorders. The total 12-month prevalence of mental disorders in Bulgaria raises up to 20% in this study, and it is amongst the highest in comparison to the other seven European countries. The highest prevalence is for anxiety disorders (13.1%), followed by depression (8.5%). This provides a sound basis for estimating needs for services among those with common mental disorders but not for those with severe mental disorders.

Although the EPIBUL study will provide data for the evidence based distribution of services, it should be mentioned that until present the management of the system of provision of mental health services is not based on health-economical analyses and that makes it unviable in the market conditions. Psychiatric services offered are not grounded on the needs assessment of the population and there is no system for efficacy assessment.

Question 5.6 What mental health research institutions or research teams exist in the country? Do they provide also research in mental health policy and financing, cost analysis etc.?

The practice of monitoring the implementation and progress of health policy is virtually nonexistent largely because accountability to the public and the consumers has not yet been embraced by either the health administration or the stakeholders. It is only NGO’s like Amnesty International which reveal the shortcomings of the system and hold the services accountable. The MHP by adopting planning and budgeting on a project by project basis hopes to build the practice of accounting within the principles of governance in the sector.

The country-level health care statistics in Bulgaria is collected by the National Centre of Health Information (NCHI) which is situated in connection with the National Centre for Public Health Protection. The data collection is organised so that the Regional Health Centers send the data they collect from the care providers to the NCHI. The Centre makes
still the final check and revision of data before publishing it as national statistics in the annual Health Statistics report.

However, it seems that the NCHI is focusing mainly on analysing data on somatic health care and that information on mental health care is not so comprehensive. For example, data on the rate and amount of compulsory treatment is not available in the published statistics although this information is collected at hospital level, at least according to the reporting paper form.

A big problem in the current Bulgarian situation is that no national data on the use of out-patient care is available, although the information about the number of visits in out-patient care is collected by the Regional Health Centres. Similarly, data is lacking also concerning the use of day care centres and other units offering psycho-social rehabilitation.

Also, the National Insurance Fund collects data about the reimbursed outpatient visits in both Primary and Secondary Health Care as well as private clinics and about the reimbursed medication. The different registers are not discussing with each other and they are neither collective measurable.

A feasible planning and distribution of mental health services needs collection of different kind of indicators. As stated above, part of the needed information can only be gathered by national population surveys conducted regularly. EPIBUL is a good start for this kind of mental health monitoring in Bulgaria but it needs continuation. This kind of surveys should be conducted at least every fifth year.

Strict scientific principles should be followed in conducting these surveys.

**Question 5.7 Are there any studies concerning mental health reforms in your country available? If yes, please provide reference, especially if in English**

1. **Epidemiological Study of Mental Illness in Bulgaria: EPIBUL (or WMH2000 Survey in Bulgaria)**
   - Principal investigator: Prof. Toma Tomov
   - Coordinator: Dr. Hristo Hinkov
   - Financing: Ministry of Health
   - Technical support: NCPHP

EPIBUL is the Bulgarian version of the ISHS (International Study of Health and Stress). In 2002 Bulgaria joined the worldwide initiative of the World Health Organization 2000 – ISHS, carried out by a distinguished international group of health researchers with principal investigators Ronald Kessler, Ph.D., Harvard University and Bedirhan Ustun, M.D., WHO. The overall goals of the survey are to: measure the prevalence of mental disorders; measure the severity of these disorders; determine the global burden of these disorders; assess service use; assess the use of medications in treating these disorders; and assess who is treated, who remains untreated, and what are the barriers to treatment.

In our country the study (EPIBUL) is one of the pilot projects of the National Mental Health Programme: 2001-2005. One of the objectives of the Programme is to explore the
epidemiology of the mental illness in Bulgaria through this representative epidemiological survey, prepared with the method and in collaboration with the WHO.

Parallel to the goals of the WMH Survey, the Bulgarian study has its specific aims to provide evidence for a much-needed governmental document on mental health policy. Big discrepancies are expected between measured incidence & prevalence, and services provided mental illness. Measuring severity will give data on the social burden of these disorders and relatedness to co-morbidity, hyperactivity, anxiety, and also domestic violence, unemployment and poverty. As a beginning this will serve for taking decisions which of the common mental illness issues should be given priority while designing the action plan for implementation of the mental health policy of in the country. Data will be obtained also for the Bulgarian DALY. Information will be obtained also for the hidden morbidity and service use, and basic information about a broad specter of ICD-10 categories what Bulgaria has not attempted until now.

The Bulgarian sample was designed to be a representative probability sample with a view of yielding a minimum of 5000 (4500 main + 500 spouse) completed interviews with respondents of the age of 18 and above. In line with previous experience it was assumed that the response rate will be 75%, which included correction for approximately 6% misleading addresses which led us to select an overall of 6300 households. Additionally, the sample was divided at random into three equal parts (releases) each containing 2100 household addresses, organized in 75 replicates. Each of the replicates included 28 households.

Stages of the survey:

Translation and Adaptation of the WMH Interview Instrument
All study materials in English were translated into Bulgarian under the direction of the principal investigator. The adaptation process included all the steps required from the Coordinating Centre of the study: (forward translation; expert panel; back-translation; pre-testing and cognitive interviewing; final version). More than 50 pretest interviews were made, including the pretest interviews conducted with the spouses of the main respondents. They were representative of the target population aged 18 or older.

Sample Design
A three-stage probability sample, stratified by place of residence (town/village) was selected on the basis of the National Civil Register (ESGRAON). First step – town (village) random selection; second step – sample of sections in the selected primary sites; third step – simple random sample of household from the selected section. This design has been shown to work well in Bulgaria. It yields a random sample, which is representative for the Bulgarian households.

Training
This was a two-step process. At first place - trainer training, which included one week training of the principal investigator at the Coordinating Centre of Ann Arbor, who afterwards trained an eight member team of trainers. The second step was training of interviewers where 70 Bulgarian interviewers were trained in one-week courses. All interviewers employed to work on the project received general interviewer training covering topics as ethical guidelines for interviewing human subjects, rules for asking questions and recording answers in an unbiased manner, proper procedures for locating and contacting respondents, and conducting refusal conversion attempts.
Field Period and Data Punching
The data collection from the release of the sample is approaching to an end together with the
data punching. A total number of interviews are 5339, 4517 interviews are based
respondents (84.60 % from all), and 822 interviews (15.4% from all) are marriage partners.
Response rate is 72 %.

Results
The survey has finished in August 2006, the first results have been ready one year later.

Preliminary results
One year prevalence of common mental disorders (<18 years old)

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<tr>
<th>Country</th>
<th>ANXIETY DISORDER</th>
<th>MOOD DISORDER</th>
<th>INTERMITTENT EXPLOSIVE DISORDER</th>
<th>ABUSE (SUBSTANCE USE)</th>
<th>ALL</th>
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<td>?</td>
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</table>

2. A Contextual Framework for Mental Health Promotion. Stage two: Capacity
Building through Innovation - Approaches to Mental Health Promotion in Cambodia
and Bulgaria.

Principal investigator: Alan Crouch
Coordinator: Dr. Vesselka Christova
Team: A. Crouch, V.Christova, R. Vladimirova, P. Swan
Dead-line: 2006
Financing: University of Ballarat, Australia
Technical support: NCPHP

This is a collaborative project of the National Centre of Public Health and the University of
Ballarat, School of Human Movement and Sport Sciences, Victoria, Australia.

The project is designed in two stages. The first deals with the elaboration of the conceptual
design, the adaptation and implementation of the methodology in the Bulgarian context
looking for the cross-cultural validity and results. The second stage will draw on the
corollaries of the first, aiming to map the impact of the introduction of this innovative
approach to mental health and mental health promotion research on national program
capacity development within the Ministry of Health and in the wider mental health networks
in Bulgaria.

In the first stage of the study an attempt is made to determine the importance of visible
culture to an understanding of the process of discovery of meaning within archival
photographic images taken in Bulgaria between 1940-1960. The research draws upon an
underpinning theoretical basis, developed in the context of survival of the Cambodian
genocide, which established the importance an ‘ethnographic semiotic’ approach. This
approach has been based on the foundational work of both Solomon Worth and Alan
Trachtenberg.
In this study, concepts of interactional and communicational meaning were explored and developed within focus group processes, based on the ethnographic semiotic approach. The focus group was composed of adult volunteers - survivors of WW II, survivors of the concentration camp of the regime afterwards and their children and grandchildren. Strategies found useful in the Cambodia study were investigated for usefulness in the discovery of the interactional and communicational meaning in the Bulgarian context. In addition, a series of interviews and literature reviews, focusing on cultural, historical, mythological, religious and political aspects of Bulgarian life, using key informants, conventional library-based searches were undertaken to create, in this context, Trachtenberg’s ‘encompassing structures’, critical to developing an interpretive framework.

The method used is an innovative image-based action research. A toolbox of instruments for the acquisition, recording and analysis of image-based data has been assembled for this study. Some of these instruments have been borrowed from traditional ethnographic methodology. Others have been adapted from other disciplines or specifically developed for the study. The strategies used to attempt to discover the interactional and communicational meaning in the photographic collection were: Phased in-depth contextual discussion – focus group; Participant observation (Fetterman, 1989); Photo-elicitation (Prosser and Swartz, 1998); Discourse and content analysis (Morgan, 1993).

The study observed that autobiographical and biographical narrative was predominant in participant responses to archival photographs, especially narratives describing the overwhelming fear of life where the rules are unspoken and the forbidden must be intuitively determined.

The theme of the post-traumatic stress turned out to be crucial both for the focus group participants - victims of organized violence and for the second and third generation. In the modern context of transition from totalitarian to democratic system the symptoms of this stress come back to life in the form of re-trauma, and the psychological mechanisms of denial and unfinished grief work are very strong. The discourse in the focus group and in the social reference group, as well as the analysis of the data imply that the interventions for people - victims of organized violence, should step out of the strict therapeutic work and support to incorporate the wider social and political context.

The study presents one aspect of the attempt to attribute meaning to the stories of survivors of organized violence. The study also stimulates wider exploration of health promotion applications of image-based approaches within the survivor community.

Second stage of an on-going collaborative project of the National Centre of Public Health and the University of Ballarat, School of Human Movement and Sport Sciences, Australia. This stage draws on the corollaries of the first stage. It aims to map the impact of the introduction of this innovative approach to mental health and mental health promotion research on national program capacity development within the Ministry of Health and in the wider mental health networks in Bulgaria.

3. International Mental Health Country Profile Project “POLICY, PROGRAMMES AND SERVICES”: Issues to consider in the assessment and further development of Mental Health Policy, programmes and services 2000-2002

The overall purpose of the project is to establish a database of Country Profiles on mental health, policy and services in order to support both national and local evidence based decision making.
**The CountryProfile** is designed to gather and enhance the use of both qualitative and quantitative data from relevant country expertise (official, professional, citizen and consumer) about the mental health of the population, extrinsic and intrinsic influences on mental health in that country, health and social services for people with mental health problems and mental illness, specific mental health policy, general health policy and general non-health policy which may impact on mental health.

The country profile seeks to:

- understand the countries context and mental health needs
- understand the existing policy and its development
- assess the implementation and practice of mental health policy and care
- be therapeutic and helpful for key stakeholders involved in policy development

The Profile is structured into four broad sections:

- Context
- Resources
- Provisions/Process
- Outcomes

Information from Countries

- Quantitative (Statistical) data
- Qualitative (Narrative) data
- Relevant and supportive policy related documents

Scientific co-ordinators: Professor Rachel Jenkins, Dr Aliko Ahmed Baba, WHO Collaborating Centre, Institute of Psychiatry, King's College, London
Scientific team for Bulgaria: Prof. Toma Tomov, Dr. Vladimir Sotirov, Dr. Maya Mladenova, Dr. Irina Lazarova, Dr. Michail Okoliyski

**4. ATTITUDES AND NEEDS ASSESSMENT IN PSYCHIATRY: A STUDY OF HUMAN ORGANIZATION AND DEVIANCE RELATED TO MENTAL HEALTH 1998-2001**

The report from the study presents the highlights of a three year endeavour in which dozens of people were involved from many different countries. It sets to describe the issues that came in focus in the course of the project and acquired special importance. The paragraphs below try to capture what was essential and meaningful in working together and to explain why. A more structured account on the project as a task dealt with by teams that work in coordination is being prepared for publication in a scientific journal.

Each of the six countries that collaborated in the project is to a certain degree representative of the geographic region to which it belongs with several other such countries. The regions are the Balkans (Bulgaria), the Baltic countries (Lithuania), Central Europe (Hungary), the New Independent States (Ukraine), the Caucasian Region (Azerbaijan), and Central Asia (Kirghizia). The co-ordinate body was set in Sofia and consists professionals from different organizations: Maya Mladenova (Bulgarian Institute for Human Relations); Irina Lazarova (State psychiatric hospital “Iv. Rilski”, Novi Askar); Vladimir Sotirov (Group psychiatric
practice “Adaptacia”); Michail Okoliyski (National Centre of Public Health); Toma Tomov (co-ordinator of the project, Bulgarian Institute for Human Relations).

The Geneva Initiative on Psychiatry (GIP) plaid an important role: it initiated the idea of EE collaboration in the mental health field in the first place. The credit for that should go to Robert van Voren, the Secretary General. GIP stood by the participating teams in a variety of ways throughout the planning and execution of the project. It provided expertise, teaching, consultation, encouragement and access to funds. Crucially, concern and interest in the work done dominated the human environment it created for the participants. This contrasted sharply with the disqualifying messages, which the teams received from professional settings in EE troubled as they are by concerns about power and influence.

**CIVIC SOCIETY**

**Question 5.8 Are there any organized patient groups? If yes, are such groups able to influence quality of care, allocation of resources?**

At present there is scarce social support practiced in Bulgaria, mainly inside families, ethnic groups or corporate groups. Although there are some consumer organisations in Bulgaria, most of which initiated and to a large extend run by professionals, they have a very limited impact on the quality of care, the allocation of resources and the political decision making at the national or local level.

Official documents, arranging mental health service provision include arrangements providing for the rights of access to services, informed consent, the legal procedures in cases of statutory commitment, access to personal files, etc. However, these rights are not organised in a special documents and consumers are not informed about having these rights. Data obtained through focus groups’ interviews indicate that even when consumers have a clear understanding for their rights, for example for their right of looking in their personal files, information there is organised and written up in such a way, that it does not provide meaningful information for the patients.

There is also very limited opportunity for consumers to choose a different environment for their care. This is possible mainly for patients who are in a position to pay for their services. Patients, who prefer to use services paid by the state or by the health insurance company have no opportunities to make their own choice.

In the field of the assessment of the needs, consumers are usually involved in the role of subjects of research. They are not involved as researchers or partners. The use of focus groups with consumers on issues concerning health care research has started only recently.

**Question 5.9 What is role of NGOs in mental health policy? Are they able to influence allocation of resource?**

In general the NGOs in Bulgaria are scattered and they are mostly dealing with children’s problems and human rights issues. The only bigger NGO in Mental Health is the Global Initiative on Psychiatry which is led by the professionals. There is no mental health user organisation but there are two relative organisations called Psycho Chronic and Society Adaptacia. Society Adaptacia is involved on the local level in the development of the newly endorsed Mental Health Strategy of the Municipality of Sofia and on the national level in the Initiative for legislative changes in the Health Law, aiming the mandatory creation of Patients Council for every Mental Health Service. This step would allow the participation of
the Bulgarian civil society (citizens, consumers, relatives etc.) at the political decision making process in the field of mental health. The overall aim of the “Patients Council” is to influence the policy of the mental health institutions. In order to have influence on the national policy level and to participate in decision making process a national users’ organization will be established.

**Question 5.10 Are there any local reform initiatives or experiments?**

In 2005 the Sofia-Office of the Global Initiative in Psychiatry started a project, supported by the MATRA program for the development of Day care centre, Protected house in the city of **Blagoevgrad** in the South-Western region of Bulgaria. A task force group (Council Board) is set for the aims of the project, composed of senior experts form Bulgaria and 3 foreign experts. The work of the task force group ensures that the created model for community-based system of mental health services is methodologically viable, the programs are developed in compliance with local needs and it will also be responsible for the analysis of the model and its effectiveness. Based on the experience from the project, the group will work out guidelines for the implementation of the model in other regions of Bulgaria beyond, which will ensure its replication, a manual for the development of a culture specific community mental health care and a model for municipal mental health strategy as well.

A manual, analyzing and describing step-by-step the process of establishing community-based mental health care is another significant instrument for the replication of the model in other regions of Bulgaria. The manual will be put together by the task force and will be a practical tool for future mental health service managers and professionals that would like to develop community-based services.

The task force group will draft guidelines for implementation of the model in other parts of Bulgaria. These guidelines are meant for the Bulgarian authorities and policy-making bodies. They will contain the basic standards that a community-based mental health care system should have, with recommendations for implementation.

In the last years, the local municipalities appear as very active and responsible player in the process of deinstitualization of the mental health services. The task force group will elaborate mental health strategy of Blagoevgrad city as good example for the rest municipalities in the country.
6. Mental Health Expenditures Analysis/ Health Accounts

Question 6.1 Are there any studies concerning mental health expenditures, mental health cost, mental health services organisation available? If yes, please provide reference, especially if in English.

Yes, for example:

IN ENGLISH

M. Okoliyski, I. Lazarova, M. Mladenova, T. Tomov, V. Sotirov, Bulgaria mental health country profile, International Review of Psychiatry (February/May 2004), http://taylorandfrancis.metapress.com/content/07pfhh9hxu5t4je7/


M. Okoliyski, “Needs and attitudes regarding the mental health and the community mental health services in the town and the region of Blagoevgrad, Bulgaria”, Social Medicine, 1/2007

This section has two parts, A and B. In part A, please, provide any available information on mental health expenditures in your country. In part B, we will check if information from part B can be transformed to OECD accounts.

PART A. Any available information.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of sick-days</td>
<td>N/A</td>
</tr>
<tr>
<td>from that F00-F99</td>
<td>N/A</td>
</tr>
<tr>
<td>F00-F99 in %</td>
<td>N/A</td>
</tr>
<tr>
<td>Expenditures on sickness benefits in millions BGN</td>
<td>241,9</td>
</tr>
<tr>
<td>from that F00-F99</td>
<td>N/A</td>
</tr>
<tr>
<td>Newly granted disability benefits 2004-2006</td>
<td>N/A</td>
</tr>
<tr>
<td>from that F00-F99</td>
<td>N/A</td>
</tr>
<tr>
<td>F00-F99 in %</td>
<td>N/A</td>
</tr>
<tr>
<td>Expenditures on disability benefits in millions BGN (2006)</td>
<td>666,1</td>
</tr>
<tr>
<td>from that F00-F99</td>
<td>N/A</td>
</tr>
<tr>
<td>Total Health Expenditures in millions BGN</td>
<td>2035,2</td>
</tr>
<tr>
<td>from that F00-F99</td>
<td>N/A</td>
</tr>
<tr>
<td>Total Expenditures on Mental Health sickness benefits</td>
<td>50,88</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Table 6.1: ICHA-HC (classification by health care function)

<table>
<thead>
<tr>
<th>disability pensions</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>health expenditures (health insurance, public health budgets and private health expenditures)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

| GDP in millions BGN | 49091 |

| Total Expenditures on MH as % of GDP | N/A |

### PART B. In following tables, provide information on mental health expenditure by different dimensions (if available).

#### Table 6.1: ICHA-HC (classification by health care function)

#### Table 6.2: ICHA-HP (by health services provider industries)

#### Table 6.3 ICHA-HF (by source of financing)