ESPN Thematic Report on Challenges in long-term care

Bulgaria

2018

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European Social Policy Network (ESPN)

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Summary

Bulgaria's long-term care (LTC) system is underdeveloped and there is a lack of an integrated and coordinated approach by the different sectors and stakeholders, such as responsible ministries, local authorities and private providers.

The geographical coverage of LTC and other social services across districts is uneven, although this normally reflects differences in population. Accessibility to long-term health care services is more even across the country, although there has been less growth in these services than in social services. There has been a small increase in the number of hospices, though, which provide a critical service to Bulgaria's elderly people who cannot receive care at home. Unfortunately, the small growth in services has not been matched by an increase in personnel or by an improvement in the patient-to-personnel ratio, which raises important questions about the quality of services.

The country does not have a cash-based LTC allowance system for family members who care for their elderly relatives. In addition to personal assistants and other home helpers, municipalities provide day care centres for elderly people, day care centres for adults with disabilities, centres for social rehabilitation and integration, protected homes and care services at home. While the bulk of long-term care services are now offered by community and home-based service providers, institutional services remain a critical part of the LTC system. Such services consist mainly of homes for adults with disabilities, homes for elderly people, specialised hospitals for continuing treatment and rehabilitation and hospices. LTC and other social services for the elderly are financed primarily from public funds. There is no LTC insurance and private contributions through fees are minimal. In terms of expenditure, most services are 'state delegated', which means that they are funded by the state but managed by the municipalities. While this ensures a minimum amount of funding available to meet local needs, it does not ensure high quality or universal coverage. Municipalities must manage the services within strict budgetary limits that are based solely on the number of beds or units of service, rather than on the quality of service.

The financial resources for LTC services come from the state budget, the local budgets and registered private providers, as well as from various projects that come under national and international programmes. Public spending on LTC in Bulgaria stood at 0.4% of GDP in 2013, far below the EU average of 1.6% of GDP. According to the 2015 Ageing Report, in 2013 100% of this expenditure went on in-kind benefits (EU: 80%), while 0% was provided via cash benefits (EU: 20%).

A comprehensive information and monitoring system for LTC is absent, information is not collated and key indicators are not calculated (such as access to different services, quality of care, funding and expenditure on both the health and the social security system, etc.).

In January 2018, the government approved an action plan for implementation of the National Strategy for Long-term Care. This envisages some of the challenges identified in the strategic document being addressed, such as developing integrated services, quality standards, focusing on prevention and outreach work, etc.; but implementation of these measures has yet to be seen and evaluated.

Key issues to be addressed as a matter of priority in order to improve the LTC system in Bulgaria are:

- developing a comprehensive monitoring and evaluation system, including setting up appropriate indicators and clarifying how, when and by whom data are to be collated, validated and reported;
- ensuring better coordination of care pathways and generally better coordination along the care continuum via dedicated governance structures for care coordination and the integration of health and care; and
- regulation of the types and procedures for integrated services development and provision, including case management and financial arrangements.

1 Description of the main features of the country's long-term care system

Legislation does not provide any definition of long-term care (LTC). As in many other countries, the social service sector and the health care sector do not have an official mechanism for coordination with regard to LTC services. Currently, medical and social services are regulated by different bodies and legislation. Depending on the specific case, LTC may be provided by the state, the municipal authorities or private providers via social insurance and social welfare.

Long-term care and other social services for the elderly are offered through two distinct systems in Bulgaria. Social services, defined as 'activities which assist and expand the opportunities of persons to lead an independent way of life and which are carried out at specialised institutions and in the community'[1] are regulated by the Social Assistance Act (SAA) and Rules for the Implementation of the Social Assistance Act (RISAA). Long-term social care is defined as social services provided for a period of more than 3 months. There is no separate definition of LTC services in Bulgarian legislation at this time, nor any official classification of who qualifies for it. Health services, on the other hand, are regulated by the Medical Treatment Facilities Act and are provided through different types of institutions, such as hospitals for further and continuing treatment, hospitals for rehabilitation and hospices.

In terms of service delivery, more than 90% of services are public, provided by either the state or the municipality. While institutional care is almost entirely public, non-governmental organisations (NGOs) and charities are increasingly involved in providing services at non-institutional centres for social rehabilitation and day care centres for adults. Home-based services are provided by individuals contracted by the municipalities or the state, depending on the type of service. To access social services, beneficiaries must submit a written request to the appropriate municipal or national authority for public services, or to the manager of a private service provider. Based on the request, the relevant authorities conduct a social evaluation and make a recommendation for placement of the beneficiary. Services are provided if certain criteria and conditions are met; these depend on the type of service, disability, income, whether there are family members who can care for the person, etc. Once placed in a residential institution, recipients of care must pay a fee for their stay. In most cases, the amount is 70% of the monthly income received, but it should not exceed the actual monthly expenditure on the service provided. The fee for community-based social services, including residential-type services, is significantly lower. Persons with no income or bank savings do not pay a fee. Access to health services is based on the insurance status of the beneficiary. However, every Bulgarian woman over the age of 60 and every Bulgarian man over 65 has full health insurance coverage paid by the state.

Unlike certain European countries (such as Austria), Bulgaria does not have a cash-based LTC allowance system for family members who care for their elderly relatives. Home care may be provided to people who are unable to take care of themselves without assistance due to the state of their health, functional impairments or old age. Legally, social care at home is defined as a complex set of social services provided in the client's home by the respective municipal departments; it includes provision of meals, maintenance of personal hygiene, cleaning, assistance with the supply of technical means and devices needed by the disabled client, daily living services, etc. These services are intended for people with different kinds of disabilities whose health constraints lead to their isolation and/or inability to organise their own daily activities; single people living alone who, for various health reasons, are unable to organise their daily lives or keep their home clean. The eligibility

[1] State Gazette No. 120/2002 of Social Assistance Act 1998.

criteria for these services include being over 60 years of age, being unable to care for oneself, having no relatives and not having signed a contract to cede property in return for financial support and/or care (Ordinance No. 4 of 16 March 1999). In the majority of cases, however, priority is given to people over the age of 75, particularly if they are living alone or have income below the social pension. Apart from social care at home (which is the home-based LTC service most widely available), LTC home-based services are also provided under various national programmes and include such forms as personal assistant and social assistant (defined under the Additional Provisions of the Social Assistance Act Regulations).

'Personal assistant' is someone who provides home-based care for children/adults with permanent disabilities and persons over 65 who are unable to meet their everyday household and social needs by themselves. 'Social assistant' is someone who provides home-based services on an hourly basis to children/adults with permanent disabilities and to those over 65 with limited or no ability to cope by themselves with meeting their leisure and social inclusion. The difference between the two services lies in the range of activities. Personal assistants are committed to fully serving the needs of children/individuals, including assisting the user in: maintaining personal hygiene and cleanliness of the room that the consumer inhabits; taking medicines and carrying out other health-promoting activities; preparing food and eating; handling of personal belongings and documents; using the bathroom and toilet; going outside the home, etc. The activity of social assistants focuses on the social inclusion of children/adults: supporting them in the organisation of their everyday activities, depending on the interests of the person; promoting their social engagement; supporting communication, creating and maintaining social contacts; diversifying everyday life by reading newspapers, magazines and books, playing board games, etc.; escorting the person outdoors for a walk, cultural events, etc. Social assistants also provide some support activities, such as dressing, washing, using the toilet, helping to control medication, attending health care facilities and rehabilitation; small purchases; administrative assistance with filling in and filing documents, etc.

At present, the provision of services in a home is carried out either under the national programme Assistants of People with Disabilities (the activities of 'personal assistants' and 'assistant-educators' are defined in the 2018 National Employment Action Plan) or under municipal projects that fall within the scope of Operation Independent Living under the Human Resources Development operational programme 2014-2020. These projects receive funding from the state budget, as well as from private providers, where the services are paid for after negotiation between the supplier and the consumer. According to the National Centre for Disabled Persons, personal assistants are employed on a 5-hour working day and are paid by the hour, at the rate of BGN 3.07 (EUR 1.57). For municipal projects, remuneration of assistants for providing services in the home environment depends on the source of the funding and is linked to the minimum salary.

In addition, municipalities provide day care centres for elderly people, day care centres for adults with disabilities, centres for social rehabilitation and integration, protected homes and care services at home. The rapid uptake of community and home-based services reflects the suitability of these services, as well as prevailing attitudes toward institutions in Bulgaria. The traditional model of care for the elderly in Bulgaria is for children to assume responsibility for caring for their parents or grandparents. Thus, Bulgarians are more comfortable with services provided in the neighbourhood or in the home, rather than in an institution where their relatives will be socially isolated.

Of all the community-based social services, the newer services of personal assistants, social assistants and home help/social help at home have proved particularly effective and popular. They meet the basic needs of the elderly and disabled, while keeping them in their home environment and out of institutions. They also often 'employ' a family member, who would otherwise be unable to work because of their full-time care responsibilities. And, in the case of outside social assistants and home helps, they provide a previously unemployed person with training and an official employment contract.

While the bulk of long-term care services are now provided by community and home-based service providers, institutional services remain a critical part of a comprehensive LTC system. In Bulgaria, institutional services consist mainly of homes for adults with disabilities, homes for elderly people, specialised hospitals for continuing treatment and rehabilitation, and hospices. Beneficiaries of these services are beyond the scope of community-based services.

As of December 2017, there were 11,000 people placed in 161 homes for adults and the elderly needing institutional long-term care.[2] In contrast to the rapid growth in community and home-based services,[3] this number has remained virtually unchanged since 2003, when Bulgaria reformed its social services sector. For comparison, in 2008 the number of people in specialised institutions was 11,750, in 159 homes. Not all types of institution are available in every district of Bulgaria. Only 5 of the 28 districts have all types; furthermore, in some cases the institutions are outside the towns, which further isolates residents. While geographical coverage is uneven, it generally corresponds to the population distribution within the country.

LTC and other social services for the elderly are financed primarily from public funds. There is no LTC insurance and private contributions through fees are minimal. In general, LTC and other social services for the elderly in Bulgaria are financed by the following methods:

- State services: financed by the state, with money paid direct to the service provider.
- State delegated services: financed from the state budget based on established standards, but funds transferred to municipalities, which then fund and manage the services. Municipalities are obliged to provide these services.
- Municipal services: financed from local budgets, with money paid direct to the service provider. Provision of these services depends on local conditions and needs.
- User fees: paid to the municipality or state, depending on the service. All but one service (personal assistants) require user fees based on the particular service and the user's income.
- Private services: financed by private organisations (NGOs, foundations, private companies/firms) that are registered with the Social Assistance Agency. The private services are provided for a monthly fee (around EUR 250) which is usually paid by the family members.

In terms of expenditure, the bulk of services are 'state delegated', which means that they are funded by the state but managed by the municipalities. While this ensures a minimum amount of funding available to meet local needs, it does not ensure either high quality or universal coverage. Municipalities must manage the services within strict budgetary limits that are based solely on the number of beds or units of service, rather than on the quality of service. In addition, the state provides an equal amount of funding for state-delegated services for each municipality, regardless of the population size or level of demand. Funding for state-delegated services comes from national target programmes (for example, Assistants for Persons with Disabilities), social assistance funds and grant schemes for social services (for example, the Human Resource Management operational programme, EC structural funds with national co-financing). For state-delegated services, the central government determines the rate at which each service is to be subsidised. Municipalities are expected to provide high-quality services within the targeted subsidy. However, they are welcome to co-finance state-delegated services from their own revenues. This is particularly important, because the state provides an equal amount of

[2] National Strategy on Long-term Care. For a full list of services, please see Appendix 1 – Specialised and community-based services in Bulgaria.

[3] The number of social services in the community in 2009 was 463; in 2010 – 542; in 2011 – 632; and by the end of 2012 it was 719.

funding for social services to each municipality, regardless of its size or the conditions under which it provides services. This has resulted in a significant increase in the amount of co-financing provided by municipalities: in 2003, 89 municipalities provided BGN 1.92 million (approximately EUR 1 million) in co-financing for social services; by 2008, 107 municipalities contributed BGN 9.53 million (approx. EUR 5 million).[4] There are no official data on contributions in the period 2008-2017.

1.1 General characteristics of policies

The National Strategy for Long-term Care (CoM Decision No. 2/07.01.2014) was approved in early 2014 to develop long-term care for elderly people and improve their quality of life. The strategy aims at providing accessible, high-quality community-based and home-based services to enable the social inclusion of people with disabilities and elderly people, while at the same time deterring the institutionalisation of those persons. It places special focus on the deinstitutionalisation of care for people with disabilities and elderly people, and the development of home-based services and support for families, with increased responsibility for the care of dependent family members. Promoting the interaction of social and health services and the implementation of an integrated approach are also prioritised in the strategy. One of the key priorities of the strategy is to establish a more effective financing mechanism for long-term care and to achieve a sustainable increase in funds for community-based and home-based services. At the beginning of January 2018, the government approved the Action Plan for the Implementation of the Long-term Care Strategy for the period 2018-2021, which envisages concrete measures for the deinstitutionalisation of care and the development of services for that period.

Key measures for the realisation of the objectives in the field of long-term care policy are:

1. Expanding access to social services, improving their quality and the interaction between health, social and educational services. This includes: (a) the construction of an adequate network of social services in the communities and the home environment (new services in the community and at home, including the provision of hourly services to support social inclusion) and uniform distribution across the country, (b) the development of innovative cross-cutting services for the elderly and people with disabilities, including rehabilitation, occupational therapy and life-long learning, (c) the development and maintenance of a map of long-term care services in Bulgaria, (d) the development and improvement of standards for the provision of long-term care services, and (e) the creation of structures for integrated home care for the elderly.
2. Regarding the deinstitutionalisation of the elderly and people with disabilities placed in institutions: (a) an assessment of the needs of each person and determination of the need for support, by applying an individual approach, (b) preventing the risk of institutionalisation by providing alternative services in the community and ensuring the active participation of the person in this process, and (c) the restructuring and phased closure of institutions.
3. Regarding the promotion process of long-term care: (a) the continued implementation of best practices for long-term care for mentally ill patients after their active psychiatric treatment and provision of adequate living conditions in the community through appropriate services and integrated cross-sectoral reintegration programmes, (b) the development and validation of a model for the provision of long-term treatment and palliative care, and (c) the provision of home care for people with chronic diseases resulting in damage to critical functions (respiratory, neuromuscular, renal failure, etc.).

[4] World Bank Report Long-term Care and Ageing Case Studies – Bulgaria, Croatia, Latvia and Poland.

4. Regarding support for individuals and professionals who care for the elderly and people with disabilities, several measures are under consideration: (a) the provision of adequate training and supervision of personnel providing long-term care services, depending on the specific needs of the target groups, creating a system of independent monitoring, (b) the development of forms of social support services for dependent family members – an increase in the number of professionals providing long-term care for sick elderly and disabled people in the home and community.
5. Regarding the increase in efficiency and improvement in funding mechanisms for LTC services: (a) encouraging providers to create services with their own funds, (b) application of the principle 'money follows the client', (c) analysis and assessment of the role of the social security system in funding and ensuring the sustainability of the long-term care system for the elderly and people with disabilities, (d) increasing the capacity of local organisations to provide services for long-term care and promote public–private partnerships, (e) promotion of entrepreneurship in the social sector and the involvement of all stakeholders, including businesses and service providers from the private sector, in the development and delivery of innovative and alternative services.

After 2015, three clinical pathways (CPs) covering LTC were introduced, paid for by the National Health Insurance Fund:

- CP No. 256 Continuous treatment and early rehabilitation after operative interventions with large and very large scope and complexity with residual health problems, financing hospital stays for 10 days.
- CP No. 255 Continuous treatment and early rehabilitation after myocardial infarction and after heart interventions, financing hospital stays for 10 days.
- CP No. 254 Prolonged treatment and early rehabilitation after acute stage of ischemic and haemorrhagic stroke with residual health problems.

The introduction of LTC CPs is a step forward, even if it is highly inadequate in terms of the number of days financed and the specialised clinics where the service can be provided.

Despite the amendments to the Health Act 2015 to regulate integrated health and social services provision, the government still has no shared philosophy and concept of how integration between health and social services should be regulated operationally and funded in legislation and in practice.

In addition, a new Law on Social Services is currently being developed, with the participation of all stakeholders, in order to adequately address all the challenges in this sector. The main objective is to improve the regulatory framework in the field of social services with a view to improving the planning, management, financing, quality and effectiveness of social services.

2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

2.1 Assessment of the challenges in LTC

2.1.1 Accessibility and quality

In Bulgaria, the geographical coverage of LTC and other social services across districts is uneven, although this normally reflects differences in population. Larger-capacity institutions are generally located in administrative centres where the population is higher. And while all types of social services have expanded in the past few years, there remain unmet needs. In 2008, the number of registered people awaiting services amounted to approximately one third of existing capacity. According to the action plan for LTC for the

period 2018-2021, 3,600 people were on waiting lists, as against 11,000 who were placed in specialised institutions.

Accessibility to long-term health care services is more even across the country, although there has been less growth in these services than in social services. There has been a small increase in the number of hospices, though, which provide a critical service to Bulgaria's elderly people who cannot receive care at home. Unfortunately, the small growth in services has not been matched by an increase in personnel or an improvement in the patient-to-personnel ratio; this raises important questions about the quality of services.

2.1.2 Employment

There is no formal definition of an LTC worker and no common competence-based standards. Each sector develops its own job descriptions, induction and training, appraisal and life-long learning systems. There are no specific efforts to address the challenges of recruiting, motivating and maintaining a competent workforce. No recruitment programmes target specific groups that do not generally consider a career in LTC (young people, men, retired people, etc.), and nothing is done to address the challenges related to the high turnover of social workers, nurses and health specialists who go abroad.

There is no established information system to collect data on formal carers providing long-term care. There is even less information about the number of people providing informal care. Since 2012, training in the professionalisation of care has been held under various schemes within the Human Resources Development operational plan. Though well intended, these efforts lack a comprehensive and systematic approach. There is also an absence of information about any skill-validation initiatives to help informal carers become LTC professionals.

2.1.3 Sustainability

Eurostat projections indicate that the share of people aged 65+ in Bulgaria will increase from 17.4% in 2010 to 32.7% in 2060. In 2015, those aged 65+ made up 20.4% of the national population. The average age of the population has risen steadily in recent years: from 38.9 years in 1995 to 40.4 years in 2001 and 43.3 years in 2015. The ageing of the Bulgarian population – which is projected to be among the most pronounced in Europe – will require a careful balance between ensuring access to the right types of LTC services and fiscal considerations.

In terms of funding, since 2008 the state has not only determined the rate for each social service, but has also instituted uniform standards for salaries and maintenance of facilities. The aim has been to eliminate inequalities between institutions and service providers in different municipalities. The state also determines a national ceiling for the funds available for a particular type of service, which means there is a limit on the amount of funding that each municipality can receive. This has implications for municipalities in terms of meeting the needs of their residents, as demand varies across municipalities. The use of predetermined rates for each service works relatively well for institutional care, because it is straightforward to calculate a figure based on the number of beds. However, as the proportion of community-based services grows, it becomes more difficult to determine a fair rate. The cost of labour becomes more important than the number of 'places', and services can vary depending on the unique needs of each beneficiary. The government is clear that the current system of funding for LTC and other social services is unsustainable, given the demographic projections. The heavy reliance on state-delegated services will need to change and local municipalities will need to find other sources of funding. The action plan for the implementation of the LTC Strategy in the period 2018-2021 acknowledges this and sets strategic objectives in this direction; but there is lack of clarity on the concrete measures that are envisaged.

2.2 Assessment of the policy reforms

It should be noted that the action plan comes 4 years after the strategy was adopted; thus the period 2014-2017 may be considered a wasted opportunity. Three years after the 2015 amendments to the Health Act, there is still no clarity on the regulations governing the types of integrated services and the procedures for their development and provision. What is currently missing is a holistic approach to both universal and targeted services – an approach that considers the complex needs of people, the introduction of a clear case-management procedure and funding arrangements. It is expected that the types of services and the conditions and procedures for their provision, as well as the criteria and standards for their quality and the arrangements for monitoring their observance, should be regulated by an ordinance adopted by the Council of Ministers, following a proposal by the minister of health and the minister of labour and social policy. A working group set up by the Ministry of Health was expected to come up with proposals by the end of 2017; but this has so far not come about.

Regarding human resources, the action plan envisages training for professionals from the social and health system. But again, what is lacking is a comprehensive and holistic approach both to the development and organisation of the LTC workforce as it tackles the growing number of dependants, and to the provision of a workforce strategy for the delivery of high-performing long-term care services in the face of growing demand.

In terms of funding, an analysis of the financial systems of other countries is envisaged for 2019-2020. But there has been no mention of evaluating the personal and social assistant schemes with a view to developing state-delegated funding standards for those specific services and outsourcing them to external providers in order to stimulate better quality and client satisfaction. Project-basis funding for these important services is linked to issues of accessibility and affordability, and there is a risk that those people who lack care and support could slip through the gaps between projects.

2.2.1 Key policy recommendations:

- Improve the governance framework and the monitoring and evaluation system to ensure that there are appropriate indicators set up, as well as clarity on who will collate, validate and monitor the data required to inform policy implementation and decision-making, and how and when this will be done.
- Regulate the procedures for integrated services development and provision, including case management and financial arrangements.
- Provide adequate levels of care to those in need of it, including: (a) adapting and improving LTC coverage schemes and the scope of coverage (i.e. setting the types of services included in the coverage); (b) providing targeted benefits to those with the highest LTC needs; and (c) reducing the risk of impoverishment of recipients and informal carers.
- Encourage independent living, providing effective home care, telecare and information to recipients, as well as improving home and general living environment design.
- Ensure the availability of formal carers, including: (a) determining current and future need for qualified human resources and facilities for long-term care; (b) improving recruitment efforts, including by tackling the outward migration of LTC workers and by extending the pool of potential workers.
- Support family carers by establishing policies to support informal carers (such as flexible working conditions, respite care, carer's allowance to replace lost wages or cover expenses incurred by caring, cash benefits paid to care recipients), while ensuring that incentives for the employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- Ensure coordination and continuity of care, by establishing better coordination both of care pathways and along the care continuum (such as having a single point of access to information) and by allocating care coordination responsibilities to providers or to care managers via dedicated governance structures and the integration of health and care.
- Facilitate appropriate utilisation across health and long-term care, including: (a) arranging for the adequate supply of services and support outside hospitals, and changing payment systems and financial incentives to discourage acute care use for LTC; and (b) steering LTC users towards appropriate settings.
- Improve value for money, including: (a) investing in assistive devices (for example, to facilitate self-care), a patient-centric approach and coordination between health and care services; and (b) investing in information and communication technology to improve sources of information, care management and coordination.
- Focus on prevention, including: (a) promoting healthy ageing and preventing the physical and mental deterioration of people with chronic care needs; and (b) employing prevention and health-promotion policies, identifying risk groups and detecting morbidity patterns at an earlier stage.[5]

3 Analysis of the indicators available in the country for measuring long-term care

3.1 Age, age dependency ratio and rate of demographic ageing

- Age: the population age is calculated as of 31 December in completed years, based on date of birth (i.e. the age reached at the end of the reference year).
- Population under, at and over working age: the age brackets used to calculate the distribution of the population under, at and over working age are defined according to the annually updated retirement age, adopted by the Council of Ministers.
- Age dependency ratio: the ratio of the number of persons under 15 years of age and the number of persons aged 65 and over per 100 persons aged 15-64 years, calculated as a percentage.
- Old-age dependency ratio: the ratio of the number of persons aged 65 and over per 100 persons aged 15-64 years, calculated as a percentage.
- Rate of demographic ageing: the rate of increase of the population over working age (according to the respective age limits for males and females) compared to the previous year, calculated as a percentage.

Information is collated annually and can be accessed from the National Statistical Institute (NSI).

3.2 Life expectancy at age 65, healthy life years, chronic morbidity and perceived health

The healthy life years indicator measures the number of remaining years that a person of a certain age is expected to live without disability (or moderate or severe activity limitation). The other indicators follow from this and calculate the number of years the person is expected to live with/without chronic morbidity and to be in very good, good, fair, bad or very bad perceived health.

[5] Bulgaria Health Care and Long-term Care Systems, an excerpt from the Joint Report on Health Care and Long-term Care Systems and Fiscal Sustainability, published in October 2016.

Although the data are derived from the EU Statistics on Income and Living Conditions (EU-SILC), the most useful presentation is on the European Health and Life Expectancy Information System Database (www.eurohex.eu), with annual data from 1995 to 2014.

Information about Bulgaria for the period 2014-2016 can be found at the NSI site, though it is available only in Bulgarian.

3.3 Number of specialised institutions and community-based services, capacity and service users

Agency for Social Assistance and MLSP, information is publicly available in the National Strategy for Long-term Care and is included in Appendix 1.

3.4 Missing indicators

- Number and structure of long-term care beneficiaries;
- Regional distribution and access to services by beneficiaries for the whole country for the 28 districts);
- Profile of the LTC workforce;
- Individual and total expenditure on health services, social services, integrated services and total LTC services;
- Types of services by funding – state, municipal and private;
- Cost of LTC per beneficiary.

Additional indicators for perceived quality of LTC services, difficulties with access, etc. could be included in the European Quality of Life Survey.

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Ludmila Mincheva and Galina Kanazireva, The long-term care system for the elderly in Bulgaria, http://www.ancien-longtermcare.eu/sites/default/files/ENEPRI%20RR%20no%2071%20_Ancien_%20Bulgaria.pdf

Appendix 1: Specialised and community-based services in Bulgaria

As of 31 August 2016, the following social services, which are state-delegated activities, were operational in the country:

1. Specialised institutions:

- Homes for mentally disabled elderly people – 27 homes with a capacity of 2,117 persons.
- Homes for elderly people with mental disorders – 13 homes with a capacity of 1,036 persons.
- Homes for elderly people with physical disabilities – 21 homes with a capacity of 1,301 persons.
- Homes for elderly people with sensory disabilities – 4 homes with a capacity of 133 persons.
- Homes for elderly people with dementia – 14 homes with a capacity of 825 persons.
- Retirement homes – 81 homes with a capacity of 5,553 persons.

2. Community-based social services:

- 2.1 Day care centres for elderly people with disabilities – 75 homes with a capacity of 1,920 persons, including 'day' care centres for elderly people with disabilities providing weekly care – 4 homes with a capacity of 88 persons.
- 2.2 Day care centres for elderly people – 47 homes with a capacity of 1,208 persons.
- 2.3 Centres for social rehabilitation and integration – 85 homes with a capacity of 2,617 persons.
- 2.4 Sheltered homes (SH) – a total of 142 homes with a capacity of 1,259 persons, including:
    - SH for people with mental disorders – 31 homes with a capacity of 307 persons;
    - SH for people with mental retardation – 96 homes with a capacity of 809 persons;
    - SH for people with physical disabilities – 15 homes with a capacity of 143 persons.
- 2.5 Supervised homes – 22 homes with a capacity of 137 persons.
- 2.6 Transitional homes – 11 homes with a capacity of 100 persons.
- 2.7 Family-type accommodation centres (FTAC) for older persons – a total of 83 homes with a capacity of 1,086 persons, including:
    - FTAC for elderly people with mental disorders – 25 homes with a capacity of 335 persons;
    - FTAC for elderly people with dementia – 12 homes with a capacity of 153 persons;
    - FTAC for elderly people with mental retardation – 23 homes with a capacity of 285 persons;
    - FTAC for elderly people with physical disabilities – 19 homes with a capacity of 259 persons;
    - FTAC for old people – 4 homes with a capacity of 54 persons.
- 2.8 Crisis centres – 5 homes with a capacity of 50 persons.

- 2.9 Temporary accommodation centres – 12 homes with a capacity of 607 persons.
- 2.10 Shelters – 2 homes with a capacity of 70 persons.

Social services in homes for elderly people with dementia and in FTAC for elderly people with dementia are provided with the aim of ensuring support for people in cases of dementia or Alzheimer's disease.