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LTC network

Quality and cost-effectiveness in long-term care and dependency prevention



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COUNTRY REPORT

Bulgaria: Emerging policy developments in long-term care

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I Highlights of the long-term care system

Providing affordable, high quality, and sustainable long-term care (LTC) services for the elderly and people with disabilities is an effective tool to improve their quality of life and to assure their inclusion in society. Bulgaria, like other member states of the European Union (EU), is facing serious challenges related to population ageing, which thereby increases the need for LTC services and, consequently, increases the public costs of these services. There are two pillars of care: formal care provided by skilled professionals in specialized institutions and through community-based and home-based social services; and informal care provided by a family member. Traditionally, care of the elderly is seen as the responsibility of family members and is provided within the family.

As mentioned in the ENEPRI Research Report (Mincheva and Kanazireva, 2010), three main principles govern the philosophy of the LTC system in Bulgaria: solidarity, equity, and access for all clients in need. In general, the system aims at improving the quality of life of disabled children and elderly people with impaired activities of daily living and instrumental activities of daily living through the establishment of conditions ensuring that each of these groups has the right to independent living and social inclusion (Mincheva and Kanazireva, 2010). Thus LTC in Bulgaria, as stipulated in the Disabled People's Integration Act (DPIA), covers those with physical disabilities, mental disorders, or who require palliative care. According to the Act, 'injury' is any loss or distortion in anatomy, physiology, or mental health of an individual (DPIA, 2004).

LTC consists of a wide range of medical and social services and is understood as lying across the boundary between medical and social care normally provided to the groups of people mentioned above.

The LTC system is based on two pillars: social services and the healthcare system. Despite the lack of legislation specific to LTC, such issues are the object of a number of policy acts, both laws and by-laws, for instance the Social Assistance Act (SAA)

and its Regulations on Implementation (RISAA); the Disabled People's Protection, Rehabilitation, and Social Integration Act (and its Regulations on Implementation); Ordinance Number 4 on the Terms and Conditions for Social Service Provision; the Ordinance on the Criteria and Standards for Social Service; and the Health Insurance Act, which provide a basis for the services offered as part of the national mandatory health insurance system (Mincheva and Kanazireva, 2010).

Under the SAA and the RISAA, social services are provided in the community and in specialized institutions. Community-based social services are provided in an environment close to the family, designed to support users and promote social inclusion. Institutional care in Bulgaria is provided mainly in homes for the disabled and older peoples' homes. Beneficiaries of these services are outside the scope of the services based in the community.

LTC services are regulated by the Health Act and the Healthcare Facilities Act, and are provided by different types of specialized medical institutions, including 'hospitals for long-term and continuous treatment, rehabilitation hospitals, state psychiatric hospitals, centres for mental health, and hospices' (Georgieva *et al.*, 2016). In the Social Security Code, the DPIA, and the Regulations for Implementation of the DPIA (RIDPIA), some cash benefits and benefits in kind aimed at helping disabled persons are defined.

Currently, the LTC system is in a transition phase with reforms aimed at strengthening the processes of decentralization by focusing on the needs of individual care recipients. This transition from institutional care to services offered in community and family environments was realized mainly through the expansion of the range of services, such as day centres, social rehabilitation and integration centres, and sheltered homes, and the evolution of the supply of services in the home environment (personal assistants, social assistants, home helpers, and in-home care). Deinstitutionalization is a crucial reform in the field of services for the elderly and disabled people.

Social services funding in Bulgaria is both centralized and decentralized. Financial resources for social services development and support are stipulated in chapter VII of the SAA and include the following sources: the state budget, municipal budgets, national and international programmes, donations from local and foreign individuals and legal entities, and the 'Social Support' fund, among others (Terziev, 2005).

Social services are financed by the state budget with the help of different mechanisms. They are listed in the ENEPRI Research Report (Mincheva and Kanazireva, 2010):

- Targeted transfers to municipalities towards the support of services that are delegated as state activity; these transfers have been determined (since 2003) on the basis of the 'financial support standards per one place'. As of 2008, these standards have been unified (i.e. they cover total support and salary costs);
- Targeted national programmes fully financed by budgetary means (for example, the programme 'Assistants for People with Disabilities', which also has the characteristics of a subsidized employment programme);
- The Social Assistance Fund under the Ministry of Labour and Social Policy, funding a small number of low-budget projects of municipalities, natural persons, and legal entities registered in the Register of the SAA; and
- Grant schemes for the delivery of social services within the framework of the Operational Programme 'Human Resources Development'. The municipalities provide funds from their own revenues (i.e. within the framework of their budgets) for local social services (social services at home, public kitchens, and pensioners' and disabled people's clubs) (Mincheva and Kanazireva, 2010). The amount and quality of social services provided by local authorities thus vary greatly depending on the municipal budget.

Recently social services financing mechanisms have undergone significant changes aimed at achieving financial sustainability. In 2008, a system of uniform standards for financing all types of social services – through institutions and in the community – was introduced by the state. Funds provided from the national budget for all social services (including community-based services and specialized institutions for children and adults) are considerable. Since 2008, they have remained at the same levels without significant changes (see Appendix, Tables 3 and 4).

Extensive public spending on LTC will continue to be required, as adults and the elderly will constitute the fastest growing social group in society for the foreseeable future.

II Recent policy developments in LTC

LTC has only recently been recognized as a key element of governmental policy. Following an intensive political debate, the LTC services were launched in late 2009 as an initiative of the non-governmental organization (NGO) sector and the National Social Security Institute.

LTC was also, for the first time, defined as a 'social risk' in terms of social insurance. It was recognized that 'Bulgaria needs a new concept for LTC, legislative and institutional solution, as well as financial provisions, bound with the state budget, the social insurance funds and the social programmes' (Slavova, 2009). Various solutions for assuring sustainable LTC were discussed. Some of the measures proposed included: integration of LTC with the social security system as a mandatory social security risk; establishment of an independent LTC fund; financing LTC from public funds, or an insurance fund and fees from the families of persons in need; and an increase of the health insurance fee to cover LTC and palliative care, among others (Open Society Institute, 2009).

In general, Bulgaria's priorities in the field of social services as a component of LTC development policy are summarized by Mincheva and Kanazireva in their ENEPRI Research Report (Mincheva and Kanazireva, 2010):

- to extend the range of services targeted specifically at elderly people and people living alone, people with disabilities and others, and improving their quality of life
- to transition from institutional care to services, permitting such people to live in their community and family environment
- to reduce the number of people using services in specialized institutions for social services delivery and to reduce the number of institutions, themselves, through the development of a modern network of community services
- to create incentives for informal carers by providing financial support and replacements for certain periods of time
- to strengthen the capacity of the LTC system by providing education and training of staff and involving young people
- to emphasise not only primary deinstitutionalization, but also preventing an individual from being placed in an institution again (Council of Ministers, 2014).

The Strategy for Long-Term Care (adopted by the Bulgarian Council of Ministers in 2014) envisages the improvement of access to social services in the community and family environment and in health services. This is planned to be achieved through the expanding the network of these services throughout the country as well as increasing their variety, volume, and scope; improving their quality; and encouraging interaction between them over the next 20 years.

The Strategy for Long-Term Care is closely tied to political and strategic documents relating to the development of services for LTC for the elderly and people with disabilities, such as:

- the National Reform Programme of the Republic of Bulgaria (2012–2020)
- the National Development Programme: Bulgaria 2020
- the National Strategy for Reducing Poverty and Promoting Social Inclusion 2020
- the National Strategy for Demographic Development of the Republic of Bulgaria (2012–2030) (updated)
- the Strategy to Ensure Equal Opportunities for People with Disabilities 2008–2015 (updated)
- the National Health Strategy, 2020 (updated)
- the Employment Strategy of the Republic of Bulgaria 2013–2020 (updated)
- the National Concept to Promote Active Ageing in Bulgaria (2012–2030).

The key objectives of LTC policy in Bulgaria are: moving from institutional care; supporting the development of community-based social services to prevent the risk of institutionalization; increasing the capacity of employees in the field of social services; and developing integrated intersectoral services.

Several key reforms should be mentioned:

Deinstitutionalization

This is characterized as a two-way process, both related to the closure and transformation of existing institutions and to the promotion of community services that are alternative to institutional care. In this sense, the deinstitutionalization of care for the elderly and people with disabilities is aimed at developing network services in the community and home environments to ensure an independent and dignified life as well as the individual's full inclusion in society. Deinstitutionalization was defined in the national strategy 'Vision for Deinstitutionalization of Children in Bulgaria', in reference to children, as the 'process of replacing institutional care for children with care in a family or family-like environment in the community, not limited to the children leaving

institutions. This is the process of preventing the placement of children in institutions, creating new opportunities for children and families to receive support in the community and takes place on many levels'. While this document focuses on the case of children, the definition is relevant to deinstitutionalization in the general sense (Ministry of Labour and Social Policy, 2010; Ministry of Labour and Social Policy, 2013).

Deinstitutionalization may be regarded as the starting point that gives impetus to the development of community-based services and services for the elderly.

As part of the implementation of the Concept of Deinstitutionalization and Prevention of Social Exclusion of People Living in Institutions, the Social Assistance Agency has developed the Plan for Reforming the Specialized Institutions for Elderly People and People with Disabilities 2010–2011, which outlines concrete measures and activities for the reformation of 14 specialized institutions for adults with disabilities. The transition from traditional institutional care in Bulgaria to community-based and family-based services is mainly to be realized by expanding the range of services, such as day-care centres, social rehabilitation and integration centres and sheltered housing, and the development of a model for services provided at home (personal assistants, social assistants, domestic assistants, and domestic social patronage/support). In 2011, the number of community-based social services for elderly people was 329, with a capacity of 6,876 places, expanding by July 2014 to 370 with a capacity of 8,043 places (Neykov and Salchev, 2014).

National Healthcare Map

Another reform in the healthcare field that is likely to have a positive impact on access to long-term healthcare is the introduction of a mandatory National Healthcare Map. As discussed in the ESPN Thematic Report (Georgieva *et al.*, 2016), this envisages the restructuring of medical establishments, particularly the transformation of inefficiently used acute beds to LTC facilities with

fewer medical personnel and less equipment, reducing costs and improving efficiency. To this end, three new clinical pathways for prolonged treatment will be introduced to help each hospital to provide continuous care for its patients. As mentioned in the report, the draft health map 'plans to open 6,230 new LTC beds nationwide' (Georgieva *et al.*, 2016).

Assessment of disability

The political will to improve the adequacy of LTC for disabled people is demonstrated by the intention on the part of the Ministry of Health and the Ministry of Labour and Social Policy to launch major reforms in the assessment and recognition of disability. Minimising the level of corruption, stopping abuses and the draining of public funds, providing transparency, and improving the current cumbersome system for proof of disability are among the declared aims.

The specific steps are designed to facilitate the process of receiving quality medical expertise for people with disabilities, and to help those who are able to work to quickly return to their previous job with active assistance from the state. Among the measures is also a new methodology to be used for the assessment of the residual functionality of people with disabilities.

It is envisaged that two new committees (medical and social committees) will replace the existing Medical Advisory Committee and Territorial Expert Medical Commission. The first committee is to be affiliated to the Ministry of Health, and will have medical expertise. It will follow the World Health Organisation (WHO) model and will be in charge of the assessment of the residual functionality of disabled people.

The second committee will be responsible for the evaluation of the decisions of the first one. In addition, its competence will cover making individual recommendations regarding a particular person with a disability (what type of job they could do, scope for further education, etc.) The social committee includes a doctor, an insurer and an expert in occupational medicine. Different age

groups will have different assessment processes: for instance children and disabled pensioners will, after medical assessment, be referred automatically to the social committee, whereas people of working age will have an assessment of performance. The latter will essentially be given two options: either a return to the same job that they had before, but with reduced performance, or the possibility of further education or rehabilitation (Investor, 2016; Georgieva *et al.*, 2016).

New approach to service planning

In order to improve the coordination and integration of social services and ensure equal access to quality social services for people from vulnerable groups, a qualitatively new approach to the development and delivery of social services through regional and municipal planning based on the analysis of the needs of social services was introduced in 2010. The new approach aims at establishing social services that meet the specific needs of the target groups not only in the municipalities, but also at the district level. Regional and municipal planning provides better involvement of all stakeholders in the planning, designing, and provision of services.

III Dependency prevention policy

At the end of 2015, there were 1,461,786 people aged 65 and older, 20.4% of the population. Compared to 2014, the proportion of the population in this age group increased by 0.4 percentage points, while compared to 2001, it increased by 3.5 percentage points. The proportion of women aged 65 and was 23.7% and of men, 17.0%. This difference is due to higher mortality among men and, as a consequence, their lower life expectancy (National Center of Public Health and Analysis, 2015).

At this stage, Bulgaria has not developed a single, unified policy oriented at dependency prevention in LTC. There are various care institutions and programmes in Bulgaria related to the delivery of LTC services, and they are specified in a number of

laws. The services provided by these institutions are 'of limited coverage and insufficient quality, and are inadequate to meet the rising needs and demands for such services. This places a big share of financial and practical responsibility on the family' (Georgieva *et al.*, 2016).

However, despite the lack of a coherent, single dependency prevention policy, there are measures being undertaken regarding the issue, such as the collection of national statistics. For example, the Ministry of Health maintains a national register of people with mental disorders. It gathers statistical data on people over 16 years of age with permanent disabilities as well as patients under observation with mental and behavioural disorders. Additionally, the National Centre of Public Health and Analyses (NCPHA) maintains an information system for the population over 16 years with permanent disabilities. These measures are discussed in greater detail in section VI of this report.

IV Informal care support

Traditionally, care for older people has been the responsibility of family members and is provided within the family. The provision of informal care may largely limit the scope for the professional activity and job retention of the carers of elderly family members, and is likely to have repercussions for the social security system and labour market and increase the risk of social exclusion. It was only after Bulgaria had restructured its social services system in 2003 that the share of formal services provided in the community or at home increased.

There are various mechanisms of support for informal carers. Among these are leaves of absence from work (both paid and unpaid) and cash benefits (financial compensation). However, there is no remuneration system for the informal services provided by family members (as described in the ESPN Thematic Report (Georgieva *et al.* 2016). The law provides an opportunity for individuals to take leave of absence from work to care for a sick family member in compliance with Article 162 of the

Labour Code in conjunction with Article 45 of the Social Security Code (The Social Security Code, 2000; Labour code, 1987). In compliance with the provisions stipulated therein, every insured person is entitled to paid leave of up to ten days per calendar year for providing care to sick family members over the age of 18, including accompanying them for medical procedures. In the case of children in the family (persons under the age of 18) being cared for, carers have the right to up to 60 days in one calendar year. Unpaid leave is also an option, but this is subject to employer approval. Periods of up to 30 days of unpaid leave per year do not have a negative impact on entitlement to the old age pension (Georgieva *et al.*, 2016).

Different terms and conditions exist in relation to granting sick leave to care for an ill family member at home as compared to hospital inpatient care (Georgieva *et al.*, 2016).

Pursuant to Article 26 of the Child Protection Act (CPA), a sick leave certificate allows for the care of an ill family member at home and for the care of a child placed with relatives or a foster family (Regulation for criteria and standards of social services for children, 2003).

The relatives also have certain rights in this respect, but only if they are ascending and descending lineal relatives of the sick person and their spouse. The rights refer to taking leave from work and to financial compensation. The right to have a personal assistant applies to the groups listed below:

- people with at least 90% permanent disability
- children with at least 50% reduced capacity for social adaptation
- people or children taken from specialized institutions for people with disabilities (Georgieva *et al.* 2016).

The money provided as daily cash benefit to care for a sick family member following the issue of a sick leave certificate is calculated at 80% of the average gross salary, or of the average insurance income used as a basis for the calculation of insurance

contributions. The situation with self-employed people is different as they receive a benefit calculated on the basis of insurance contributions for sickness and maternity leave for 18 calendar months proceeding the month of onset.

It is important to note that opportunities for a temporary leave from work in accordance with sick leave schemes are only available for short periods of time. This means that support is provided for only a limited time with family members having to organise new arrangements for relatives needing LTC afterwards. Sick leave certificates are only accessible for jobholders in employment, not for the self-employed or people with freelance contracts (Georgieva *et al.*, 2016).

As already mentioned, Bulgaria has no solid remuneration system regarding the provision of informal services by family members; however, someone caring for a seriously ill family member may claim social financial assistance on a monthly basis. Monthly allowances are granted only to people meeting certain conditions, for example if they live alone or are in a family whose income for the previous month is below the differentiated minimum income. This applies to carers acting as either personal assistants (relatives) or social assistants (professional employees). Due to a lack of funds, the remuneration system applying to carers has been temporarily suspended.

The everyday tasks that were once carried out by social assistants are now being provided by private companies at different prices depending on the region or combination of services. Similarly, the right to a disability pension is restricted by conditions that have to be met in order for the pension to be awarded (at least 50% reduced working capacity is required). For pensioners whose degree of disability exceeds 90% and who need constant help an additional pension allowance of 75% of the social pension for old age is provided by the state (Georgieva *et al.*, 2016).

Taking unpaid sick leave in order to care for elderly and sick family members is more widespread

among women than men. According to the data mentioned in the ESPN Thematic Report (Georgieva *et al.*, 2016), in 2015, ‘only about 13,000 men took leave in order to care for a sick family member, compared with 133,000 women’. This is one of the factors which negatively influences women’s careers and the size of their pensions. Some difficulties can be associated with both home-based care and care outside the family. Bulgaria’s specific support for home-based care is very limited, covering only a very low proportion of related expenses, while failing to include lost income due to provision of care. On the other hand, care outside the family also faces serious challenges due to shortages of qualified nursing staff. Recently, Bulgaria has experienced a very large emigration of nurses and associated health professionals.

To summarise, the current situation is a complicated one. In order to provide an evidence base for the continuation of reforms, the lack of in-depth studies and analyses on the employment effects for carers, and of the overall effects of the existing LTC regime on the well-being of informal carers and the cared-for, needs to be addressed (Georgieva *et al.*, 2016).

Legislation for another organizational form of LTC (homes for medical and social care) was approved in 2010, with a view to implementing continuing medical observation and specific care for individuals of all ages with chronic illnesses. However, special care in homes for people with chronic incapacitating diseases and medical and social problems does not yet exist: such homes have not been established and there is no public funding for their activities.

V Information policy and use of new technologies

Currently, there is no effective information exchange between agencies and clients. In 2011, a project was launched to work towards a single information system for the Agency for People with Disabilities. The project finished with only a conceptual framework and without real information exchange among agencies.

VI Coordination of long-term care

Coverage and access to services

Because of a lack of a single organization or a programme devoted to LTC specifically, social services in Bulgaria are still of limited coverage, and their quality fails to satisfy the increasing demands for such services, placing a huge burden on the family, and, for the majority of citizens, impeding access to quality care. A good illustration of the of these issues is that the National Reform Programme (2015) noted slightly more than 500 service institutions for the elderly across the country, covering roughly 18000 persons – a negligible proportion of the elderly population (Georgieva *et al.*, 2016).

Therefore, if Bulgaria wants to keep abreast of the ageing of its population and find a solution to the problem arising from the scarcity of good-quality social services for the elderly, it needs to establish new types of services at a substantially faster pace. Despite the many political measures and legislative changes that have been proposed recently in this area, there is still no clarity as to how this can be achieved (Georgieva *et al.*, 2016).

Needs assessment

The term ‘need of care’ has not been legally defined. The lack of definition is partially compensated by establishing specific eligibility criteria in different legal acts regarding the different types of services available and addressing different populations, children and people with a disability among them.

Assessment of needs is normally conducted on an individual basis following the submission of an application to the respective welfare service. The eligibility criteria vary depending on the target group and the type of service. The minimum eligibility criteria for services are legally binding, being stipulated in various by-laws (i.e. regulations for the implementation of the respective law). The criteria may take into consideration the applicant’s income, family status, potential care providers (friends or relatives), property status, and type and severity of

disability, among others. Severity of disability is assessed by independent bodies, with the procedure being different for children and adults. Regarding disabled adults, the competent bodies are the Territorial Expert Consultative Panel and the National Expert Consultative Panel (Mincheva and Kanazireva, 2010).

There is a high demand for institutional care, especially for the elderly; the numbers of people with physical disabilities, people with mental disorders, and people in need of palliative care is increasing, and the capacity of existing services and programmes is insufficient.

Services for LTC need not be limited to elderly people, but should include people with disabilities and those who cannot independently carry out daily activities. According to the European Commission, one in six people has a disability ranging from mild to severe; implying an EU total of about 80 million people. More than a third of people aged over 75 have a disability. In Bulgaria, there are approximately 100,000 people with dementia, and at least 50,000 with Alzheimer's disease (Council of Ministers, 2014).

To date, Bulgaria does not record statistics on the number of people with disabilities. The information system for monitoring and evaluation, which is being constructed under the project 'Establishment of a Unified System for Managing the Overall Process in Implementation of State Policy to Work with People with Disabilities in Bulgaria', will analyse applicable strategic and operational documents with respect to the policy for people with disabilities using pre-defined indicators. The Ministry of Health creates and maintains the national official register of people with mental disorders. This system collects data and statistics on disabled people over 16 years of age with permanent disabilities, as well as patients under observation with mental and behavioural disorders.

According to NCPHA data based on annual processing of expert decisions, the number of persons with "permanent disability" over the age of

16 in recent years reduced in 2013 and 2014. It increased during 2015 then decreased again, with the latest figure being 65,751. Under amendments to the Health Act, which came into force in early 2005, the permanently reduced ability of persons aged 65 years is determined for life. After 2008, albeit there were fluctuations in the dynamics, an overall increase was observed in the number of persons with a lifetime permanent disability, reaching 38,875 persons in 2015 (or 21.2% of all certifications and re-certifications). At the same time, it should be recognized that the number of certifications and re-certifications of persons with a permanent disability and the prevalence is considerable – in 2015, it was 183,804 people, almost equally divided between men and women. The highest proportion of these people was in the over 60 age group (37.9%), followed by 50–59 years (35.8%) (National Center of Public Health and Analysis, 2015).

The above data and analysis clearly show that an ageing population will also require increased public spending on LTC: older people who have lost their independence and are in need of intensive care will constitute the fastest growing social group in the future. This will lead to an increased need to develop social and health services and networks of solidarity and care.

Key challenges for the system of social services for the elderly and disabled

Social services in Bulgaria are decentralized, with their management entrusted to municipalities. Services are provided according to the wishes and personal choices of the individuals who need them. To improve the coordination and integration of social services and to ensure equal access for people in vulnerable groups, a new approach to the development and provision of services through planning on the municipal and regional levels and based on needs analysis was introduced in 2010. The Social Assistance Agency maintains a register of individuals under the Commercial Act, as well as organizations and individuals engaged in commercial activity, and people operating under the

laws of another member state of the EU or of another member of the European Economic Area willing to provide social services. The Register listed 1,284 social service providers that have been issued a total of 3,710 certificates for the provision of different types of social services for children and adults (Council of Ministers, 2014).

The system for LTC and social services in Bulgaria has expanded considerably in recent years due to the various actions undertaken, deinstitutionalization, and the provision of more community-based and family-based services. However, there are serious challenges that will need to be addressed by further successful development of policies for LTC in Bulgaria (see Appendix, Table 1).

The geographical coverage of LTC and other social services in Bulgaria is uneven, although it usually reflects differences in population. Institutional models of care are still prevalent are, especially for people with disabilities and the elderly; sometimes institutional care is characterized by depersonalization and a lack of flexibility in daily routines and programmes as well as a group approach and social distance. But the fact remains that in Bulgaria there is still demand for institutional care, especially for the elderly. A similar situation is observed for the terminally ill, who need palliative care, and for patients with psychiatric disorders, where there is a particularly strong national bias to overcome in relation to these types of disorders. These are the only types of institutional care that show an increase in demand and in users (Council of Ministers, 2014).

In particular, as indicated by Mincheva and Kanazireva in the ENEPRI Research Report (2010), this is often observed in remote regions and villages, where residents are frequently left to cope on their own because of the impossibility of family physicians and social workers (the latter generally living and working in towns), to quickly respond to emergencies or organize regular home-based LTC. The situation is aggravated by the length of time passing before such patients can be placed in specialized public institutions. Hence, the care of

LTC patients often falls to hospitals, usually small municipality acute hospitals offering higher quality services at lower costs in an environment better adapted to this purpose. Although hospital authorities may view this demand sympathetically, financial constraints intervene.

Another serious issue – typical of the system of services in Bulgaria – is the insufficient number of preventive social and health services for adults in an early stage of a problem (also popular as premorbid prevention). The provision of these services has a key role in preventing the risk of social exclusion among the target group. A problem remains with the provision of services by unqualified personnel, mostly family members with a dependent elderly person. The lower economic value and the lack of social recognition of these services are factors limiting their development as a real sector of the economy.

Some of the main factors that influence the institutional model of care and the demand for this kind of care are listed in the National Strategy for Long-term Care (Council of Ministers, 2014):

- Insufficient number of services for the elderly and people with disabilities to meet demand, as well as uneven distribution throughout the country;
- Insufficient financial resources, which often results in the social exclusion of older people and people with disabilities, as well as their accommodation in institutions;
- No inclusive social and architectural environment;
- Increasing needs for institutional care, especially for the elderly. This may indicate the absence of genuine and safe alternative care that ensures a dignified and independent life with the family and community;
- Low pay for home care services provided in the home environment for the elderly and people with disabilities and a lack of social recognition and motivation for employed social workers; and

- Lack of comprehensive health and social services in the home environment meeting the needs of the elderly and people with disabilities and a lack of financing activities for long-term treatment and aftercare.

Quality of care

Improving the quality of care entails improving the facilities, structures, and professional capacity of staff and increasing compliance with the criteria and standards for the provision of social services. Additional efforts to enhance coordination between the social and health systems are necessary in order to achieve practical results, providing quality and affordable integrated services for the elderly and people with disabilities. Improved interaction between the social and health systems is a key to providing quality medical and social care for patients with chronic diseases. The construction and development of a model for long-term treatment, as well as integrated care for patients with chronic diseases by establishing health-social centres that can provide services by nurses and social workers at home is an important stage in the process of introducing new models conducive to the improved quality of life of these people.

One of the successful social services to support families caring for a dependent family member are the services of personal assistants, social assistants, and domestic assistants. Social services personal assistants and social assistants have been made available since 2003 under the national programme ‘Assistants for People with Disabilities’, which provides home care to people with permanent disabilities or to those who are seriously ill through personal and social assistants and also provides employment opportunities for unemployed people.

Organizations from the NGO sector support the development of services in the home environment and encourage the introduction of innovative approaches to social and health issues.

In the healthcare system, services (including palliative care) for the elderly and disabled are provided in hospitals and as outpatient assistance

and hospice care. Psychiatric care is provided through 12 state psychiatric hospitals, 12 community mental health centres and psychiatric wards in general/multi-profile acute care hospitals (see Appendix, Table 2).

The main legislation regulating the practice of medicine through the establishment of hospices is the Healthcare Facilities Act. Hospice care concentrates not only on the health or illnesses of patients, but on relieving their suffering through palliative care. It is imperative to establish clear rules for the organization of palliative care to guarantee the right to pain relief and reduced suffering, and to offer specialized care and emotional, social, and spiritual support for the terminally ill by their family and friends.

In view of the current situation of the system of services in Bulgaria and the serious challenges for its development implied by an ageing population and Bulgaria’s increasing needs for LTC, special emphasis is placed on:

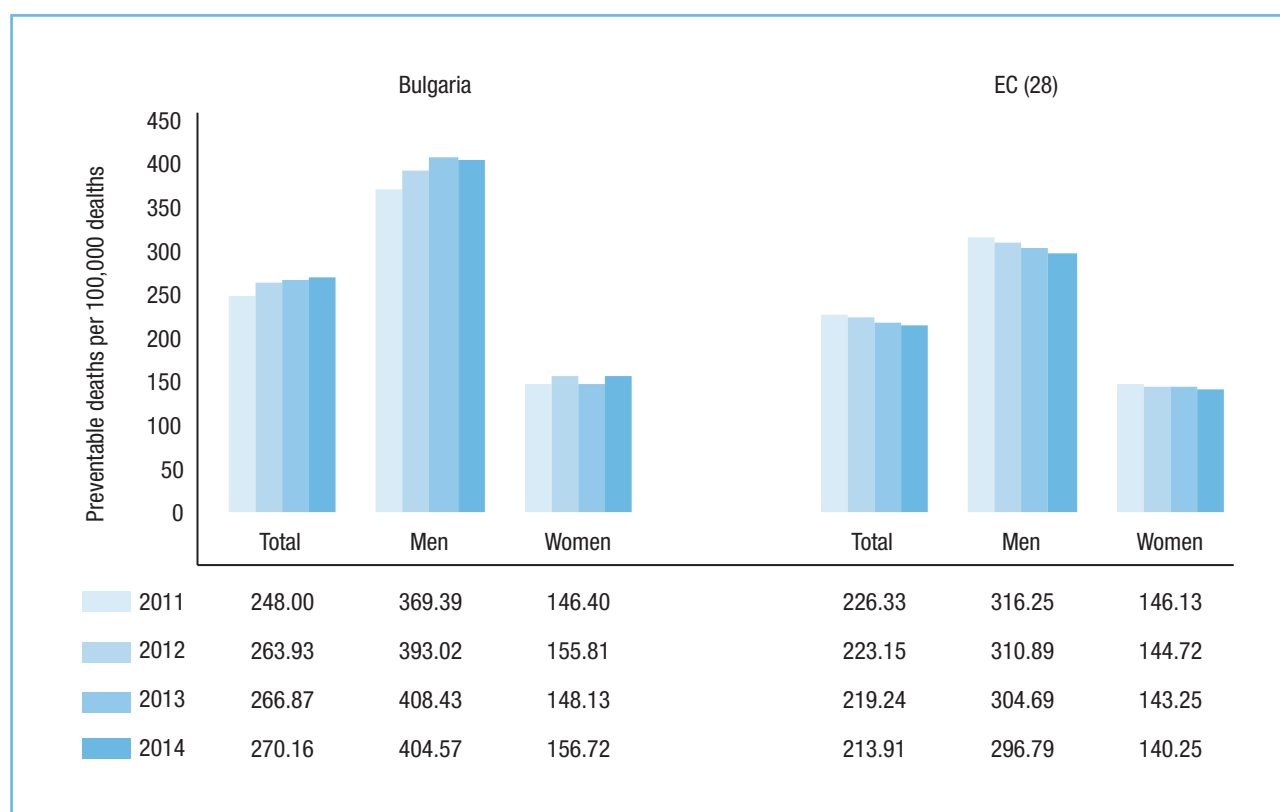
- Developing LTC through innovative cross-sectoral services (with a focus on the integration of social and health services) to be provided in accordance with the real needs to the neediest;
- Building an adequate network of community-based and home environment services (creating new community-based and at-home social services, including providing hourly services in support of social inclusion);
- Improving access to preventive health and social services for adults at an early stage;
- Providing comprehensive support for families caring for dependent members;
- Reviewing and discussing mechanisms for sustainable financing and the institutional settlement of LTC;
- Analysing practices in other EU Member States regarding funding for LTC, including through the instruments of the insurance system;

- Strengthening the role of social partners and businesses in the process of the development of LTC; developing public-private partnerships;
- Promoting volunteering and the implementation of closer interaction with the NGO sector
- Using information and communication technologies.

Bulgaria has many opportunities, through health policies at the national and regional level, to reach a better population health status by preventing many

diseases and reducing premature mortality (Figure 1). Yet the resources that were earmarked for this purpose are insufficient and constantly decreasing. Moreover, the state tends to withdraw from its main function in ensuring the implementation of such policies. Under these political circumstances the money and other resources allocated are used inefficiently without setting clear priorities, target horizons, risk determinants, and group assessments, and are used without the required monitoring.

Figure 1: Preventable deaths, Bulgaria (2011–2014)



Source: Eurostat, March 2017.

Conclusions

The LTC system in Bulgaria has expanded in recent years as a result of actions aimed at deinstitutionalization and the provision of more community-based and home-based services. Despite some progress – as discussed in this report – there remain considerable obstacles to making sufficient formal and informal LTC services available.

Regardless of their health status, elderly people sometimes need extra care that can be a heavy burden on their family, especially for those having stressful jobs. The only option left may be for the elderly person to be found a place in a home for the elderly or a hospice, or for the family to hire a professional carer. Using such institutions or services, particularly if they are private, may be too expensive and the care may be out of reach for those on low incomes. The impact is very significant for those living alone or below the poverty threshold.

Currently, as a result of population ageing trends, the number of public homes for the elderly available does not correspond to the growing number of elderly people dependent on LTC. Placements can take a considerable length of time to be made, sometimes even six months, and without care or help in the interim, during which time thousands of elderly people with scarce pensions and deteriorating health are compelled to live in sickness, poverty, and neglect (Mincheva and Kanazireva, 2010).

The national programmes and strategies, though announced at the governmental level, have so far failed to yield the desired results, largely due to the limited financial resources for their implementation. An interesting phenomenon can be seen in Bulgaria: community-based LTC services do appear very promising for the efforts towards deinstitutionalization, but this enthusiasm is perhaps over-hastily expressed as their efficiency has not been studied in depth. Financial constraints combined with insufficiently qualified staff to implement planned programmes, and the current lack of an effectively operating LTC system complete the picture of LTC in Bulgaria.

In view of this situation and analysis, urgent measures are needed to create a viable network of LTC services as an alternative to expensive institutional care. Of key importance is the support for informal LTC services, as this is often a less costly form of care for those in need.

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Appendix

Table 1: Number of social services facilities and places (specialized institutions and social services) available for the elderly and people with disabilities, at 31 October 2015

Type	Number	Capacity
Specialized institutions		
Homes for adults with mental disabilities	27	2,137
Homes for adults with mental disorders	13	1,036
Homes for adults with physical disabilities	21	1,315
Homes for adults with sensory disturbances	4	133
Homes for adults with dementia	14	825
Homes for the elderly	81	5,593
Total	160	11,039
Social services in the community		
Day care centres for adults with disabilities	65	1,740
Day centres for the elderly	50	1,304
Centres for social rehabilitation and integration for the elderly	71	2,277
Social training professional centres	7	447
Total	193	5,768
Social services in the community (residential)		
Sheltered housing	119	1,061
Observed housing	17	104
Transitional housing	11	100
Family-type accommodation centres	53	677
Crisis centres	4	45
Temporary accommodation centres	13	625
Shelters	2	70
Total	219	2,682
Total number of social services for the elderly and disabled people	572	19,489

Source: Social Assistance Agency.

Table 2: Health network and accommodation provision for long-term health services, 2014

Type	Number	Beds
Specialized hospitals for further or continuous treatment	5	251
Specialized hospitals for post treatment and rehabilitation	18	1,942
Specialized hospitals for rehabilitation	24	3,633
Psychiatric hospitals	12	2,438
Centres for mental health	12	1,358
Hospices	41	802

Source: NCPHA.

Table 3: Total expenditure for social protection, Bulgaria

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Euros (millions)	3,511.4	3,762.7	4,353.4	5,486.9	6,013.0	6,515.0	6,820.0	6,956.9	7,389.6	7,920.9
Percentage of GDP	14.7	13.8	13.4	14.7	16.1	17.0	16.5	16.6	17.6	18.5

Source: Eurostat, 8 March 2017.

Table 4: Social protection expenditure, cost allocation by type, Bulgaria

		2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Social protection benefits	(% GPD)	14.20	13.40	13.00	14.20	15.60	16.50	15.90	16.00	16.90	17.90
	(% TE)	96.58	96.93	96.69	96.60	96.82	97.07	96.55	96.23	96.27	96.75
Administration costs	(% GPD)	0.40	0.30	0.30	0.40	0.40	0.40	0.40	0.40	0.40	0.40
	(% TE)	2.47	2.41	2.49	2.49	2.40	2.06	2.33	2.41	2.26	2.10
Other expenditures	(% GPD)	0.10	0.10	0.10	0.10	0.10	0.10	0.20	0.20	0.30	0.20
	(% TE)	0.95	0.66	0.81	0.90	0.78	0.87	1.13	1.36	1.47	1.15
Sickness/health care	(% GPD)	4.10	3.50	3.50	4.20	3.70	4.00	4.20	4.20	4.40	4.90
	(% TE)	28.04	25.28	26.17	28.49	22.78	23.49	25.21	25.33	24.85	26.71
Disability	(% GPD)	1.20	1.20	1.10	1.10	1.30	1.30	1.20	1.20	1.40	1.40
	(% TE)	8.13	8.86	8.01	7.44	8.04	7.67	7.41	7.44	7.84	7.53
Old age	(% GPD)	6.60	6.40	6.10	6.40	7.30	7.70	7.20	7.10	7.60	7.90
	(% TE)	44.94	46.34	45.29	43.50	45.26	45.16	43.67	42.90	43.34	42.57
Survivors	(% GPD)	0.70	0.60	0.60	0.60	0.80	0.80	0.80	0.90	1.00	1.00
	(% TE)	4.45	4.69	4.49	4.31	4.87	4.82	4.91	5.49	5.52	5.30
Family/children	(% GPD)	1.00	1.00	1.10	1.20	1.90	1.90	1.70	1.70	1.80	1.90
	(% TE)	6.57	7.18	8.37	8.39	11.58	11.07	10.57	10.10	10.14	10.25
Unemployment	(% GPD)	0.30	0.30	0.30	0.30	0.50	0.60	0.60	0.60	0.50	0.50
	(% TE)	1.82	2.13	1.94	2.23	3.05	3.33	3.34	3.44	3.06	2.80
Housing	(% GPD)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	(% TE)	0.01	0.01	0.02	0.03	0.04	0.05	0.07	0.07	0.07	0.07
Social exclusion n.e.c.	(% GPD)	0.40	0.30	0.30	0.30	0.20	0.30	0.20	0.20	0.30	0.30
	(% TE)	2.62	2.43	2.41	2.22	1.19	1.49	1.37	1.45	1.45	1.52
Sickness/healthcare and disability	(% GPD)	5.30	4.70	4.60	5.30	5.00	5.30	5.40	5.40	5.80	6.30
	(% TE)	36.16	34.14	34.17	35.93	30.82	31.15	32.62	32.77	32.70	34.23
Old age and survivors	(% GPD)	7.30	7.10	6.70	7.10	8.10	8.50	8.00	8.00	8.60	8.90
	(% TE)	49.39	51.04	49.78	47.81	50.13	49.98	48.58	48.39	48.86	47.87
Housing and social exclusion n.e.c.	(% GPD)	0.40	0.30	0.30	0.30	0.20	0.30	0.20	0.30	0.30	0.30
	(% TE)	2.63	2.45	2.43	2.24	1.23	1.54	1.43	1.53	1.51	1.59

Source: Eurostat, 8 March 2017.

% GPD = Percentage of gross domestic product; % TE = Percentage of total expenditure