Document of
The World Bank

Report No: 20239-BUL

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF US$63.3 MILLION

TO THE

REPUBLIC OF BULGARIA

FOR A

HEALTH SECTOR REFORM PROJECT

May 30, 2000

Europe and Central Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective May 24, 2000)

Currency Unit = Bulgarian Lev
1Levi = US$ 0.4622
US$ 1 = Lev 2.1634

FISCAL YEAR

January 1 - December 31

ABBREVIATIONS AND ACRONYMS

AHIC	Australian Health Insurance Commission
APL	Adaptable Program Loan
BMA	Bulgarian Medical Association
CAS	Country Assistance Strategy
CEGA	Creating Effective Grassroots Alternatives
CoM	Cabinet of Ministers
CQ	Consultants' Qualification
DC	Direct Contracting
EA	Executing Agent
ECA	Europe and Central Asia
EMS	Emergency Medical Services
EU	European Union
FM	Financial Management
FMS	Financial Management Status
GDP	Gross Domestic Product
GOB	Government of Bulgaria
GP	General Practitioner
GPN	General Procurement Notice
HIF	Health Insurance Fund
HNP	Health, Nutrition and Population
HSRP	Health Sector Restructuring Project
IBRD	International Bank for Reconstruction and Development
IC	Individual Consultants
ICB	International Competitive Bidding
IDA	International Development Association
IFAC	International Federation of Accountants
IMF	International Monetary Fund
IPR	Implementation Progress Report
IS	International Sopping
MLSP	Ministry of Labor and Social Policy
MOF	Ministry of Finance
MOH	Ministry of Health
MW	Minor Works
NCB	National Competitive Bidding
NGO	Non-Government Organization
NHIF	National Health Insurance Fund
NS	National Shopping
OECD	Organization for Economic Cooperation and Development
PAD	Project Appraisal Document
PCU	Project Coordination Unit
PHC	Primary Health Care
PHRD	Population and Human Resources Development (Japanese Grant)
PMR	Project Management Report
PMU	Project Management Unit
POM	Project Operational Manual
QCBS	Quality and Cost-Based Selection
SDC	Swiss Agency for Development and Cooperation
SFB	Selection under Fixed Budget
SIL	Specific Investment Loan
SOE	Statement of Expenses
TA	Technical Assistance
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAT	Value Added Tax
WHO	World Health Organization

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BULGARIA
HEALTH SECTOR REFORM PROJECT

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MAP(S)

Republic of Bulgaria -- IBRD 26532R

BULGARIA

HEALTH SECTOR REFORM PROJECT

Project Appraisal Document

Europe and Central Asia Region
ECSHD

Date: May 24, 2000
Team Leader: Dominic S. Haazen
Country Manager/Director: Andrew N. Vorkink
Sector Manager/Director: Annette Dixon
Project ID: P055157
Sector(s): HY - Other Population, Health & Nutrition
Lending Instrument: Specific Investment Loan (SIL)
Theme(s):
Poverty Targeted Intervention: N

Project Financing Data

☒ Loan ☐ Credit ☐ Grant ☐ Guarantee ☐ Other (Specify)

For Loans/Credits/Others:

Amount (US$m): $63.3

Proposed Terms: Variable Spread & Rate Single Currency Loan (VSCL)

Grace period (years): 5 **Years to maturity:** 20

Commitment fee: 0.75%

Front end fee on Bank loan: 1.00%

Financing Plan: Source	Local	Foreign	Total
GOVERNMENT	18.62	5.04	23.66
IBRD	14.95	48.35	63.30
Total:	33.57	53.39	86.96

Borrower: GOVERNMENT OF BULGARIA

Responsible agency: MINISTRY OF HEALTH

Address: 5, Sveta Nedelya Square, Sofia, Bulgaria
Contact Person: Ms. Denitsa Sacheva - Atanassova
Head of the Office of the Minister of Health
Tel: 359 -2 - 930 1112 Fax: Email: Dsacheva@Mh.Government.Bg

Other Agency(ies):
National Health Insurance Fund
Address: 1, Krichim Street, 1407 Sofia, Bulgaria
Contact Person: Dr. Boyan Doganov, Head of PMU
Tel: 359-2-965 91 08 Fax: 359-2-965 92 28 Email: Bdoganov@Internet-Bg.Net

Estimated disbursements (Bank FY/US$M):

FY	2001	2002	2003	2004	2005		
Annual	6.4	17.8	19.4	13.3	6.4		
Cumulative	6.4	24.2	43.6	56.9	63.3		

Project implementation period: 5 years
Expected effectiveness date: 10/01/2000 **Expected closing date:** 09/30/2005

A. Project Development Objective

1. Project development objective: (see Annex 1)

The project development objective is to support the Government of Bulgaria in implementing a fundamental reform of its health sector, designed to improve access to quality health services and ensure financial and operational sustainability. Through revised funding, provider organization, and provider payment mechanisms, as well as the formulated package of benefits, the health system will provide better access to more effective and efficient health care and health promotion, especially for disadvantaged population groups and those in the remote areas.

This project forms an integral part of an overall Framework Program for health reform which includes substantial Government investments, as well as technical assistance support from other external agencies. This program is described in Section C and Annex 2 of this document.

2. Key performance indicators: (see Annex 1)

A set of key indicators is selected to track the extent to which the development objectives of the project are being met. The selection of indicators is based on a detailed decision-tree and logframe analysis for the project. The criteria used to select indicators include ensuring that: (a) indicative measures are available for *outputs* from each of the project components; (b) the selected indicators measured actual outputs, rather than simply measuring the number of items procured under the project; (c) all major issues and conditionalities will be monitored regularly; (d) the indicators, while being easy to measure, provide insight into the performance of the project; and (e) indicators are relatively small in number, so as to be meaningful for the project management while not being overly burdensome to collect. Given these criteria, the indicators are designed to give a sense of how the project is doing, rather than to measure every possible potential indicator.

A nationally-representative survey, will be carried out at the beginning and toward the end of the project to address the question of whether the health reform is having an impact on morbidity and mortality rates in Bulgaria. While the project cannot be held wholly responsible for health status changes, as many non-project variables affect health status, it is important for the Government to monitor these trends and to change strategy if required. These indicators will be an integral part of the strategy to measure project performance.

The key performance indicators for the project are detailed in Annex 1. The primary objectives of (a) improving access and effectiveness of health care, and (b) ensuring financial and operational sustainability in the health sector will need to be achieved within the Government's current budget ceiling of 4.5% of GDP. Once the reforms have substantially taken hold and efficiencies realized within the system, the adequacy of health sector financing will be analyzed.

Specific indicators address the activities under each of the sub-objectives. Under *(a) access*, indicators are specified for the following areas of activity: increasing access to services, improving the quality of services, improving capacity of providers, and improving communications with the public. Under *b): ensuring financial and operational sustainability*indicators or qualitative analyses are specified for: ensuring financial sustainability through labor adjustment, improving information flows, and ensuring a fully-functioning health insurance system.

B. Strategic Context

1. Sector-related Country Assistance Strategy (CAS) goal supported by the project: (see Annex 1)

Document number: 17655-BUL **Date of latest CAS discussion:** 04/09/98

The Bank's overall assistance strategy for Bulgaria aims at providing direct support to the Government in three priority areas: (a) the restructuring of social protection programs; (b) the improvement of incentives for private investment by further liberalizing trade and market structures, removing impediments to foreign investment, and facilitating private ownership of land; and (c) the implementation of European Union accession-related institutional and legislative reforms. The CAS also indicates that special attention will be given to support the Government's effort to fight poverty and develop human capital. The relative priority of social sector programs in the strategy reflects the need to prepare the country for EU membership pursuant to the agenda now emerging in the Accession Partnership Agreement and the National Strategy on Accession to the EU.

In health, the CAS aims to support the Government's efforts on a number of fronts. The key areas with respect to the health sector include assistance in:

- putting into place an efficient and sustainable health financing regime through an effective health insurance system and an increased role for the private sector;
- reducing structural inefficiencies by reducing excess capacity, strengthening sector management at the central and local levels, and promoting competition among providers;
- increasing the efficiency of public expenditures on health by prioritizing the most essential health services;
- helping the Government to generate dialogue among the stakeholders, including policy makers and the public, and to build consensus on reform options.

2. Main sector issues and Government strategy:

2.1. Background.

The economic transition towards a more market-oriented economy in Bulgaria, which began in late 1989, has been difficult. It has been characterized by the emergence of previously unknown unemployment, falls in real wages, and increased poverty. The resultant limitations on fiscal resources, coupled with changing demographics (increased needs due to a rapidly aging population), have constrained the Government's ability to address societal needs. The Government's short-term strategy has focused on both ensuring that the costs of the transition are socially sustainable and on reducing the number of families living in poverty. The longer-term strategy points to the need to reform and diversify both the health care delivery/financing and the pension systems. The following key objectives for the reform of the social protection systems are the foundations of the Government's strategy:

- to ensure the medium- and longer-term fiscal sustainability of the system in a manner that is consistent with economic growth objectives in a market-oriented economy;
- to increase fiscal transparency and reduce duplication and fragmentation among the various social protection systems; and,
- to ensure adequate protection of clearly identified vulnerable population groups through improved targeting and provision of meaningful benefits and quality services.

2.2 Sector Issues.

The health system has been analyzed by the Ministry of Health and others, and found to be inadequate. The system is deteriorating because of:

- a lack of service standards and quality assurance, coupled with inflexible, central control;
- a lack of incentives to provide high quality care;
- over-concentration of staff and resources in urban areas, and inequitable distribution of health financing;
- under-the-table payments;
- inefficiency and lack of management expertise at the service provider level; and
- lack of economic sustainability because of excessive health facility infrastructure and staffing.

2.3 Government of Bulgaria Health Reform Agenda.

The recently released Updated Government Program (March, 2000 - April, 2001) sets up specific objectives for the improvement of the quality of life of all Bulgarians. The Government's most important goal in this regard is the practical implementation of the health reform, which is expected to lead to a more humane attitude towards the patient and to improvements in access to high quality health services.

The priorities that have been identified by the Government for overcoming these sector issues and the needs for adaptation and accession of the Bulgarian health system to the EU include:

1. ***Mitigating the negative trends in the nation's health***
   Reducing infant mortality, limiting morbidity and mortality from socially important diseases (CVD, neoplasms, trauma and intoxication, diabetes, tuberculosis, HIV/AIDS and others), limiting occupational health risks and increasing safety at work, restricting health risks to disadvantaged social groups (ethnic minorities, elderly, unemployed, etc.), and improving the mental health of the population.

2. ***Enhancing health system effectiveness through institutional and structural changes in health services production and delivery***
   Including re-organizing or improving primary health care, specialized outpatient care, hospital care, blood transfusion, public health, emergency medical care and the pharmaceutical sector.

3. ***Promoting the quality of medical care***
   Development of standards, criteria and indicators for health care quality, improving health care management, updating equipment and premises of health care establishments, developing a unified information system, integrating the telecommunication systems in health to the national and the European systems, and developing an evaluation capacity for medical technologies and introduction of good medical practice guidelines.

4. ***Increasing health system effectiveness through change of the financing system***
   Completing the establishment and development of the structural units of the National Health Insurance Fund and its territorial structures, and developing its human resources, developing new investment policy and improving the financing within the MOH, introducing a contracting system between the financing body and the health care

providers, and introducing a system for medical and financial control.

5. ***Adapting human resources in health to the new economic circumstances and the institutional and structural changes in health***
   Addressing the pre-qualification and redistribution of medical staff, aligning the medical school curriculum with those of the EU countries and providing the grounds for free movement of specialists, and creating possibilities for constant professional training and participation in research activities.

The Government has defined the following strategy related to structural changes and development in health care:

1. to complete the establishment of the National Health Insurance Fund and to develop managerial, administrative and information capacity for the operation of a health insurance system in Bulgaria;
2. to create conditions for the development of voluntary health insurance funds through support for the establishment of insurance supervision administration;
3. to improve the collection of health insurance contributions through their incorporation in the system of tax and insurance payments collection by a unified state revenue collection agency;
4. to grant legal, financial and economic independence to health care establishments;
5. to complete the re-registration of the health care establishments as trade companies in the light of creating opportunities for subsequent privatization, with guaranteed preferential participation of doctors and dentists working within the health care system;
6. to create new types of medical institutions, such as hospices, to provide employment to the medical staff with college education;
7. to initiate the accreditation of health care establishments in the second half of year 2000;
8. to provide opportunities for professional self-governance of physicians and dentists, professional monitoring of the quality of medical care and ethic rules for relations with patients;
9. to organize and supervise measures to control corruption in health care (with the support and assistance of municipalities, NGOs, and citizens);
10. to provide transparency of structural and financial changes, with a view to place health care institutions and administration at the service of people; and
11. to create the required conditions for pharmacies' registration and operation.

The challenge is to build popular support for the reforms and to calibrate them in such a way as to ensure that they will succeed in making the systems financially and operationally viable, and both politically and socially acceptable. The Government's medium-term agenda encompasses action on health in poorer regions aimed at reducing disparities. The authorities have asked the World Health Organization (WHO) for assistance in defining a comprehensive health sector strategy. The aim is to enhance sector efficiency, increase resources allocated to the sector by tapping alternative sources of financing, and target public resources to the most cost-effective interventions.

2.4 Impact of Health Reform Agenda

It is clear that the current health reform agenda will substantially alter the service delivery, institutional, and financial arrangements within the health care system in Bulgaria. These changes include:

- employment arrangements for physicians changing from salaried state employees to independent

contractors;

- hospitals changing from public to private ownership, and the simultaneous implementation of a facility rationalization scheme that has been developed within the Ministry of Health;
- institutionalization of the change in the focus of ambulatory care toward a primary health care/general practice approach, and away from the current specialty-driven system;
- change in the payment arrangements from salaries or direct budget financing to capitation or global budgets, as described above;
- change in the entitlement for health care from a "free service" guaranteed by the constitution to an insurance entitlement based on contributions from employees and employers (or various levels of government for selected groups);
- change in out-of-pocket payments from officially non-existent and practically whatever the market would bear, to standard rates that are approved and backed up by legislation.

These changes reflect an overall implementation approach as part of a comprehensive health system reform package. The introduction of health insurance is being used as a catalyst to implement these reforms. It is clear that these changes will happen fairly quickly once the health insurance system is introduced. Some of the stakeholders in the health system are just now beginning to understand the implications and scope of these changes, and the points of view of these groups are now prevalent in the media. Effective public information campaigns are required to ensure that the media and the population at large have a clear idea of the scope and impact of these reforms.

2.5 Progress on Health Reform.

The Government has taken the first steps towards meeting these objectives. The box below provides a timeline of the actions to date, and those that are anticipated as the reforms evolve. Annex 14 gives more details on these developments and the current status of the reform process.

Activity	Planned Completion Date
The Parliament passes a National Health Insurance Act	June 4, 1998 (Completed)
The Parliament passes a Health Care Establishments Act	July 9, 1999 (Completed)
The Ministry of Health drafts a comprehensive program for implementing the health care reform, as a part of the overall Government Program	January 2000 (Completed)
Reform of the legal and property status of Primary Health Care establishments is implemented	March 15, 2000
Full geographic coverage of the country with General Practitioners is ensured	April 1, 2000 (Continuous)

The National Framework Contract between NHIF and the Bulgarian Medical Association is legally adopted	April 30, 2000 (Completed)
Full coverage of all individual citizens by a General Practitioner is ensured (registration process – patients select their doctors)	May 15, 2000
NHIF signs individual contracts with the PHC providers	May - June 2000
The new system of financing of the Primary Health Care Sector is launched	July 1, 2000
Reform of the legal and property status of Hospital Care establishments is completed, through a process of re-registration	September 2000 (Continuous)
Full re-evaluation of the hospitals and other health care establishments is completed, and formal accreditation is issued for all establishments	September 2000 (Continuous)
The new system of financing of the hospital care sector is launched	July 1, 2001

2.6 Bank Involvement

The Government is undertaking a large-scale reform in the health sector. As seen above, considerable effort and investment have already been made to create a reform strategy and to begin its implementation. The Government has started working on virtually all of the components of the planned reform, and is strongly committed to making the necessary investments. The Bank project will link into this process and provide needed support into the ongoing transformation, helping the Government meet the investment needs of the reform process.

The Bank has been assisting the Government for the last several years through the initial Health Sector Restructuring Project (HSRP) Loan Agreement, which was signed in 1996 and is currently under implementation. It encompasses Primary Health Care, Emergency Medical Services, Blood Transfusion, and Policy Analysis and Management. The Primary Health Care component of this project was recently formally restructured to direct the intervention more toward rural and remote areas of the country, thereby targeting the project more to the poor and vulnerable.

The Government views the Bank as the major partner in designing and implementing the health sector reform and, through the Ministry of Health, has requested continuing assistance for the reform process.

2.7 External Agency Support

A PHRD Grant was secured for a new Bank operation. The Australian Health Insurance Commission was

contracted to provide project preparation activities, and has already completed its work. Among the areas examined were: financial modeling of various options for the health insurance system, examination of administrative and information systems needs, definition of a basic package of services, examination of legal issues, and public information.

In recent months, the Bank has worked with the Swiss Government to arrange a grant from the Swiss Agency for Development and Cooperation (SDC) in support of NHIF. The Swiss Grant totals CHF 3 million (about US$2 million) and is implemented through a Bank-administered and recipient-executed Trust Fund. It provides for technical assistance and training to NHIF staff and its senior management. This assistance forms a key component of the overall Framework Program to support health sector reform.

3. Sector issues to be addressed by the project and strategic choices:

This project is designed to provide critical assistance to the Ministry of Health, NHIF, and the Government of Bulgaria in support of the health reform process. The key sector issues supported by the project include:

- improved service standards and quality assurance;
- increased incentives to provide high quality care;
- rationalization of staff and resources in urban areas, and improvements in the distribution of health financing;
- replacement of under-the-table payments with formal co-payments at prescribed levels;
- increased management expertise at the service provider level;
- improved economic sustainability through better health facility infrastructure and rational staffing levels.

Another key element of the project is ongoing policy dialogue between the Bank team and the Government with regard to the health reform agenda and implementation of this agenda. The effects of this ongoing dialogue are already apparent in the health insurance legislation and the various strategic choices that have been made by the Ministry of Health and NHIF management on issues such as the organization and staffing of the Fund and the selection of financing arrangements. The project is designed to maximize this policy dialogue by linking specific project components to the key policy thrusts, and utilizing the base that has been created through the significant institution building/technical assistance components included in the overall Framework Program.

C. Project Description Summary

1. Project components (see Annex 2 for a detailed description and Annex 3 for a detailed cost breakdown):

As noted above, the proposed project would be part of an overall program of health reform and It will be implemented over the next five years. The total cost of the project is estimated at US$86.96 million, including contingencies. The project would be financed by an IBRD Loan of US$63.30 million and Government counterpart financing of about $23.66 million.

The Framework Program has already been progressing without Bank financing for the past year, and other agencies are also supporting to the overall health reform program. The cost of the Framework Program is $119.41 million, with the Government contributing US$51.67 million, or 43 percent of the total. The Framework Program has seven components. Of these, four componenst comprise the project which will be financed through the Bank loan.

The World Bank Project

Component	Sector	Indicative Costs (US$M)	% of Total	Bank-financing (US$M)	% of Bank-financing
A. Primary and Ambulatory Care Reform	Basic Health	23.25	26.7	17.58	27.8
B. Hospital Care Reform	Basic Health	26.61	30.6	17.05	26.9
C. Health Financing Reform/NHIF	Health	24.74	28.4	16.44	26.0
D. Capacity Building	Health	11.73	13.5	11.60	18.3
Total Project Costs		86.33	99.3	62.67	99.0
Front-end fee		0.63	0.7	0.63	1.0
Total Financing Required		86.96	100.0	63.30	100.0
Other Elements of Framework Program					
E. NHIF Infrastructure Development	Health	28.01	23.5	0.00	0.0
F. Technical Assistance (Swiss Government)	Health	2.00	0.02	0.00	0.0
G. Technical Assistance (USAID)	Health	2.50	0.02	0.00	0.0
Total Costs of Framework Program		119.41	100.0	63.30	100.0

The following components are financed under the project:

Primary and Ambulatory Care Reform is designed to facilitate the reform and sustainability of the primary and ambulatory care sector. It includes providing practice equipment for primary health care, funding physician office information systems, providing training in GP practice management, funding a public information campaign to inform the public about changes in the ambulatory care system, financing a health reform investment program to provide low-interest loans for physicians, and funding a labor adjustment strategy to transition surplus physicians out of the health sector in Bulgaria.

Hospital Care Reform is designed to facilitate the reform and sustainability of the hospital care sector. It involves support for the implementation of reform of the hospital system, including funding hospital information systems, providing training in hospital management, funding a public information campaign to inform the public about changes in the hospital care system, financing a health reform investment program to provide low-interest loans to hospitals that make desired investments in new equipment and facilities, and funding a labor adjustment strategy to transition surplus hospital staff out of the health sector in Bulgaria.

Health Financing/NHIF will ensure a smoothly functioning health insurance administration in Bulgaria. It would assist the National Health Insurance Fund in establishing the technological infrastructure required to operate the national health insurance system, including the extensive hardware and software systems needed, as well as the training and technical assistance required to implement and maintain them.

Capacity Building is designed to strengthen the management and institutional capacity within the Ministry of Health, the National Health Insurance Fund, and the health system generally. It would fund project management and financial management, monitoring and evaluation activity. It will also provide funds for

the general training of NHIF, Regional and local staff, and finance an essential public information campaign to inform Bulgarians of the significant changes that will be taking place within their health care system and advise them of how these changes will improve the overall delivery and effectiveness of health care.

As part of the Framework Program, the following components are financed by other agencies:

NHIF Infrastructure Development provides a base upon which the Bank financed project is built. It represents the investments that have already been made by the National Health Insurance Fund in establishing its operations, including the purchase and/or renovation of the national office and 28 regional offices, plus the office equipment, computer hardware and software, furniture, and training required to bring the NHIF to its current level of readiness.

Technical Assistance - Swiss Government includes the substantial technical assistance grant (CHF 3 million equivalent) from the Swiss Government, which will fund essential support in the areas of general management, health insurance operations, human resources managment, information systems management and essential training for senior managers.

Technical Assistance (USAID) includes additional technical assistance from the United States government through USAID to strengthen financial and investment management within the NHIF. The Bank has worked with USAID to ensure that the package of technical assistance being provided complements the activities financed by the Swiss Government and the Bank.

2. Key policy and institutional reforms supported by the project:

The proposed project supports a fundamental reform in the health system in Bulgaria, involving virtually all components of the system. Under the general rubric of the implementation of national health insurance, a new package of primary health care benefits is being introduced, changes are being made in the way that primary health care services are paid and organized, and the payment arrangements and ownership of hospitals and specialist physicians (medical specialists, surgeons and diagnostic specialists) are being altered. An integral part of the process is the rationalization of facilities and personnel throughout the country and the encouragement of greater equity in the access to health services both geographically and to various socio-economic groups, according to a carefully developed national health map. All of these measures are essential to ensure the long-term viability of health care financing in Bulgaria.

3. Benefits and target population:

As noted above, the implementation of national health insurance is the catalyst for a comprehensive reform program designed to stop the deterioration of health services throughout the country and ensure that the available resources are spent wisely to provide needed, high quality services.

The entire population of Bulgaria would benefit from the implementation of the health system reforms, including the introduction of national health insurance, and from the certainty that these programs would provide in terms of ensuring the long-term sustainability and availability of health services. Since premiums are tied to income, while the range of services would be equally available to everyone, national health insurance will have a distributional effect in favor of the poor. Premiums for the most vulnerable members of society, including pensioners, the unemployed and those on social assistance, are paid for by either the municipal or national government. Moreover, improved access to services should particularly favor the poor that are in ill health.

The move from the current methods of resource allocation to one based on population, demographic and other needs-based indicators will particularly favor those in rural and remote areas, many of whom live in poverty. The proposed project will continue the approach included in the first health project, where rural and remote communities were targeted in particular for improvements in health facilities and services.

4. Institutional and implementation arrangements:

The overall responsibility for project coordination and implementation will lie with the Project Management Unit (PMU), which will be an independent unit supervised by a joint board comprising senior management of the Ministry of Health and the National Health Insurance Fund. The first four staff of the PCU were hired in early April, 2000 and will ensure that an appropriate project management, financial management, and procurement system is established very quickly. The Project Management and Project Preparation consultants hired under the Swiss Grant, and the Financial Management consultant hired under Component 1 of the first project will also assist in ensuring that implementation can commmence immediately once the loan is approved.

Close coordination will be maintained with other potential external aid agencies during the life of the project, and will play an important role in successful project implementation. Regular aid coordination conferences will be held, agency representatives will be invited to participate on supervision missions, and aide memoires will be shared with them.

D. Project Rationale

1. Project alternatives considered and reasons for rejection:

(a) Small technical assistance package: While this could be mobilized fairly quickly, technical assistance alone would not give the Government of Bulgaria the resources it needs to actually implement its health reform agenda. Moreover, the Bank has already worked to attract other donors (the Swiss and US governments), which are already providing significant technical assistance to the Government of Bulgaria.

(b) Adjustment Lending: An adjustment operation to support health reform could be mounted fairly quickly and provide a significant amount of money to meet the specific needs of the health reform process. However, Bulgaria currently has a number of large adjustment operations and there is no room within the overall country allocation for additional adjustment lending. In addition, an investment operation appears to provide more scope for ongoing policy dialogue with the Government as the reforms are implemented and modifications are required.

(c) Loan for NHIF only: Although this was discussed earlier and advocated strongly by the former Minister of Health, it was considered that it is essential that the significant impact that the introduction of National Health Insurance will have on health care service providers should be addressed by a new lending operation for the health sector generally. Otherwise, the mechanisms for implementing the insurance will be there within the Insurance Fund, but those contracting with the fund will not be able to either enter into appropriate contracts or provide the services required by these contracts.

(d) Adaptable Program Loan (APL): The APL has increasingly been used in the last several years as a means of linking ongoing Bank funding to continued progress on the policy and reform agenda. Given the state of development of the health reform process in Bulgaria, and its ongoing implementation, it is felt that a staged approach is not appropriate for this operation. As noted in Part B of the PAD, all of the major elements of the reform process are already well thought out and are already in the process of being

implemented. The timing of these reforms is such that it would be very difficult to design a multi-stage loan with appropriate triggers that would still address the needs of the client.

2. Major related projects financed by the Bank and/or other development agencies (completed, ongoing and planned).

Sector Issue	Project	Latest Supervision (PSR) Ratings (Bank-financed projects only)	
		Implementation Progress (IP)	Development Objective (DO)
Bank-financed			
	Health Sector Restructuring	S	S
	Social Insurance Admin.	HS	HS
	Social Protection Adj.	S	S
	Regional Initiatives Fund	S	S
Other development agencies			
PHARE (TRANSFORM)	NHIF Staff Training		
PHARE	PHC Training (completed)		
Swiss Agency for Development and Cooperation (SDC)	NHIF Technical Assisstance		
USAID	NHIF Technical Assistance		
Government of Spain	Hospital Management Training		

IP/DO Ratings: HS (Highly Satisfactory), S (Satisfactory), U (Unsatisfactory), HU (Highly Unsatisfactory)

3. Lessons learned and reflected in the project design:

Through the existing health restructuring and social insurance administration project, the project team has gained a good appreciation of the strengths and weaknesses of the Bulgarian health and social security systems. The proposed Bank financing provides the Ministry of Health and the NHIF with both the expertise and the financial resources to further address a number of key policy issues. The Health Sector Restructuring project has greatly improved the infrastructure of the health system, especially in the areas of emergency medical services and blood transfusion. In the area of primary health care, almost all preparations are being made to implement the new primary health care system by July 1 of this year, including the PHC-package of the NHIF, but it is clear from this project that additional resources are required in several areas to resolve the key structural issues that plague the health system today:

- significant over-capacity and over-employment, including inefficient skills mix of health personnel;
- inadequate targeting of services to those most in need;
- uncertainties in funding to providers, and inconsistent availability to patients; and
- inequitable distribution of health care funding to different regions of the country.

The use of selective contracting and restructuring of the service providers should address the first three of these issues, while the use of a population based funding allocation methodology should alleviate the fourth. The Bank has had an ongoing policy dialogue with the Ministry of Health and the National Health Insurance Fund to address these and other issues. These discussions are reflected in the overall thrust of the health reform agenda. It is clear that financing reform in the form of national health insurance in the absence of other fundamental reforms of the health system will no more alleviate these issues than health restructuring without health financing reform. The project therefore addresses both of these aspects as part

of a comprehensive package.

Lessons learned from other health projects in ECA (see Health Sector Development Strategy) include:

1. Health sector reform is a lengthy and politicized process and expectations have often been optimistic;
2. The institutional aspects of reform are as important as the technical approaches used;
3. Greater attention needs to be paid to the political economy through marketing reforms to lawmakers, the medical community and the general public; and
4. Projects have often been too complex.

These lessons have been reflected in the project design in a number of ways. First, the Bank team was consistent in urging the Government of Bulgaria to postpone the implementation of national health insurance to provide more time for the up-front activity that was required. Second, considerable attention and resources have been devoted in the project to the development of public information strategies which explain the reforms to all of the stakeholders and to address issues such as corruption within the health sector. The PHRD grant activities specifically addressed this issue, and technical assistance funding is also being provided through the Swiss Grant. Third, the general technical assistance component, as well as the specific financing through the Swiss grant are designed to develop significant institutional capacity to ensure sustainability at that level. Finally, the project components themselves are few in number and based on proven approaches.

4. Indications of borrower commitment and ownership:

The Government of Bulgaria is very committed to the successful implementation of a major health reform program, including the introduction of national health insurance. It has passed enabling legislation for health insurance, health personnel, and health providers and made the necessary modifications to the social security law to create the room for the collection of health insurance premiums. It has also appointed some of the most talented individuals in the Ministry of Health and the health system in Bulgaria generally to head up the NHIF and plan for the implementation of health insurance. Premiums are currently being collected, and plans are underway for the commencement of provider contracts and payments for ambulatory care services, beginning July 1, 2000. NHIF has also started building successfully its regional structure and information network, and is well-advanced in its preparation for the start of the first phase (coverage of outpatient care) of the health insurance financing. Approximately US$28 million has already been spent in setting up the health insurance system. In-patient care will continue to be financed directly by the Ministry of Health until the second phase, expected to begin on July 1, 2001. Comprehensive health strategies and a national health map have also been developed to guide the overall health reform efforts.

5. Value added of Bank support in this project:

The Bank is one of the few major development lenders still engaged in the health sector in Bulgaria. Bank staff have been involved in the health reform process as well as the national health insurance initiative for many years, providing policy advice and assistance to the Government of Bulgaria in a variety of areas, including development of the health insurance legislation, addressing key issues related to NHI implementation (with the assistance of the PHRD grant), and focusing on critical organizational and sustainability issues. The Bank has the capacity to mobilize both the significant financial and intellectual resources required to support successful health system reform, including the implementation of national health insurance. By focusing the discussion on key policy issues through the way in which the loan is designed, the Bank will also have the leverage to address some of the critical structural problems that have confounded health reform initiatives in many countries. The ongoing Bank interest in this sector have also appeared to generate renewed interest in the health system by other multi-lateral and bi-lateral donors.

E. Summary Project Analysis (Detailed assessments are in the project file, see Annex 8)

1. Economic (see Annex 4):

● Cost benefit NPV=US$40 million; ERR = 55.7 % (see Annex 4)
○ Cost effectiveness
○ Other (specify)

Presently within the HNP sector of the Bank, there is considerable discussion regarding the most appropriate form of economic analysis to be used for health projects. In the absence of clear guidance, it is felt that the cost-benefit approach used here is most appropriate for the type of project being proposed.

The economic analysis is based primarily on the savings that can be achieved as a result of the project activities (including activities already undertaken by the NHIF), compared to the costs of implementing health reform in the absence of the project. In some cases, this reflects the substitution of equipment and information systems for staff, while in other cases the savings include the cost reductions resulting from transitioning redundant personnel out of the health system. The analysis is based on the investment and recurring costs and benefits of undertaking the project, and examines the impact on the health sector alone (e.g., increased VAT from project expenditures is not considered as a benefit). The analysis shows a positive NPV of US$40.0 million. The key assumptions are shown in Annex 4. This calculation is based on a a twenty year time frame and utilizes a 10 percent discount rate. Annex 4 also contains a sensitivity analysis that shows a significant positive NPV for all of the variants utilized, and assesses the risks related to each variant. The payback period under the standard assumptions is 10.9 years from the beginning of the project implementation.

Other potential areas of savings not included in the above analysis include reductions in the average lengths of stays in hospitals (estimated US$24.3 million per year, of which **US$7.3 million** annually could be attributable to improved information systems), and more effective use of pharmaceuticals as a result of the introduction of clinical practice guidelines (estimated annual savings of around **US$7.5 million.**) These areas are also described in Annex 4.

2. Financial (see Annex 5):

NPV=US$ million; FRR = % (see Annex 4)
N.A.

Fiscal Impact:

Average annual project costs (excluding tax), are approximately 2.8 percent of 1999 public health expenditure. Recurrent costs under the Project amount to approximately 2 percent of projected public health expenditure. The recurrent costs of depreciation, repairs and maintenance and consumables associated with the project investments are offset by related savings as indicated in the economic analysis. The project will produce a positive net cash flow starting in year 5 of the project implementation.

On a broader level, the fiscal sustainability of the health system is a key consideration, and is explored in more detail in Part F.

3. Technical:

3.1 General

The project's components are well-focused, mutually reinforcing, and technically sound. A large body of knowledge exists, both in the region and elsewhere, regarding the implementation of health reform, including national health insurance. The approach selected by Bulgaria has made extensive use of this body of knowledge, and reflects the lessons learned from this experience to develop a system that should be both feasible and sustainable. None of the technical solutions chosen are particularly complex, and all utilize existing and proven technology.

3.2 Health Information and Health Information Systems

General. The project envisions a highly integrated approach to the implementation of health information systems, including the critical, but often under-emphasized, investments in management capacity building, health information standards, and reporting forms rationalization/revision. The core operational information systems for the health insurance fund are "surrounded" by complementary system investments in the primary care and hospital sub-sectors. Also, NHIF's needs for management and analytical systems, in addition to its core operational systems, are addressed. A more detailed analysis of the information technology issues is found in a background paper in the project files. The key issues are summarized below:

National Health Information Standards Formulation / Health Forms Rationalization. Comparable information is essential both for management and for closer cooperation among health service providers at the operational level (e.g., among hospitals and between the primary and hospital care providers). In both dimensions, comparable information requires common information standards. The project supports a multi-agency initiative to formulate health information standards on a national level. The rationalization of reporting forms critically depends on the establishment a solid foundation of health information standards, since the health sector's operational systems (e.g., the clinical and resource management systems) operate at this base level. The project supports the forms rationalization process in close conjunction with the health standards formulation process.

Quality of Care / Accreditation. The project includes an initiative to strengthen the national capacity to undertake health care quality assessments and accreditation activities. This is a closely allied effort to the health information standards and forms rationalization process.

Software / Knowledge Engineering. Two of the most frequent points of failure of major information systems initiatives are: (a) the translation of an agency's business processes into the detailed logic embedded in the application code; and (b) the user's acceptance of the new technologies and the new procedures/practices that accompany with them. Limiting both these risk areas depends on how well the formal and *de facto* business processes are discovered and articulated by the systems analysts. The project supports the strengthening of the NHIF's software/knowledge engineering capacities, through the acquisition of a computer assisted software engineering tool (CASE tool) and related professional training. During the course of the project, the NHIF will continuously shift the emphasis of its in-house informatics professionals, towards greater emphasis on software/knowledge engineering and less on the technical support of the underlying technology infrastructure (e.g., the workstations, servers, network technologies).

Systems Integration. The complexity and evolving nature of the HIF's business processes, and corresponding information systems, requires the NHIF to adopt a phased and modular approach to information systems implementation. This means that at each stage of the process, the newly introduced systems must function with all of the existing, "incumbent" systems. The NHIF has already launched its systems implementation, including (a) the interim basic system, (b) the insured and provider registers, (c) the basic insured accounting module, and (d) the contracting and payment module for the primary health

care providers. Modules to support the management of the hospital care sub-sector (as well as other functions) will be implemented under a competitively-procured contract and financed by the project. Initially, the providers' systems will be provided on a reduced-cost or free basis. However, the subsequent annual licenses and upgrades will be financial responsibilities of the health care service providers. This will help ensure a competitive market for primary care and hospital information systems develops in Bulgaria. It will also help ensure that NHIF is not saddled with a permanent responsibility to further develop and/or finance such provider level information systems.

4. Institutional:

4.1 Executing agencies:

The Ministry of Health (MOH) will be the key executing agency, although both the MOH and the NHIF will be involved in the project implementation, supported by the Project Coordination Unit.

The NHIF has a very strong top management team. It enjoys the benefit of having a "greenfield" in its line of business. The agency itself is also new and without the debilitating legacies that many previously existing agencies suffer under. Notwithstanding the inevitable constraints, this should give the NHIF a fair degree of freedom to invent itself and its business, as it goes along. The NHIF has also benefited from the "surplus" of doctors in Bulgaria and assembled a well-educated and intelligent staff.

4.2 Project management:

This is the second Bank financed health project in Bulgaria, therefore substantial institutional capacity already exists in the implementing agencies. In addition, the NHIF is currently in the midst of the actual implementation of national health insurance, which has required a great deal of procurement and contract management. This has been done using either World Bank or Bulgarian procurement standards, which are similar in many respects. Project management and preparation expertise is being provided through the Swiss Grant, and was in place in late March to assist the NHIF and the Project Management Unit. Funding for staff training has also been included in the project.

4.3 Procurement issues:

An experienced procurement specialist has already been hired by the PMU and he will be assisted by the Project Management and Project Preparation consultants funded through the Swiss Grant. A procurement assessment and procurement plan have also been completed (see Annex 6). Procurement arrangements and policies will be reflected in the Project Implementation Plan and Operations Manual. Funding has been provided for additional procurement consulting expertise during implementation, as well as specific training for PMU staff in procurement.

4.4 Financial management issues:

An experienced project accountant has already been hired by the PMU and is being assisted by the Project Preparation Consultant, as well as the Financial Management consultant funded through the first project. Project accounting and procurement software has already been selected and installed. A financial management assessment was prepared during the project appraisal to determine if there any outstanding issues that need to be addressed prior to the Board presentation. The action plan has been reviewed and all of the necessary steps have been completed. Financial management policies and procedures are reflected in the Project Implementation Plan. Considerable training and consulting assistance in financial management

is being provided to both the PMU and the NHIF through the Swiss Grant and the project. An action plan is also being developed to move to PMR-based disbursements by June 30, 2001.

Compliance with the financial covenants with respect to the first project is acceptable, and there does not appear to be a high degree of risk in the banking sector in Bulgaria. The PMU will shortly open a Special Account (for the Swiss Grant) at a commercial bank or the National Bank, and will do the same for the Bank loan. Fiduciary controls also appear to be very good in the first project with respect to equipment and vehicles provided by the project. Most of the equipment is in the control of the Ministry of Health, and the balance is being controlled by the municipalities. Each of the participating municipalities have signed contracts with the Minister of Health which provide, *inter alia*, for controls over the equipment provided. It is expected that municipalities will also be involved in the control of some of the equipment provided under the second project, and the remainder will be covered by direct contracts between the service providers and the MOH/NHIF.

5. Environmental: Environmental Category: F (Financial Intermediary Assessment)

5.1 Summarize the steps undertaken for environmental assessment and EMP preparation (including consultation and disclosure) and the significant issues and their treatment emerging from this analysis.

The Government has prepared an environmental management plan as required by the Board condition. The plan will be included in the Project Implementation Plan, and it will be enforced by the Project Management Unit and the National Health Insurance Fund in its implementation of the Health Reform Investment Program.

5.2 What are the main features of the EMP and are they adequate?

In Bulgaria there are environmental regulations in force that makes control and supervision of construction works mandatory. Particularly, Council of Ministers Ordinance Nr.56 /1999. The Bill of Quantities will nevertheless include clauses for appropriate disposal of unacceptable existing construction materials and disposal of construction waste. Procurement documents will specify that no environmentally unacceptable materials will be used. As appropriate bidding documents will include planting of trees, the rehabilitation of adequate sanitary facilities, including appropriate disposal of waste water and sewerage. There is on going experience with the current Health Reform Project, Primary Health Care Component, where no environmentally harmful materials have been utilized in similar MW. The PMU will be responsible to hire and oversee the required architects, engineers and contractors. In the context of the refurbishment activities, the PMU's role is to manage the design, bidding, supervision of projects (including civil works, goods and services). The PMU's responsibility includes the following activities:

- hire the services of private architectural/engineering firms capable of providing comprehensive services, i.e. architectural, all required engineering, preparation of tender documents and site supervision;
- supervise the work performed by the architectural/engineering firms to ensure that they are applying adequate standards and are following agreed procedures, as well as the agreed environmental plan.
- organize tendering procedures, review tender evaluation performed by the architectural/engineering firms, arrange for the contracts to be signed in accordance with agreed procedures.
- ensure that the architectural/engineering firms are providing adequate site supervision, particularly the supervision of carrying out the environmental plan (monitoring the disposal of unwanted materials, disposal of waste water and sewage, and procurement documents specify that no lead based painted will be used).

5.3 For Category A and B projects, timeline and status of EA:

Date of receipt of final draft:

N/A

5.4 How have stakeholders been consulted at the stage of (a) environmental screening and (b) draft EA report on the environmental impacts and proposed environment management plan? Describe mechanisms of consultation that were used and which groups were consulted?

N/A

5.5 What mechanisms have been established to monitor and evaluate the impact of the project on the environment? Do the indicators reflect the objectives and results of the EMP?

See above.

6. Social:

6.1 Summarize key social issues relevant to the project objectives, and specify the project's social development outcomes.

The key social issue will be the potential displacement of health workers as a result of the rationalization of services precipitated by the introduction of national health insurance. As part of the project preparation, the Government has been developing a labor adjustment strategy to deal with this displacement. This will include severance costs, training costs and other adjustment expenses. The Government will fund these costs as part of their contribution to the overall project costs.

The issue of adequate health care services to the poor and to rural populations (mostly the same groups) is being addressed in the first Health Sector Restructuring Project. This project is being restructured to target the improved general practice clinics and staff to areas that are currently under-serviced. This approach is being encouraged in the second project, both in the direct support to the health system to facilitate health reforms and the implementation of the health insurance program with regard to user charges and regional allocation models. As noted above, the national health insurance approach being implemented is an inclusive and progressively financed program. As such, it should be of greater benefit to the poor and disadvantaged in Bulgarian society.

Finally, there is a concern about public perceptions that some physicians engage in corrupt practices. The following box identifies the problem, suggests reasons why corruption occurs, and details how the project will address this concern.

A Multi-Pronged Strategy for Combating Corruption

The Problem: public concerns about corrupt practices by the physicians, include:

- Public-sector doctors who direct clients to private practitioners where they have to pay for services that should be "free";
- Clients do not receive health care services in a timely manner unless the physician is given a favor or a bribe;
- And, to a lesser extent, physicians write prescriptions for expensive medications that can only be procured in pharmacies in which the physician has a financial interest.

Why Corruption Occurs:

- Low pay of physicians given their high level of education and experience;
- Difficulty in distinguishing between gifts given freely as an expression of gratitude (allowed by legislation) and payments extorted as a pre-condition for services (a corrupt practice);
- The absence of measures against those who take bribes;
- Absence of clear norms to define the relationship between physicians and their patients.

How the Project will Address:

- The Labor Adjustment Strategy will reduce the total number of medical doctors employed, allowing part of the savings to be used for improved remuneration for the remaining physicians;
- Development and widespread dissemination of public information messages on patient rights and responsibilities under the health care reform --- including what prices should be charged for services;
- Hot-lines at National Health Insurance Fund and 28 Regional Insurance Funds to provide information and to receive complaints;
- Regular medical audits to be carried out in 2% of practices every month;
- Establishment of procedures to investigate and possibly cancel the contract with NHIF of any physician engaging in corrupt activities;
- Regular monitoring and evaluation on this issue, including annual reporting by the Government.

6.2 Participatory Approach: How are key stakeholders participating in the project?

Parliamentary Commission on Health: during discussion of the health insurance legislation
Bulgarian Medical Association: various times regarding impact of health insurance on physicians
The Nurses Association: regarding impact of health insurance on nurses.
Ministry of Health: constant contact throughout development of health insurance concept
National Health Insurance Fund: constant contact since its inception
National Association of Municipalities: contact on how the proposed project will impact health care provision/financing at the local level.

6.3 How does the project involve consultations or collaboration with NGOs or other civil society organizations?

The project team met with representatives of CEGA (Creating Effective Grassroots Alternatives), a leading NGO working with the vulnerable Roma population. NHIF has been working with CEGA to see how best to reach the Roma and other vulnerable populations through its public information campaign.

The team also worked with "Coalition 2000", the leading NGO working to combat corruption in the public sector in Bulgaria.

6.4 What institutional arrangements have been provided to ensure the project achieves its social development outcomes?

The Project Management Unit has been given the responsibility to ensure that activities proposed for advance social development are carried out. In addition, the PMU will prepare regular updates on the status of the social development indicators that were defined.

6.5 How will the project monitor performance in terms of social development outcomes?

A set of key indicators will be used to assess project performance in terms of social development outcomes. Specific effort was made to ensure that the main concerns of the social assessment are being addressed, i.e. that the physicians who are down-sized out of the health care system are receiving severance payments and retraining, that the vulnerable populations have access to health care services, and that "under-the-table" payments are curtailed. Data collection methods are specified in the monitoring-and-evaluation strategy.

7. Safeguard Policies:

7.1 Do any of the following safeguard policies apply to the project?

Policy	Applicability
☐ Environmental Assessment **(OP 4.01, BP 4.01, GP 4.01)**	☒ Yes ☐ No
☐ Natural habitats **(OP 4.04, BP 4.04, GP 4.04)**	☐ Yes ☒ No
☐ Forestry **(OP 4.36, GP 4.36)**	☐ Yes ☒ No
☐ Pest Management **(OP 4.09)**	☐ Yes ☒ No
☐ Cultural Property **(OPN 11.03)**	☐ Yes ☒ No
☐ Indigenous Peoples **(OD 4.20)**	☐ Yes ☒ No
☐ Involuntary Resettlement **(OD 4.30)**	☐ Yes ☒ No
☐ Safety of Dams **(OP 4.37, BP 4.37)**	☐ Yes ☒ No
☐ Projects in International Waters **(OP 7.50, BP 7.50, GP 7.50)**	☐ Yes ☒ No
☐ Projects in Disputed Areas **(OP 7.60, BP 7.60, GP 7.60)**	☐ Yes ☒ No

7.2 Describe provisions made by the project to ensure compliance with applicable safeguard policies.

See Section 5.2 above.

F. Sustainability and Risks

1. Sustainability:

The Government of Bulgaria has already invested a substantial amount of time, money and other resources in the health reform process, and has made numerous public commitments to achieve the goals of health reform. The policy commitment to a continuation of the reform process is therefore significant.

The other key area is the sustainability of the health financing system itself. Here, a substantial portion of the Bank loan is for the establishment of appropriate administrative and information systems. In addition, the institutional building/technical assistance component will contribute to a well-managed and fully functioning health financing system that is able to fund high-quality services on an ongoing basis.

The NHIF has already accumulated impressive expertise in the area of key revenue and expenditure projections. The latest projections indicate that, once a steady state is reached, there should be sufficient

income to cover ongoing health care expenditures and administrative expenses. A key assumption is an increase in health insurance revenue to cover the additional cost of providing hospital services when this part of the finance reform comes on line in July, 2001. One potential problem area on the revenue side is the collection rate for health premiums. A recent analysis for the first quarter of CY00 shows that, while current collection rates are 90% of the target, collection rates of less than 60 percent are noted for several insured groups, and the problem is mainly due to insufficient contributions made by municipalities in respect of these groups. Specific conditionality has been included in the project to monitor this on an ongoing basis.

On the expenditure side, the economic analysis shows a number of potential savings in providing health services. While a portion of these savings are correctly targeted to improving the wage levels of health workers, the magnitude of the savings that can be achieved should give a large enough buffer to ensure continued sustainability. Of course, a key risk is the willingness to actually achieve these savings by making the necessary structural changes. All indications from the Government to date are that they are indeed prepared to take the required action.

2. Critical Risks (reflecting assumptions in the fourth column of Annex 1):

Risk	Risk Rating	Risk Minimization Measure
From Outputs to Objective		
1. Workers and facilities will not be removed as the health reforms are implemented. Political will required at the MOH, NHIF and government level to ensure required reductions are made.	S	- Specific inclusion of labor adjustment programs in the new loan should help to focus attention on this issue. - Continued policy dialogue, as well as monitoring and evaluation activities will keep attention focused on this issue. - Reductions in excess capacity are also clearly linked to the ongoing sustainability of the system.
2. Reductions in inter-regional variations will not lead to improved access/health status, or inter-regional variations will not be reduced.	M	- Significant amounts of technical assistance, together with in-house analytical capacity should ensure that appropriate funding models and implementation plans are developed. - The provider payment methods selected lend themselves to population-based funding approaches. - Monitoring and evaluation strategies will focus specifically on this issue. - The quality assurance and monitoring function within the NHIF will also assess issues of access and quality of care on an ongoing basis.

3. Cost-effective health insurance administration will not help to control overall health care costs.	S	- Utilize proven approaches for health insurance management, adapted to local conditions. - With technical assistance provided through the project, develop effective monitoring and analysis tools to highlight potential issues in health care cost control before they reach crisis proportions. - Maintain ongoing dialogue with the Bulgarian Medical Association and provider groups to address cost control issues.
4. Health care costs and demand for health services can be controlled through effective NHIF and health provider management.	S	- Controlling health care costs and demand are global problems, however, the national health insurance system as designed provides provider and consumer incentives that are proven to be effective. - Utilize the extensive monitoring and analysis capability included in the system at the provider level to evaluate trends in health services demand.
5. Financing of system could be jeopardized by deterioration of the economic situation (low economic growth, inflation) or by public backlash or avoidance of contributions (through working in informal sector).	M	Prudent fiscal policy; public education efforts.
From Components to Outputs 1. A well-trained physician population with better clinical equipment and information systems does not provide improved health care services.	M	- The quality assurance and monitoring function within the NHIF and available to providers will help to assess issues of access and quality of care on an ongoing basis.
2. A smaller number of well-equipped hospitals with improved information systems do not provide better inpatient care services.	M	- The quality assurance and monitoring function within the NHIF and available to providers will help to assess issues of access and quality of care on an ongoing basis.
3. The incentives contained in the package of benefits, provider payment methods, and NHIF infrastructure will not support a sustainable health financing system.	S	- With technical assistance provided through the project, develop effective monitoring and analysis tools to highlight potential issues in health care cost control before they reach crisis proportions. - Maintain ongoing dialogue with the Bulgarian Medical Association and provider groups to address cost control issues.

4. Improved salaries/benefits and access to better medical equipment and technologies will fail to undermine old system of informal payments between patient and doctor.	S	- Extensive public information campaigns will be utilized to ensure that citizens are aware of their rights and responsibilities under the new financing system, including the fact that the only allowable co-payment is the one provide for in the Health Insurance Act. - Regular monitoring of this issue is included in both project conditionalities and in the monitoring and evaluation plans.
5. Training, public information and technical assistance will not be sufficient to the smooth implementation and sustainability of the health reforms.	M	- Utilize proven approaches based on the recommendations of experts in the field. - Ensure that the government commitment to the health reform process is well known to the various stakeholders.
Overall Risk Rating	S	

Risk Rating - H (High Risk), S (Substantial Risk), M (Modest Risk), N(Negligible or Low Risk)

3. Possible Controversial Aspects:

Social Issues: The rationalization of the health system and the proposed improvements in efficiency will result in reduced numbers of physicians, and health workers in Bulgaria. Considerable numbers will lose their jobs, which could lead to social conflicts and tensions. Appropriate management of the process of releasing these workers is imperative, as the health insurance system will not be able to support the inflated number of health professionals and could undermine the solvency of the insurance fund. To address this concern, the project will offer services to meet the needs of the displaced health workers, including retraining opportunities, severance payments, and access to funds to set up entrepreneurial pursuits.

G. Main Loan Conditions

1. Effectiveness Condition

A. Negotiations Conditions:

(i) Agreement has been reached on the criteria and conditions for the Health Reform Investment Program.

B. Board Conditions:

(i) the Financial Management Action Plan, developed as a result of the FMS review conducted during the appraisal mission, has been implemented to the satisfaction of a certified Financial Management Specialist.

(ii) the Project Implementation Plan has been completed in a format satisfactory to the Bank, including the procurement for the first year of implementation.

(iii) a short list of auditors, as well as the Terms of Reference for the audit function, have been provided to the Bank and received No Objection.

(iv) an Environmental Management Plan satisfactory to the Bank has been prepared by the Project Management Unit.

C. Effectiveness Conditions:

(i) the Project Operations Manual (for the operation of the Health Reform Investment Program) has been completed in a format satisfactory to the Bank, and adopted by the PMU,

(ii) key PMU staff have been hired (Project Director, Chief Accountant, Procurement Specialist and Project Administrator).

(iii) a project auditor, acceptable to the Bank, has been appointed.

2. Other [classify according to covenant types used in the Legal Agreements.]

Dated Covenant:

(i) the Labor Adjustment Strategy for physicians and hospital workers will be formulated and implemented by April 30, 2001, and operated continuously throughout the life of the project

Implementation:

Project Management:

(i) The PCU will prepare quarterly Project Management Reports (PMRs) which detail project financing needs and sources for the subsequent quarter of project implementation, and describe the financial situation of the project in terms of actual versus planned expenditures for each project activity.

Project Monitoring and Evaluation:

(i) The PCU will have drafted a mid-term review report by April 30, 2003, highlighting both progress towards the agreed-upon indicators and implementation progress and constraints, to be used as the basis for a joint MOH-NHIF-Bank mid-term review mission which will be completed by July 31, 2003, and thereafter the Government will take measures which are required to ensure the efficient completion of the project and achievement of project objectives.

(ii) The Government of Bulgaria will report annually to the Bank (by April 30 for the previous calendar year) on progress that has been made towards combating corruption in the health sector, with specific focus on under-the-table payments and the effectiveness of the official co-payment mechanisms.

(iii) The Government of Bulgaria will report annually to the Bank (by April 30 for the previous calendar year) on progress that has been made towards ensuring uniform access to health services for all ethnic, economic and geographic groups, as well as the level of health insurance coverage for these groups and the population generally.

Health Policy:

(i) The Government of Bulgaria will review by June 30 each year with the Bank (to ensure input into the Government's budget process) progress on project implementation and health reform generally. This discussion shall include, *inter alia*, current and proposed premium levels and premium collection rates, other sources of financing for health services, current and future requirements for Government contributions to the project activities, and a business plan for the next year's project operations.

H. Readiness for Implementation

☐ 1. a) The engineering design documents for the first year's activities are complete and ready for the start of project implementation.
☒ 1. b) Not applicable.

☒ 2. The procurement documents for the first year's activities are complete and ready for the start of project implementation.
☒ 3. The Project Implementation Plan has been appraised and found to be realistic and of satisfactory quality.
☐ 4. The following items are lacking and are discussed under loan conditions (Section G):

I. Compliance with Bank Policies

☒ 1. This project complies with all applicable Bank policies.
☐ 2. The following exceptions to Bank policies are recommended for approval. The project complies with all other applicable Bank policies.

Dominic S. Haazen	Annette Dixon	Andrew N. Vorkink
Team Leader	**Sector Manager/Director**	**Country Manager/Director**

Annex 1: Project Design Summary

BULGARIA: HEALTH SECTOR REFORM PROJECT

Hierarchy of Objectives	Key Performance Indicators	Monitoring & Evaluation	Critical Assumptions
Sector-related CAS Goal: To stop deterioration in the health status of the Bulgarian population while gradually improving to Western European standards.	**Sector Indicators:** Mortality and morbidity rates for major health concerns (such as cardio- vascular disease and stroke), by age, sex, region, ethnic group, and socioeconomic status	**Sector/ country reports:** Nationally-representative sample survey to be carried out at beginning and at end of project. Over-sampling will be done for minority, rural, and other population sub-groups.	**(from Goal to Bank Mission)** The project objectives: (a) to improve the cost-effectiveness and (b) access to health care services will contribute to improvements in health status, given budget constraints. While the project cannot be held wholly responsible for health status changes, as other variables affect health status, it is important for the Government to gauge whether the health reform in having a discernible impact on important disease and mortality patterns.
Project Development Objective: Support the GoB in implementing a fundamental reform of its health sector, designed to improve access and ensure ongoing financial and operational sustainability.	**Outcome / Impact Indicators:** Ability to implement reform within a fixed percent of GDP spent on health care, annually. (initially 4.5%, to be reviewed throughout project)	**Project reports:** (a) National Statistics; (b) National Income and Expenditure Accounts; (c) Utilization and financial reports from NHIF and MOH.	**(from Objective to Goal)** (a) stable political and economic environment required to stay within MOF and IMF-mandated 4.5% cap; (b) introduction of health reforms, including national health insurance, will lead to improved access and higher standards of health care.

Sub-Objectives			AS ABOVE.
1. Ensure on-going financial and operational sustainability of health sector	1.1 Administrative costs of NHIF as a percentage of total revenue (initially 3-4%, target 2-3%); 1.2 Operating surplus/deficit of NHIF (after subsidies) (target: balanced budgets) 1.3 Health expenditures per capita by category of health provider (baseline TBD, initially PHC increasing, hospitals stable, then PHC stable, hospitals decreasing)	1.1 - 1.3 Administrative records of NHIF and census estimates of population (for 1.3)	
2. Improve access and effectiveness of health care and health promotion in Bulgaria	2.1 Percentage of population, by region and socioeconomic status, who report that basic package of health care services is available to them within one hour from home (Baseline TBD, target 20-25% improvement over baseline) 2.2 Percentage of population, by region and socioeconomic status, who report that health care services were provided without coercion to provide extra payments or gifts (baseline TBD, target 40-50% improvement over baseline).	2.1, 2.2 Question in public opinion polls/focus group discussions financed under public information component, with over-sampling of vulnerable populations and rural areas	

Hierarchy of Objectives	Key Performance Indicators	Monitoring & Evaluation	Critical Assumptions
Output from each component:	**Output Indicators:**	**Project reports:**	**(from Outputs to Objective)**
1.1 To ensure **financial sustainability** of health insurance system by funding a labor adjustment strategy to transition surplus doctors out of the health sector and to improve provider payment mechanisms.	1.1.1 Number of physicians and other medical personnel receiving severance payments (needs TBD, project target to meet 60% of identified need) 1.1.2 Units costs for specific services. Specific services to identified and agreed upon by 30 June 2000, target: stable unit costs over time.	1.1.1 - 1.1.2 Administrative records of NHIF and MLSP	1.1 Removing/ retraining redundant health workers and eliminating excess facilities will improve system cost-effectiveness.
1.2 To improve **information flows** through provision and use of information systems in GP offices, hospitals, and the NHIF	1.2.1 Number of GP offices and hospitals equipped with information system technologies (target 3500 physicians and 150 hospitals equipped)	1.2.1 Administrative records from NHIF and regional health insurance funds 1.2.2 PMU will provide a short written qualitative assessments strengths and weaknesses of the system annually	1.2 Transition to computerized environment will be "bug-free", allowing the timely exchange of information.
1.3 To ensure a **fully-functioning health insurance system**, including: (a) premium collection (b) subscriber registration (c) provider contracting/ payment (d) utilization analysis and financial management	1.3.1 Set of four indicators, analyzed against annual targets: (a) premium collection rates, by category (employee, unemployed, etc.) and source of funding (municipality, employee,, Unemployment Bureau); (b) number of subscriber registrations by location; (c) utilization rates per provider [aggregated]; and (d) reimbursements to physicians by region, in absolute and per capita terms (desired baseline TBD, target 85% of baseline levels. 1.3.2 Administrative costs of NHIF, compared to target and compared to other jurisdictions (initially 3-4%, target 2-3%)	1.3.1 Adminstrative records of NHIF and regional insurance funds 1.3.2 Comparison of health insurance administrative costs to those of other jurisdictions (NHIF and OECD reports).	1.3. Cost-effective health insurance administration will help to control overall health care costs.

2.1 To ensure **access** to basic package of well- functioning services to all members of the population, including vulnerable groups, through a newly-designed network of GPs & hospitals.	2.1.1 Number of GPs contracted with NHIF by geographic area & by "undesirable" location (baseline need TBD, target 75% of need). 2.1.2 Percentage of Roma population who report satisfactory or better access to and treatment by GPs (baseline TBD, target 80% improvement over baseline).	2.1.1 Administrative records of NHIF. 2.1.2 Qualitative, focus group discussions with Roma, organized by NGOs or research study groups.	2.1.1 That physicians who are contracted are working in the locations specified. 2.1.2 Roma selected for focus groups are representative of the Roma population rather than those pre-selected from physician registers.
2.2 To heighten **quality of health services** through provision of better equipment and supplies, improved service standards for quality assurance, and increased incentives to provide high-quality care.	2.2.1 Number of municipalities with current contracts to lease medical equipment to GPs, compared to target number (Target 1500 practices). 2.2.2 Medical audit results (on adherence to conditions of contract, appropriate use of practice guidelines, and rational prescribing practices), comparing practices who have received equipment vs. those who have not (target 95% of those who receive equipment have favorable or better results).	2.2.1 Administrative records of NHIF and regional health insurance funds. 2.2.2 Administrative records of the Medicat Audit Dept of the National Health Insurance Fund	2.2.1 - 2.2.2 That provision of better equipment to physician will translate to better health care; that physician has received the appropriate training to use the equipment, and that equipment contracted out is appropriate for the disease profile of the municipality.
2.3 To improve **capacity of providers** through training in use of upgraded equipment, regular conduct of medical audits, and availability of the Investment Program for locally- selected upgrades to facilities and equipment.	2.3.1 Disbursements and repayments to the Investment Program for: (a) physicians, and (b) hospitals (target 600 physicians and 80 hospitals, 90% repayment).	2.3.1 Adminstrative records of the Health Reform Investment Program Implementing Agency	2.3.1 Most effective methods to improve capacity of providers is to provide training, additional opportunities for better equipment, and through medical audits.

2.4 To better **inform public** about the benefits and their responsibilities under the heatlh reforms.	2.4.1 Percentage of respondents who report: (a) being registered with or knowing how to register with a GP: (b) being aware of benefits provided and expected out-of-pocket expenses for provision of services; and (3) being aware of "hot-lines" for information, complaints (baseline TBD, target 80% in all 3 areas).	2.4.1 Questions in public opinion polls.	2.4.1 That a well-informed public will be supportive or and compliant with the health reform.

Hierarchy of Objectives	Key Performance Indicators	Monitoring & Evaluation	Critical Assumptions
Project Components / Sub-components: A. Primary and Ambulatory Care Reform	**Inputs: (budget for each component)** IBRD $17.64 M GOB $5.7M	**Project reports:** Project Management Reports (Quarterly and Annual), as detailed in Monitoring and Evaluation section.	**(from Components to Outputs)** 1. A well-trained physician population with better clinical equipment and information systems will provide improved health care services.
B. Hospital Care Reform	IBRD $17.1 M GOB $9.6 M		2. A smaller number of well-equiped hospitals with improved information systems will provide better inpatient care services.
C. Health Financing Reform/NHIF	IBRD $16.4 M GOB $8.3 M		3. The incentives contained in the package of benefits, provider payment methods, and NHIF infrastructure will support a sustainable health financing system.
D. Capacity Building	IBRD $12.2 M GOB $0.1 M		4. Training, public information and technical assistance will contribute to the smooth implementation and sustainability of the health reforms.

Annex 2: Project Description

BULGARIA: HEALTH SECTOR REFORM PROJECT

The proposed project would be implemented over five years. The project would be financed by an IBRD Loan of US$63.30 million and Government financing of about $23.66 million ($15.0 million net of taxes). The project is part of an overall Framework Program to implement health reform. The project itself has four components, while an additional three components are included in the Framework Program. The costs shown below are total costs, including the Government contribution.

By Component:

Project Component 1 - US$23.25 million

A. PRIMARY AND AMBULATORY CARE REFORM

This component would include providing practice equipment to another 1,500 primary health care doctors, funding physician office information systems for 3,500 practices, providing training in GP practice management to 2,500 physicians, funding a public information campaign to inform the public about changes in the ambulatory care system, financing a health reform investment program to provide low-interest loans to physicians who make desired investments in new equipment and facilities, and funding a labor adjustment strategy to transition surplus physicians out of the health sector in Bulgaria. In this way, the project is addressing the key reform issues in the ambulatory care sector: lack of equipment and facilities, lack of training, surplus capacity, and lack of knowledge on the part of the public about the implications and benefits of the health reforms.

The component would include the following activities:

(1) **Primary Care Practice Equipment (US$7.2M).** This activity would provide PHC practice equipment to 1,500 newly established family physicians focusing on those in rural and under-serviced areas of the country. This would continue the approach of the PHC component of the first Health Sector Restructuring Project. The criteria for the selection of these practices would be similar to that used in the first project, and would reflect the overall health needs as defined in the National Health Map. The equipment and supplies purchased would also be essentially the same as that purchased through the first project, although some modifications may be made to reflect the lessons learned from that project. Training on the use of the equipment, and primary care practice management would be provided through the training sub-component described below.

Inputs: Equipment acquired through ICB and UNICEF
Outcome: Fully functioning primary care practices.
Responsible Unit: MOH, PMU

(2) **Health Reform Investment Program (US$3.0M).** This Program will be supported by the NHIF as a means of encouraging physicians to make investments in equipment and facilities that are necessary to ensure high quality and efficient patient care within a sustainable financing system. Lease-to-own arrangements will be available to (a) General practitioners not covered under the previous activity, (b) medical and surgical specialists, and (c) diagnostic specialists, to permit them to purchase specific types of equipment or make particular

improvements to their physical infrastructure. The interest rate, though preferential, will be set at a level so that it would not need to be subsidized. Payments would be guaranteed by the future income of the GP practices from the NHIF, and secured by the equipment until it is fully paid for. Payments would be made through deductions from the regular payments made by the NHIF to these physicians (a valid contract with the NHIF would be one of the key eligibility conditions), and the funds recaptured in this way would be available to finance further investment activity. The criteria, payment terms and other procedures will be included in the Operations Manual and defined in advance, so that physicians can make an informed decision on whether to access these funds. A maximum amount of $5,000 per physician is envisioned. The primary objective is to encourage physicians to make the necessary investments, while getting the maximum benefit out of a limited pool of funds. Current Bulgarian legislation places specific requirements before credit-giving institutions, and NHIF will need some type of special arrangement in order to create and run this Program. Administratively, the investment program will have to be in compliance with Bulgarian legislation on banking and credits. In similar cases with other target funds, either special legislation was developed, or a licensed financial intermediary was used. NHIF will work with MoH and appropriate government agencies to define the legal framework in which the Program will function, and will take necessary steps to ensure that the fund complies with all requirements of other relevant Bulgarian laws and regulations.

Inputs: Investment funds, administrative infrastructure of NHIF.
Outcome: Well equipped and functional ambulatory care facilities.
Responsible Unit: NHIF, PMU

(3) Labor Adjustment Strategy (US$2.6M). It is clear that in order to have a functional and sustainable ambulatory care sector, something needs to be done to address the substantial excess capacity that currently exists in the health system. Unless this is done, the NHIF will be faced with increasing pressure to contract with more physicians, with the likely result that costs will be much higher than they should be. This labor adjustment program is designed to transition excess physicians (an estimated 1,000 physicians with the funds available) out of the health care sector and into other areas of the economy. It will include severance payments, retraining, and start-up funds for entrepreneurial activity, and will be financed by the Government.

The severance payments component will be based on existing options and experience as well as on new programs especially designed for the health sector workers. The classic part of the program will constitute a one-time payment of 6 to 12 monthly salaries (or approximately USD 1000 per person) for health sector workers and physicians leaving the sector because of closing down of clinics and other PHC establishments.

The Bulgarian experience in designing and administering severance payments programs, and the available opportunities under current legislation include the following:

1. The scheme for severance payments under the CoM Regulation 100 from 1996, which applies for large-scale state enterprises under liquidation, restructuring and privatization. The package in this case consists of 2 components: (a) a passive labor market measure in the form of one-time universal payment for all laid-off, amounting to BGL 1000 (USD 500) and (b) an active labor market measure in the form of additional payment of BGL 1000 after the submission of a business plan for the start-up of a family business or self

employment. To deal with the problem of the insufficient budget of the Professional Qualification and Unemployment Fund, as well as the active labor market programs (ALMP's), the project will provide a targeted funding allocation.

2. The framework of the existing legal regulations (Unemployment Security and Employment Promotion Act) allows the introduction of special training and retraining programs, leading to permanent employment in areas requiring a mix of the "new" and the "old" skills of the trainees. These activities might include: (a) financial support to participate in professional qualification courses under art. 91 of the Unemployment Security and Employment Promotion Act for people who are already unemployed; and (b) professional qualification for people working in enterprises under restructuring (art. 90, para 1(4) of the Law). Specialized training events can be organized to allow people with secondary and tertiary medical education to move to the social services provision area. The Social Assistance Act and the Regulation for its implementation provide opportunities for NGOs and other non-government providers to take over the provision of specific social services after licensing. Similar programs can be developed for inspectors of the sanitary conditions in food-processing companies, markets, food warehouses, etc., and for counsellors to work with marginalized groups - drug addicts, HIV positive, alcoholics, heavy smokers, street children, delinquent children, prisoners and ex-prisoners, abused persons, heavily handicapped, people with suicidal behavior and other psychological problems, etc. There is a need for such services and for job openings in schools, hospitals, community centers, etc.

3. It is possible to encourage private business settings where the educational background and the professional qualification and experience of the laid-off medical staff could be best utilized - e.g. running small-scale institutions for children, people with disabilities, old people terminally ill people, etc. This is a still unoccupied "niche" of the Bulgarian social services emerging market. Its development needs different types of interventions and support, including:
   - marketing and detailed needs assessment;
   - business education and motivation of the people to grasp the business opportunities;
   - counseling to build confidence, entrepreneurial spirit and awareness of the social importance of this type of business enterprises;
   - information and training for getting acquainted with the best and most advanced foreign professional and business practices;
   - financial support (loans, credit quarantees) for the start-up costs at favorable rates and repayment conditions;
   - elaborate licensing and other standards for the establishment of such businesses, set monitoring indicators and regulatory body.

Inputs: International expertise, existing and newly developed labor adjustment programs, severance and start-up payments.
Outcome: Lower number of physicians in the health sector.
Responsible Unit: MOH, NHIF and BMA

(4) Physician Office Information Systems (US$8.2M). This activity would provide approximately 3500 physician offices and clinics with computer hardware and specialized application software to allow physicians to communicate with the NHIF regarding patient eligibility, provide activity and diagnostic information to the NHIF, and facilitate practice

management and quality assurance activities. By capturing this information at source for both physicians offices and hospitals, the NHIF estimates that approximately 1,000 full-time staff hires can be averted in the insurance fund administration. In addition, access to this data will allow the NHIF to carry out its medical audit and quality assurance functions in a more cost-effective manner by providing physician profiling and patterns of practice review.

Inputs: Information technologies (hardware, standard and specialized software) and training (see below).
Outcome: More cost-effective ambulatory care system and health insurance administration.
Responsible Unit: NHIF, PMU

(5) **Training and Public Information (US$2.2M).** To ensure that the equipment and other investments provided under this component are used properly, this sub-component provides training in practice management and the use of new equipment and information systems to physicians contracted by the NHIF. In addition, a public information campaign will be funded to ensure that the general public are aware of their rights and obligations under the new financial and organizational arrangements.

Inputs: International expertise and local knowledge, media materials
Outcome: A well informed public that is confident that they will be able to obtain the care they need, when they need it.
Responsible Unit: MOH, NHIF, PMU with additional local input

Project Component 2 - US$26.61 million

B. HOSPITAL CARE REFORM

This component involves support for the implementation of health reform in the hospital system. Although the contracting process will not commence until July 1, 2001, owing to the size and complexity of the hospital system, it is critical that the planning and implementation of these reforms commence as soon as possible. This component would include funding hospital information systems for 150 hospitals, providing training in hospital management to almost 2,000 managers and staff, funding a public information campaign to inform the public about changes in the hospital care system, financing a health reform investment program to provide lease-to-own arrangments for hospitals to make desired investments in new equipment and facilities, and funding a labor adjustment strategy to transition surplus hospital staff out of the health sector in Bulgaria.

The component would include the following activities:

(1) **Health Reform Investment Program (US$8.0M).** This Program will be supported by the NHIF as a means of encouraging hospitals to make investments in equipment and facilities that are necessary to ensure high quality and efficient patient care within a sustainable financing system. Low-interest lease to own arragements will be available to hospitals to permit them to make investments that improve energy efficiency or hospital hygiene, or to purchase specific types of equipment or make particular improvements to their physical infrastructure. The criteria, repayment terms and other procedures will be defined in advance, so that hospital managers can make an informed decision on whether to access these funds. A maximum

sub-project size of $150,000 per hospital is envisioned, and the average is expected to be $100,000. Payments would be made through deductions from the regular payments made by the NHIF to these hospitals (a valid contract with the NHIF would be one of the key eligibility conditions), and funds recaptured in this way would be available to finance further investment activity. The primary objective is to encourage hospitals to make the necessary investments, while getting the maximum benefit out of a limited pool of funds. Conditions will the similar to those explained in Component 1(2) above.

Inputs: Investment funds, administrative infrastructure of NHIF.
Outcome: Well equipped and functional hospital care facilities.
Responsible Unit: NHIF, PMU

(2) Labor Adjustment Strategy (US$7.0M). It is clear that in order to have a functional and sustainable hospital care sector, something needs to be done to address the substantial excess capacity that currently exists in the health system. Unless this is done, the NHIF will be faced with increasing pressure to contract with more hospitals, with the likely result that costs will be much higher than they should be. This labor adjustment program is designed to transition excess hospital workers out of the health care sector and into other areas of the economy. It will include severance payments, retraining, and start-up funds for entrepreneurial activity, and will be financed by the Government. The severance payments component will be based on existing options and experience as well as on new programs especially designed for the health sector workers (as discussed for Component 1(3) above). The classic part of the program will constitute a one-time payment of 6 to 12 monthly salaries (or approximately between USD 1000 per person) for health sector workers and physicians leaving the sector because of closing down hospitals. It is expected that approximately 2,800 hospital workers will be included in this program.

Inputs: International expertise, existing and newly developed labor adjustment programs, severance and start-up payments.
Outcome: Lower number of hospital workers in the health sector.
Responsible Unit: MOH, NHIF

(3) Hospital Management Information Systems (US$7.5M). This activity would provide approximately 150 hospitals with computer hardware and specialized application software to allow them to communicate with the NHIF regarding patient eligibility, provide activity and diagnostic information to the NHIF, and facilitate hospital management and quality assurance activities. By capturing this information at source for both physicians offices and hospitals, the NHIF estimates that approximately 1,000 full-time staff hires can be averted in the insurance fund administration. In addition, access to this data will allow the NHIF to carry out its medical audit and quality assurance functions in a more cost-effective manner by providing physician and hospital profiling and patterns of practice review. These systems would also serve as a platform for future development of DRG systems which will allow easier comparisons of hospital activities.

Inputs: Information technologies (hardware, standard and specialized software) and training (see below).
Outcome: More cost-effective hospital system and health insurance administration.
Responsible Unit: NHIF, PMU

(4) Training and Public Information (US$4.1M). To ensure that the equipment and other investments provided under this component are used properly, this sub-component provides training in hospital management and case mix systems for hospital managers and their staff for those hospitals contracted by the NHIF. In addition, a public information campaign will be funded to ensure that the general public are aware of their rights and obligations under the new financial and organizational arrangements.

Inputs: International expertise and local knowledge, media materials
Outcome: A well informed public that is confident that they will be able to obtain the care they need, when they need it.
Responsible Unit: MOH, NHIF, PMU with additional local input

Project Component 3 - US$ 24.74 million

C. HEALTH CARE FINANCING/NHIF

This component would assist the National Health Insurance Fund in establishing the technological infrastructure required to operate the national health insurance system. This would include the extensive hardware and software systems needed, as well as the training and technical assistance required to implement and maintain them.

The original estimate of staffing requirements for the NHIF was 4,500 individuals, but as a result of the investments being proposed, both in the NHIF itself and in provider offices and facilities, it is expected that no more than 1,800 staff will be required when the system is fully operational.

The component would include the following activities:

(1) NHIF Information Systems (US$16.4). This sub-component of the project would include: (a) the expansion of the NHIF and RHIF's technology infrastructure (hardware, standard software, communications equipment); (b) the establishment of a fully-redundant back-up / disaster-recovery facility outside of Sofia; (c) document management and work flow systems; and (d) a large capacity back-up generator for NHIF HQ building. Database licenses and communications service charges are included, to be funded out of NHIF resources.

Inputs : International expertise, together with local knowledge, Information technologies (hardware, standard and specialized software) and training (see below).
Outputs: State-of-the-art information systems providing a high level of functionality
Responsible Unit: NHIF, PMU

(2) Training/Software Development (US$9.7). This sub-component includes specialized training for the information technology (IT) staff, as well as: (a) the extension of NHIF's core operational system software to cover the contracting and reimbursements of the primary and hospital sub-sectors; (b) computer-assisted software engineering tools, i.e., "CASE" tools; (c) general purpose business management software and related hardware, e.g., payroll, personnel, budget, accounting, etc.; and (d) specialized analytical software to allow NHIF management to make the maximum use of their accumulated databases.

Inputs : International expertise, together with local knowledge
Outputs: State-of-the-art information systems providing a high level of functionality
Responsible Unit: NHIF, PMU

Project Component 4 - US$12.36 million

D. CAPACITY BUILDING AND PROJECT MANAGEMENT

This component would strengthen the management and institutional capacity within the Ministry of Health, the National Health Insurance Fund, and the health system generally. It would also provide an overall package of technical assistance and public information to support the health reform process, and would fund project management and financial management, monitoring and evaluation activity.

The component would include the following activities:

(1) **Training of Staff (US$1.9M).** This activity would provide training to staff of the NHIF related to new procedures and operations, and would fund study tours to allow NHIF and MOH staff to observe and study first-hand the approaches used by other jurisdictions in administering their national health insurance system.

Inputs: Training materials and external technical expertise
Outcome: Fully capable, professional health system managers
Responsible Unit: MOH, NHIF, PMU

(2) **Public Information and Technical Assistance (US$6.8M).** This sub-component will finance an overall public information campaign for potential providers and the general public to highlight the key changes that will be made to the health system in terms of both organization and financing, and to describe the rights and responsibilities of each of the affected groups with regard to these changes. One of the key messages will be the official level of co-payments contained in the Health Insurance Act, and the fact that payments beyond this level are not appropriate. This sub-component also funds technical assistance in a number of key areas to assist in the implementation of the health reforms and to build capacity within the NHIF, including (but not limited to) the areas of:

- modern management methods (especially in large, geographically decentralized organizations)
- health insurance management, focusing on each of the core business processes of the NHIF
- health care organization and management, including human resource management
- health care utilization management and statistical/financial analysis
- understanding and using actuarial reports and analysis
- managing large distributed information systems
- population-based funding methods

Inputs: External expertise, media materials.
Outcome: Smooth implementation of health reforms, good level of understanding of reform process, rights and responsibilities by consumers and providers.
Responsible Unit: NHIF, MOH, PMU

(3) **Health Information Standards, Forms Rationalization (US$1.4M).** This sub-component will finance the formulation of health information standards on a national level. The topical areas of health information standards will include: (a) subject of care; (b) heath status; (c) health provider; (d) health care activities; and (e) health care resources. Health information privacy and authorization standards will also be addressed. These standards will reflect national needs and practices, yet be consistent with international best practices, including EU standards. In conjunction with the health information standards formulation process, the sub-component will also finance work to rationalize and streamline the numerous reports and reporting formats used throughout the health sector. This will both improve the efficiency of reporting and monitoring actives, as well as improve the quality of information by reducing the burden of line-of-care health service providers.

Inputs: International and local expertise.
Outcome: More effective operational and management systems based on rationalized and streamlined set of reporting forms (across the various health sector agencies).
Responsible Unit: NHIF, MOH, PMU, with input from various other health sector agencies and proffessional associations

(4) **Quality of Care / Accreditation (US$0.2M).** This sub-component will finance the expansion of the recently launched activities to strengthen the NHIF and MOH's capacity to assess and actively manage the quality of health care though, among other mechanisms, accreditation processes. This work will be closely coordinated with the health information standards and forms rationalization initiatives, especially in the quality of care related monitoring and evaluation activities.

Inputs: International and local expertise.
Outcome: Higher and more uniform quality of health care provided.
Responsible Unit: NHIF, MOH, PMU, with input from various other health sector agencies and proffessional associations

(5) **Project Management (US$1.1M).** This sub-component provides for the overall coordination and management of the project activities through funding the PMU director and six additional staff and paying the operating costs of the PMU. It also provides for project management and procurement consulting advice, training for the PMU staff, and office equipment, renovations and a PMU vehicle.

Inputs: Local experts, materials and supplies.
Outcome: Exceptional project coordination and management.
Responsible Unit: MOH, NHIF and PMU

(6) **Monitoring and Evaluation (US$0.3M).** This sub-component would provide for annual project audits and for technical assistance to conduct ongoing monitoring and evaluation activities.

Inputs: Financial and technical assistance.
Outcome: Clear understanding of financial situation and project impact.
Responsible Unit: PMU

(7) Front-end Fee (US$0.6M). The Government of Bulgaria has asked that the front-end fee be paid out of the proceeds of the loan.

Project Component 5 - US$28.01 million

E. NHIF INFRASTRUCTURE DEVELOPMENT

This component includes the significant investment in facilities, hardware, software and training that has already taken place, as form an integral part of the overall implementation of the health insurance system, and the health reform it supports. These investments will ensure that the first phase of contracting with physicians can commence as planned on July 1, 2001.

Inputs : International expertise, together with local knowledge
Outputs: State-of-the-art information systems providing a high level of functionality
Responsible Unit: NHIF

Project Component 6 - US$2.00 million

F. TECHNICAL ASSISTANCE (SWISS GOVERNMENT)

This component includes the substantial technical assistance grant (CHF 3 million equivalent) from the Swiss government, which will fund essential support in the areas of general management, health insurance operations, human resources managment, information systems management and essential training for senior managers. These activities form an essential foundation for the activities supported by the project.

Inputs : International expertise, together with local knowledge
Outputs: Improved management capability and state-of-the-art information systems providing a high level of functionality
Responsible Unit: NHIF

Project Component 7 - US$2.50 million

G. TECHNICAL ASSISTANCE (USAID)

This component includes additional technical assistance by the United States government through USAID with respect to their project to support financial and investment management within the NHIF. The Bank has worked with USAID to ensure that the package of technical assistance being provided compliments the activities financed by the Swiss government and the Bank. Ongoing aid coordination will be an essential element of the project implementation.

Inputs : International expertise, together with local knowledge
Outputs: State-of-the-art information systems providing a high level of functionality
Responsible Unit: NHIF

Annex 3: Estimated Project Costs

BULGARIA: HEALTH SECTOR REFORM PROJECT

Project Cost By Component	Local US $million	Foreign US $million	Total US $million
1. Primary and Ambulatory Care Reform	8.71	13.95	22.66
2. Hospital Care Reform	16.46	9.50	25.96
3. Health Care Financing Reform/NHIF	2.60	19.88	22.48
4. Capacity Building	4.60	6.60	11.20
Total Baseline Cost	32.37	49.93	82.30
Physical Contingencies	0.44	1.34	1.78
Price Contingencies	0.76	1.49	2.25
Total Project Costs	33.57	52.76	86.33
Front-end fee		0.63	0.63
Total Financing Required	33.57	53.39	86.96

Project Cost By Category	Local US $million	Foreign US $million	Total US $million
Goods	11.44	38.19	49.63
Works	1.85	0.47	2.32
Services	1.66	6.97	8.63
Training	5.68	1.56	7.24
Operating Costs	1.45	5.57	7.02
Other	9.60	0.00	9.60
Technical Services	1.89	0.00	1.89
Total Project Costs	33.57	52.76	86.33
Front-end fee		0.63	0.63
Total Financing Required	33.57	53.39	86.96

Annex 4: Cost Benefit Analysis Summary
BULGARIA: HEALTH SECTOR REFORM PROJECT

Macro-Economic Context

According to the CAS, economic dislocation has hit the population of Bulgaria hard. Limited fiscal resources have sharply constrained the Government's ability to address the needs of the poor. In the short term, the Government's efforts are focused on ensuring that the costs of transition are socially sustainable and on reducing the number of families living in poverty after the recent crisis. As shown in the table below, although economic growth is currently positive in real terms, it has had several setbacks in the last eight years.

In the medium term, and following the slow-down caused by the war in Kosovo in 1999, the economy of Bulgaria is expected to show a sustained robust recovery of aggregate output. Inflation is expected to be moderate, and the exchange rate is expected to strenghten against the dollar over the next five years.

BULGARIA: MACRO-ECONOMIC INDICATORS

	1993	1994	1995	1996	1997	1998	1999
Per capita GNP (Atlas method, constant US$)	1,250	1,250	1,370	1,200	1,180	1,230	1,470
Real Annual Growth of GDP	-1.5%	1.8%	2.9%	-10.1%	-7.0%	3.5%	2.5%
% increase in Consumer Prices, annual avg.	72.8%	96.0%	62.1%	123.0%	1082.0%	22.3%	0.5%
Public Expenditures on Health (US$ million)	521.6	396.3	474.0	307.1	375.8	460.3	509.4
Public Expenditures on Health (% of GDP)	4.8%	4.0%	3.6%	3.12%	3.7%	3.8%	4.2%

Source: MoF, National Statistical Institute, WB staff estimates
Data for 1999 are preliminary.

Scope of Work

The economic analysis included here is a cost-benefit analysis and it is limited to an exploration of the likely impact of the key elements of the project relating to the sector reforms being supported and the establishment of the National Health Insurance Fund. Given that the NHIF implementation and the related sector reforms are proceeding, this analysis compares the "with" and "without" project alternatives. The analysis is based on the investment and recurring costs and benefits of undertaking the project over a 20-year period, and examines the impact on the health sector alone (e.g., increased VAT from project expenditures is not considered as a benefit).

To provide a conservative assessment of the likely costs and benefits of the health reform project implementation, this analysis focused primarily on the direct impact of the reforms. As a result of the significant investments being made in information systems it is expected that the National Health Insurance Fund will be able to operate with a total of 1,800 staff. This compares to an original plan -- which had been approved by the Government -- by the NHIF for 4,500 staff without these investments. In addition, the severance programs to be funded by the Ministry of Health should permanently remove about 3,840 physicians and hospital staff from the workforce, thereby relieving some of the pressure on future growth in health expenditures. The final area examined includes the various investment programs, which will

primarily have the impact of improving quality of care, but will also generate some ongoing savings due to the requirement to pay back some of the funds provided. The following table summarizes the key benefits:

Key Benefits Identified

Provider Information Systems	1,000	fewer staff required in NHIF
Central Information Systems	1,700	fewer staff required in NHIF
Severance Programs	3,840	fewer staff in health system
Investment Programs	2,200	physicians and hospitals affected
		better quality of care, funds reinvested

Costs include the direct investment costs, the replacement of equipment (estimated life of 5 years), plus equipment maintenance (estimated at 10 percent of the value of the equipment each year).

Potential Savings Not Included

Other areas where savings can be expected, and which are not shown below, include the impact of the improved information systems on quality assurance and patterns of practice monitoring. The Slovenia Health Sector Management Project, based on detailed analysis by the Australian Health Insurance Commission, projects reductions in average lengths of stays in hospitals of almost 30 percent over five years, with 20 to 30 percent of the decrease attributable to improved health information systems. It should be pointed out that the ALOS for Slovenia was 8.6 days in 1999, compared to 12.9 for Bulgaria. Conservatively, a 20 percent reduction or more should be feasible in Bulgaria.

With expected hospital expenditures under the NHIF of approximately BGL 700 million, equivalent to about US$350 million, and assuming that the reduction in ALOS would (in the short run) result in lower costs in drugs, food, linen and plant operations, the impact of this reduction would be approximately US$24.3 million per year. If 30 percent of this saving was attributable to improved information systems, the effect would be US$7.3 million annually. Of course in the longer run, changes can be made to salaries and other more fixed costs.

Another area of potential savings is the more effective use of pharmaceuticals as a result of the introduction of clinical practice guidelines (which include recommendations for prescribing behaviour), and the ability to monitor prescribing behavior through the clinical information systems (for pharmacies as well as service providers) being introduced through this project. Based on expected drug costs of about BGL 150 million (US$ 75 million), even a 10 percent reduction in unnecessary drug use would result in annual savings of around US$7.5 million.

Summary of Benefits and Costs:

The table below provides an overview of the cost-benefit analysis:

BULGARIA HEALTH REFORM PROJECT
COST-BENEFIT ANALYSIS

SUMMARY		Initial Investments	Replace & Maintain Equipment	Total Costs	Total Benefits	Net Benefits (Cost)	NPV	Cumulative NPV
	2001	7,446		7,446	1,859	-5,587	-5,587	-5,587
	2002	21,665	308	21,972	6,198	-15,774	-14,340	-19,927
	2003	26,687	1,629	28,316	10,780	-17,536	-14,493	-34,419
	2004	19,734	2,893	22,627	14,924	-7,703	-5,787	-40,207
	2005	11,434	4,053	15,487	18,600	3,113	2,126	-38,081
	2006		8,588	8,588	22,787	14,199	8,816	-29,264
	2007		20,725	20,725	26,794	6,069	3,426	-25,839
	2008		19,124	19,124	28,739	9,615	4,934	-20,905
	2009		16,263	16,263	29,431	13,168	6,143	-14,762
	2010		12,274	12,274	29,123	16,849	7,146	-7,616
	2011		10,174	10,174	31,336	21,162	8,159	543
	2012		26,451	26,451	35,995	9,545	3,345	3,888
	2013		24,408	24,408	37,603	13,194	4,204	8,092
	2014		20,756	20,756	37,184	16,428	4,759	12,851
	2015		15,665	15,665	36,175	20,510	5,401	18,252
	2016		12,985	12,985	40,314	27,329	6,542	24,794
	2017		33,759	33,759	48,391	14,632	3,184	27,978
	2018		31,151	31,151	50,743	19,592	3,876	31,854
	2019		25,813	25,813	48,618	22,805	4,102	35,956
	2020		19,993	19,993	44,939	24,946	4,079	40,035
Sum		86,965	307,014	393,979	600,533	206,554	40,035	
PV		71,832	101,844	173,676	213,711	40,035		

Main Assumptions:

The following table highlights the key assumptions used in the analysis:

ASSUMPTIONS		
Loan Amount	$63.3	million
Discount Rate	10.0%	
Wage Inflation	5.0%	
Non-wage Inflation	5.0%	
Exchange Rate (BGL/USD)	2.00	
Aveage Salary (BGL-2001)	321	/month
NHIF Staffing no project	4,500	
- savings Provider Systems	1,000	
- savings Central Systems	1,700	
NHIF Staffing with Project	1,800	
Severance -- Physicians Affected	1,040	
Severance -- Hospital Staff Affected	2,800	
Severance -- Total Staff Affected	3,840	
Unit $ NHIF Workstation	2,900	

Sensitivity analysis / Switching values of critical items:

The sensitivity analysis looked at four areas: the discount rate used, the average increase in salary costs, the expected savings (cost avoidance) in the NHIF, and the expected savings in staff due to the severance arrangements. The results are shown in the attached table, and indicate that in most cases, even significant changes in the underlying assumptions do not result in negative net present values. The two areas that are most sensitive are the NHIF staff savings, where minimum savings of 1,850 staff (4,500-2,650) are required to break even, and the severance staff savings, when minimum reductions of 1,685 staff are required.

Sensitivity Analysis			
		Base Case	
Discount Rate	4%	10%	12%
NPV ($M)	110.7	40.0	26.7
Wage & Non-wage Inflation	3%	5%	10%
NPV ($M)	24.0	40.0	111.7
NHIF Staff Savings	2,000	2,700	3,000
NPV ($M)	7.1	40.0	54.1
Breakeven @ 2,650 total staff			
Severance Staff Savings	2,500	3,840	5,000
NPV ($M)	16.9	40.0	68.7
Breakeven @ 1,685 staff reductions			

Risk Analysis

In terms of risks related to the sensitivity analysis, there are minimal risks associated with either the selection of a discount or inflation rate. The inflation rate used reflects the current projections of medium-term inflation. The biggest down-side risk here from a macro-economic perspective is that inflation will increase significantly. However, since the key savings are related to staffing avoidance or reduction, higher inflation will amplify the benefits.

The risks clearly reside with the potential staff savings or avoidance. The savings in the NHIF shown in the base case are the result of considerable discussion by the Bank team with the Fund, and are reflected in agreements that serve as the basis for the development of this project. As such, there is a high probability that the agreed staffing levels will be achieved.

Severance staff savings are more problematic, since there are fewer controls to ensure that staff making use of the severance programs actually stay out of the health care system. The NHIF has some control on the numbers of physicians, as these have direct contracts with the fund. The hospital sector will have contracts only at a global budget level, so there are fewer controls on workers who have received severance payments coming back into the system. The global budgets themselves will tend to serve as a barrier to the re-entry of these staff. Thus, the system taken as a whole points to a high probability that those people severed will remain outside the health system. The severance program will be well funded on a per-staff basis to ensure that people who are severed feel well treated, and have a good chance at achieving long-term alternative employment. As long as minimum of 1,685 people are be permanently severed, the overall project will show a positive NPV (*ceteris paribus*).

Annex 5: Financial Summary
BULGARIA: HEALTH SECTOR REFORM PROJECT

Project Costs by Component and Expenditure Type

Totals Incl. Contingencies (US$'000)

	Civil Works	Goods	Other	Tech. Services	Training	TA	Oper. Costs	TOTAL
IBRD Plus Local Contributions								
A. Primary and Ambulatory Care I	300.0	18,142.5	2,600.0	550.0	1,655.5			**23,248.0**
B. Hospital Care Reform	2,000.0	13,534.2	7,000.0	550.0	3,528.0			**26,612.2**
C. Health Financing Reform/NHIF		17,147.8			1,548.8	600.0	5,445.0	**24,741.6**
D. Capacity Building	20.0	805.0	633.0	790.0	504.0	8,034.2	1,576.6	**12,362.8**
Total PROJECT COSTS	**2,320.0**	**49,629.5**	**10,233.0**	**1,890.0**	**7,236.3**	**8,634.2**	**7,021.6**	**86,964.6**
IBRD Costs								
A. Primary and Ambulatory Care I	255.0	15,118.8		550.0	1,655.5			**17,579.3**
B. Hospital Care Reform	1,700.0	11,278.5		550.0	3,528.0			**17,056.5**
C. Health Financing Reform/NHIF		14,289.8			1,548.8	600.0		**16,438.6**
D. Capacity Building	17.0	670.8	633.0	790.0	504.0	8,034.2	1,576.6	**12,225.7**
Total PROJECT COSTS	**1,972.0**	**41,357.9**	**633.0**	**1,890.0**	**7,236.3**	**8,634.2**	**1,576.6**	**63,300.0**
Local Costs								
A. Primary and Ambulatory Care I	45.0	3,023.8	2,600.0					**5,668.8**
B. Hospital Care Reform	300.0	2,255.7	7,000.0					**9,555.7**
C. Health Financing Reform/NHIF		2,858.0					5,445.0	**8,303.0**
D. Capacity Building	3.0	134.2						**137.2**
Total PROJECT COSTS	**348.0**	**8,271.6**	**9,600.0**				**5,445.0**	**23,664.6**
								27.2%
Total PROJECT COSTS net of Taxes								
Total Costs	1,975.0	41,357.9	10,233.0	1,890.0	7,236.3	8,634.2	7,021.6	**78,348.0**
IBRD Costs	1,972.0	41,357.9	633.0	1,890.0	7,236.3	8,634.2	1,576.6	**63,300.0**
Local Costs			9,600.0				5,445.0	**15,045.0**
Local Percent			93.8%				77.5%	**19.2%**

Project Costs by Fiscal Year

	Totals Incl. Contingencies (US$'000)					
	2001	**2002**	**2003**	**2004**	**2005**	**Total**
TOTAL ALL FUNDING SOURCES						
A. Primary and Ambulatory Care Refoı	1,293.0	6,539.0	6,557.0	6,375.5	2,483.5	**23,248.0**
B. Hospital Care Reform	220.0	2,646.0	9,145.0	8,205.3	6,395.9	**26,612.2**
C. Health Financing Reform/NHIF	3,283.7	8,922.0	7,769.0	3,144.4	1,622.5	**24,741.6**
D. Capacity Building	2,649.0	3,557.7	3,215.9	2,008.6	931.7	**12,362.8**
Total PROJECT COSTS	**7,445.7**	**21,664.6**	**26,686.9**	**19,733.8**	**11,433.6**	**86,964.6**
Cumulative	**7,445.7**	**29,110.3**	**55,797.2**	**75,531.0**	**86,964.6**	
IBRD Costs						
A. Primary and Ambulatory Care Refoı	1,132.5	5,138.8	4,954.5	4,773.0	1,580.5	**17,579.3**
B. Hospital Care Reform	220.0	2,339.7	5,773.5	5,017.6	3,705.8	**17,056.5**
C. Health Financing Reform/NHIF	2,443.5	6,839.9	5,447.9	1,537.8	169.6	**16,438.6**
D. Capacity Building	2,634.3	3,505.2	3,180.9	1,973.6	931.7	**12,225.7**
Total PROJECT COSTS	**6,430.3**	**17,823.5**	**19,356.8**	**13,302.0**	**6,387.5**	**63,300.0**
Cumulative	**6,430.3**	**24,253.7**	**43,610.5**	**56,912.5**	**63,300.0**	
Local Costs						
A. Primary and Ambulatory Care Refoı	160.5	1,400.3	1,602.5	1,602.5	903.0	**5,668.8**
B. Hospital Care Reform		306.3	3,371.5	3,187.7	2,690.2	**9,555.7**
C. Health Financing Reform/NHIF	840.3	2,082.1	2,321.1	1,606.6	1,452.9	**8,303.0**
D. Capacity Building	14.7	52.5	35.0	35.0		**137.2**
Total PROJECT COSTS	**1,015.4**	**3,841.2**	**7,330.1**	**6,431.8**	**5,046.1**	**23,664.6**
Cumulative	**1,015.4**	**4,856.6**	**12,186.7**	**18,618.5**	**23,664.6**	

Project Costs by Calendar Year

	Totals Incl. Contingencies (US$'000)						
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**Total**
TOTAL ALL FUNDING SOURCES							
A. Primary and Ambulatory Care R	110.0	4,353.8	6,328.3	6,504.8	4,459.5	1,491.8	**23,248.0**
B. Hospital Care Reform	110.0	2,701.0	9,145.0	8,232.8	6,395.9	27.5	**26,612.2**
C. Health Financing Reform/NHIF		7,744.7	8,345.5	5,456.7	2,383.5	811.3	**24,741.6**
D. Capacity Building	1,190.2	3,419.1	3,360.5	2,617.0	1,284.3	491.7	**12,362.8**
Total PROJECT COSTS	**1,410.2**	**18,218.5**	**27,179.3**	**22,811.3**	**14,523.1**	**2,822.2**	**86,964.6**
Cumulative	**1,410.2**	**19,628.7**	**46,808.0**	**69,619.3**	**84,142.4**	**86,964.6**	
IBRD Costs							
A. Primary and Ambulatory Care R	110.0	3,534.4	4,868.1	4,902.3	3,165.5	999.0	**17,579.3**
B. Hospital Care Reform	110.0	2,394.7	5,773.5	5,045.1	3,705.8	27.5	**17,056.5**
C. Health Financing Reform/NHIF		5,863.4	6,143.9	3,492.9	853.7	84.8	**16,438.6**
D. Capacity Building	1,175.6	3,419.1	3,308.0	2,582.0	1,249.3	491.7	**12,225.7**
Total PROJECT COSTS	**1,395.6**	**15,211.5**	**20,093.5**	**16,022.2**	**8,974.2**	**1,603.0**	**63,300.0**
Cumulative	**1,395.6**	**16,607.1**	**36,700.6**	**52,722.8**	**61,697.0**	**63,300.0**	
Local Costs							
A. Primary and Ambulatory Care R		819.4	1,460.1	1,602.5	1,294.0	492.8	**5,668.8**
B. Hospital Care Reform		306.3	3,371.5	3,187.7	2,690.2		**9,555.7**
C. Health Financing Reform/NHIF		1,881.3	2,201.6	1,963.9	1,529.7	726.5	**8,303.0**
D. Capacity Building	14.7		52.5	35.0	35.0		**137.2**
Total PROJECT COSTS	**14.7**	**3,007.0**	**7,085.7**	**6,789.1**	**5,548.9**	**1,219.2**	**23,664.6**
Cumulative	**14.7**	**3,021.7**	**10,107.4**	**16,896.5**	**22,445.4**	**23,664.6**	

Because of the scheduling of project activities, the Government contribution to the project is US$ 14,700 in CY00. In subsequent years it is US$3.0 million in CY01, US$7.1 million in CY02, US$6.8 million in CY03, US$5.5 million in FY04, and US$1.2 million in CY05. The Government contribution to the Bank project is 19.2 percent of the total project cost, net of taxes, and consists of the following key elements:

Software Licenses and Communications	$ 5.45 million
Labor Adjustment Programs	$9.60 million
Subtotal	**$15.05 million**
Taxes	$ 8.61 million
Total	**$23.66 million**

A Government contribution of US$28 million was made in CY99, as part of the Framework Program activities, which needed to be initiated prior to Bank financing. The Government contribution, net of taxes, represents 38.9 percent of the total cost of the overall Framework Program (net of taxes).

Annex 6: Procurement and Disbursement Arrangements
BULGARIA: HEALTH SECTOR REFORM PROJECT

Procurement

Procurement methods (Tables A, A1 and B1):

Civil works and goods under the Bank financed components of this project will be procured in accordance with the Bank's Guidelines: *Procurement under IBRD Loans and IDA Credit published in January 1995*including all revisions up to January 1999. Contracts for Consulting Services required for the Project will be awarded following the World Bank Guidelines "*Selection and Employment of Consultants by World Bank Borrowers" dated January 1997,*revised in September 1997 and January 1999. Project activities not financed by Bank will be procured in accordance with the national regulations. The project elements, their estimated cost and procurement methods, are summarized in Table A. Other procurement information, including estimated dates for publication of SPN and the Bank's review process is presented in Table B1.

Implementation: A Capacity Assessment has been done for the Project, and the risk rating is high. A Project Management Consultant will be recruited for the entire life of the project to support the Project Management Unit. A Procurement Consultant will also be recruited for the first three years of the project to assist the PMU in procurement activities.

Advertisement: A General Procurement Notice (GPN) will be published in June 2000 issue of Development Business, announcing works, goods and consultant services to be procured and inviting interested eligible suppliers, contractors and consultants to express interest and to request any complementary information from the PMU. The GPN will be annually updated. The Specific Procurement Notices will be published at later dates (see Table B1). For large-value consultants contracts, invitation for bids will be advertised in the Development Business and national gazette. In the case of NCB for civil works, invitation for bids will be advertised in a major local newspaper.

1. Civil Works

National Competitive Bidding (NCB) procedures will be used for the Health Reform Investment Fund under the Hospital Care Reform component. There will be 10 separate packages with approximately $150,000 for each contract, up to an aggregate contract amount of $1.50 million. Bids will be advertised in the national press and/or official gazette, opened publicly, and awarded to the lowest evaluated bidder. Bank's Regional SBDs and Evaluation forms will be used. Government entities are ineligible to participate in Bank financed contracts unless they meet the criteria under the Bank guidelines that they are legally and financially autonomous.

Minor works (MW) procedures will be used for the Health Reform Investment Fund under the Primary & Ambulatory Care Reform component. There will be approximately 560 small contracts with about $500 for each contract, up to an aggregate contract amount of $0.28 million. Minor works procedures will be used for about 70 smaller contracts with an aggregate amount of $500,000 under the Health Reform Investment Fund from the Hospital Care Reform component. Minor works procedures will also be used for the renovation of PMU office with an estimated contract value of $20,000. Minor works will be awarded on the basis of quotations obtained from at least three qualified contractors in response to a written invitation. The invitation shall include a detailed description of the works, including basic

specifications, the required completion date, a form of agreement acceptable to the Bank and the relevant drawings. The contract shall be awarded to the lowest evaluated bidder.

2. Goods

International Competitive Bidding (ICB) procedures will be used for contracts above $100,000 equivalent for a total amount of $6.96 million for the procurement of workstation and standard software. ICB will be used for a total amount of $1.26 million for the procurement of practice and application software and practice software licensing/training. The procurement of file servers and workstation and standard software for a total amount of $6.04 million will also use ICB procedures. Specialized application and hospital system licensing/training contracts above $100,000 equivalent with the total amount of $1.18 million will use ICB procedures. The procurement for communications technologies will use ICB procedures for a total amount of $317,500. Similarly, the main technology plant for the Disaster Center (i.e. back up servers and related computing equipment) will be procured through ICB for a total amount of $1.7 million. Workstations and standard software and advanced workstations will be procured using ICB procedures for contracts above $100,000 for a total amount of $2.21 million. ICB procedures will be used for contracts above $100,000 for a total amount of $1.34 million for the procurement of communications network. Document management workflow will use ICB procedure for procurement for contracts above $100,000 for a total amount of $1.31 million. Software engineering tools and core operational software will be procured through ICB for a total amount of $6.55 million. ICB procedure will be used for the procurement of business management software and analytic and modeling tools for a total amount of $1.02 million.

ICB procedures will also be used for the procurement of medical equipment for contracts above $100,000 equivalent for a total amount of $6.9 million. A total of $1.7 million of medical equipment in 10 separate packages will be procured through ICB for contracts above $100,000 equivalent for Health Reform Investment Fund under Primary and Ambulatory Care Reform component. Under the Health Reform Investment Fund for Hospital Care Reform component, ICB will be used for contracts above $100,000 equivalent for 10 separate packages of medical equipment with a total value of $5.2 million. Backup power supply for a total amount of $280,000 will be procured using ICB procedures under the Health Financing/NHIF component. For the Capacity Building component, there will be $770,000 of staff training equipment/multimedia center to be procured through ICB.

National Competitive Biddiing (NCB). NCB procedure will be used for the three separate procurement of media campaign under Primary and Ambulatory Care Reform component (estimated contact to be $550,000), the Hospital Care Reform component (estimated value to be $550,000), and the Capacity Building component (estimated contract value to be $790,000).

International Shopping (IS). There will be about 20 different packages of equipment for a total amount of $0.52 million for international shopping for the Health Reform Investment Fund under Primary and Ambulatory Care Reform component. Under the Health Reform Investment Fund from Hospital Care Reform component, there will be 20 separate packages of medical equipment to be procured through international shopping with the total amount of $0.50 million.

National Shopping (NS). Approximately 20 separate packages of equipment for a total amount of $300,000 will be procured through national shopping under the Health Reform Investment Fund from Primary and Ambulatory Care Reform component. Under the Health Reform Investment Fund of Hospital Care Reform component, 20 different packages with a total of $300,000 of medical equipment will be procured using national shopping. National shopping method will also be used for the procurement of

vehicles with the aggregate amount of $50,000, and office equipment for PMU with the total amount of $20,000.

Procurement from UN agency. Medical equipment for Primary and Ambulatory Care Reform component will be procured from UNICEF catalogues for available stock items. The estimated amount will be $1.5 million.

Direct Contracting (DC). Upgrade/expand operations and back up servers hardware and software will be procured using direct contracting procedures for a total amount of $2.75 million. The NHIF has already installed a pair of servers to support its operational system. The decision was taken to use competitive procurement method (ICB) to acquire server for the backup/disaster recovery (which the incumbent supplier will not be excluded). The upgrades to NHIF's existing production server are proprietary technologies, and as such, these will be directly procured from the manufacture Compac/Digital (and through the manufacture's distribution chain, in accordance with the manufacture's internal business practices). In relation to the disaster-recovery server, the initial purchase will be ICB. However, the subsequent capacity upgrade (in concert with the upgrade of the production server) will similarly entail proprietary technologies and necessitate direct procurement from the manufacturer. If Compac/Digital wins the ICB for the disaster-recovery server, then the direct contracting for the upgrades would be handled as a single procurement. If a vendor other than Compaq/Digital wins the ICB, there will need to be two direct contract procurements.

3. Consulting Services and Training

Quality and Cost-based Selection (QCBS). For the Primary & Ambulatory Care Reform component, consultants will be selected using QCBS methods for GP management training/curriculum development (contract value $550,000). Under the Hospital Care Reform component, QCBS will be used for the selection of consultants for hospital management training/curriculum development (contract value $190,000). Under the Health Care Financing/NHIF component, the consultant for specialized IT training will be selected using QCBS. The total estimated value of the contract is about $1.54 million. The consultant for core operational system modification and enhancement will be selected through QCBS with the total contract value of $600,000. Under the Capacity Building component, QCBS will be used for separate packages for a total amount of $5.18 million for the purpose of technical assistance. Under the same component, the contracts that will be selected using QCBS are: the production of publications (estimated amount of $350,000), video/film production (estimated contract value $230,000), information standards (estimated amount of $540,000), quality of care/accreditation (estimated value $130,000). Project Management Consultant (estimated amount of $226,000), Procurement Consultant (estimated amount of $180,000), and GP management training/delivery of training (estimated value of $280,000) will be contracted using QCBS.

Consultants' Qualification (CQ) For Capacity Building component, the contracts to use CQ method are: consultant for public opining polling (estimated amount of $60,000) and Project Auditors (estimated value of $80,000).

Individual Consultants (IC). Under the Hospital Care Reform component, IC method will be used for the selection of technical assistance on legislative review (contract value $70,000). Under the Capacity Building component, individual consultant method will be used for the selection of local consultants for health information standards (contract value $53,000), local consultants for quality of care/accreditation (contract value $80,000) and monitoring and evaluation (six separate contracts with the total value of $220,000).

4. Operating Costs

In the case of health information standards and quality of care/accreditation, local staff will be selected based on quality (Individual Consultant) to conduct the work. Bank will finance the cost of hiring these staff using operating cost (total value estimated to be $610,000). The Project Management Unit staff salaries will be financed under the operating cost of the Loan.

Procurement methods (Table A)

Table A: Project Costs by Procurement Arrangements
(US$ million equivalent)

Expenditure Category	Procurement Method[1]				Total Cost
	ICB	NCB	Other[2]	N.B.F.	
1. Works	0.00 (0.00)	1.50 (1.27)	0.82 (0.70)	0.00 (0.00)	2.32 (1.97)
2. Goods	43.69 (36.41)	0.00 (0.00)	5.93 (4.95)	0.00 (0.00)	49.62 (41.36)
3. Services	0.00 (0.00)	1.89 (1.89)	15.88 (15.88)	0.00 (0.00)	17.77 (17.77)
4. Miscellaneous Severance Payments	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	9.60 (0.00)	9.60 (0.00)
5. Front-end fee	0.00 (0.00)	0.00 (0.00)	0.63 (0.63)	0.00 (0.00)	0.63 (0.63)
6. Operating Costs	0.00 (0.00)	0.00 (0.00)	1.57 (1.57)	5.45 (0.00)	7.02 (1.57)
Total	43.69 (36.41)	3.39 (3.16)	24.83 (23.73)	15.05 (0.00)	86.96 (63.30)

[1/] Figures in parenthesis are the amounts to be financed by the Bank Loan. All costs include contingencies

[2/] Includes civil works and goods to be procured through national shopping, consulting services, services of contracted staff of the project management office, training, technical assistance services.

Table A1: Consultant Selection Arrangements (optional)
(US$ million equivalent)

Consultant Services Expenditure Category	Selection Method							
	QCBS	QBS	SFB	LCS	CQ	Other	N.B.F.	Total Cost[1]
A. Firms	10.50 (10.50)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.14 (0.14)	4.34 (4.34)	0.00 (0.00)	14.98 (14.98)
B. Individuals	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.90 (0.90)	0.00 (0.00)	0.00 (0.00)	0.90 (0.90)
Total	10.50 (10.50)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	1.04 (1.04)	4.34 (4.34)	0.00 (0.00)	15.88 (15.88)

1\ Including contingencies

Note: QCBS = Quality- and Cost-Based Selection
QBS = Quality-based Selection
SFB = Selection under a Fixed Budget
LCS = Least-Cost Selection
CQ = Selection Based on Consultants' Qualifications
Other = Selection of individual consultants (per Section V of Consultants Guidelines), Commercial Practices, etc.

N.B.F. = Not Bank-financed
Figures in parenthesis are the amounts to be financed by the Bank Loan.

Prior review thresholds (Table B)

Review by the Bank of Procurement Decisions

Procurement of civil works, goods and services for the project will be carried out in accordance with the agreed procurement plan (Table B1), which will be updated if necessary and included in the progress reports for Bank review.

1) Civil Works: The first two contracts per year under NCB and Minor Works will be prior reviewed. The region's updated standard bidding documents for NCB and Minor Works will be used for civil works contracts.

2) Goods: Prior review of bidding documents, including review of evaluation, recommendation of award and contract will be conducted for all ICB, and the first two contracts for International Shopping and National Shopping contracts each year regardless of their value.

3) Consulting Services and Training: Terms of reference for all consulting assignments will be subject to prior Bank review. Prior review will be carried out for individual consultant contracts of $30,000 and above and for contracts with firms valued at $50,000 and above. The prior reviews by the Bank will include request for proposal (RFP), short lists, terms of condition of contracts as well as evaluation reports and recommendation for award of contracts for technical assistance as well as for training. All documents and recommendations involving sole source contracting will be subject to Bank prior review.

Following award of contracts, should any material modifications or waiver of terms and conditions of a contract resulting in an increase or decrease above 15 percent of the original amount, the Bank will reserve the right to prior review of such modifications (including modifications to contracts for consulting services).

Table B: Thresholds for Procurement Methods and Prior Review [1]

Expenditure Category	Contract Value Threshold (US$ thousands)	Procurement Method	Contracts Subject to Prior Review (US$ millions)
1. Works	Below $200,000 Aggregate $1.50m.	NCB	First two contracts each year
	Below $50,000 Aggregate $0.8m.	MW	First two contracts each year

2. Goods	Above \$100,000 Aggregate \$43.55m. Above \$100,000 Aggregate \$1.89m. Less than \$100,000 Aggregate \$1.02m. Below \$50,000 Aggregate \$0.67m. Aggregate \$1.5m. Aggregate \$2.75m.	ICB NCB IS NS UNICEF Direct Contracting	All bidding documents and contracts All bidding documents and contracts First two contracts each year First two contracts each year All documents All documents
3. Services	Above \$50,000 Aggregate \$10.36m. Below \$100,000 Aggregate \$0.14m. Individual Consultants Aggregate \$0.90m.	QCBS CQ IC	All steps All steps TOR, Qualification and Evaluations All Steps TOR, Qualification and Evaluations
4. Ex-post Review			Review carried out in accordance with Para.4 of Appendix 1 of the Bank's Guidelines and reviews during supervision missions. 1 in 5 contracts.
5. Miscellaneous			
6. Miscellaneous			

Total value of contracts subject to prior review: \$53.91 million

Overall Procurement Risk Assessment

High

Frequency of procurement supervision missions proposed: One every 4 months (includes special procurement supervision for post-review/audits)

Procurement Plan (Table B1)

Description	Type	Proc. Method	Proposed Num. of Packages	Est. Total Cost (US$ million)	Invitation GPN/SPN Local Advertise-ment	Bid Docs/RFP 1. Preparation 2. Documents Issue	Bid/RFP 1. Opening 2. Evaluation 3. Recom. For Award	Contract Signing	Contract complete
WORKS									
Primary and Ambulatory Care/ Health Reform Investment Fund	CW	MW	560	0.28		Through-out the life of the project			
Hospital Care / Health Reform Investment Fund	CW	MW	70	0.50		Through-out the life of the project			
Hospital Care / Health Reform Investment Fund	CW	NCB	10	1.50	First Package: Local 9/00 Other subsequent packages will be carried out throughout the life of the project.	1. 8/2000 2. 9/2000	1. 10/2000 2. 10/2000 3. 10/2000	10/2000	6/2001
PCU Office Renovation	CW	MW	1	0.02		1. 8/2000 2. 9/2000	1. 10/2000 2. 10/2000 3. 10/2000	10/2000	11/2000

GOODS									
Computer Equipment and Software									
1. Physician Office Information Systems									
Workstation and Standard Software	G	ICB	1	2.34	SPN 8/2000	1. 9/2000 2. 10/2000	1. 12/2000 2. 1/2001 3. 1/2001	2/2001	5/2001
Workstation and Standard Software	G	ICB	1	2.32	SPN 2/2002	1. 3/2002 2. 4/2002	1. 6/2002 2. 7/2002 3. 7/2002	8/2002	11/2002
Workstation and Standard Software	G	ICB	1	2.32	SPN 7/2004	1. 8/2004 2. 9/2004	1. 11/2004 2. 12/2004 3. 12/2004	1/2005	4/2005
Practice and Application Software & Practice Software Licensing and Training	G	ICB	1	1.26	SPN 8/2000	1. 9/2000 2. 10/2000	1. 12/2000 2. 1/2001 3. 1/2001	2/2001	6/2005

2. Hospital Management Information Systems									
File Servers & Workstations and Standard Software (1)	G	ICB	1	3.02	SPN 3/2001	1. 4/2001 2. 5/2001	1. 7/2001 2. 8/2001 3. 8/2001	9/2001	12/2003
File Servers & Workstations and Standard Software (2)	G	ICB	1	3.02	SPN 3/2002	1. 4/2002 2. 5/2002	1. 7/2002 2. 8/2002 3. 8/2002	9/2002	12/2004
Specialized Application Software & Hospital System Licensing/ Training (1)	G	ICB	1	0.88	SPN 3/2001	1. 4/2001 2. 5/2001	1. 7/2001 2. 8/2001 3. 8/2001	9/2001	12/2003
Specialized Application Software & Hospital System Licensing/ Training (2)	G	ICB	1	0.30	SPN 3/2002	1. 4/2002 2. 5/2002	1. 7/2002 2. 8/2002 3. 8/2002	9/2002	12/2004
Communica-tions	G	ICB	1	0.32	SPN 3/2001	1. 4/2001 2. 5/2001	1. 7/2001 2. 8/2001 3. 8/2001	9/2001	12/2004

3. NHIF Information Systems									
Disaster Backup Center	G	ICB	1	1.70	SPN 8/2000	1. 9/2000 2. 10/2000	1. 12/2000 2. 1/2001 3. 1/2001	2/2001	5/2001
Upgrade/Expand Servers	G	Direct Con-tracting	1	2.75	N/A	N/A	N/A	12/2001	3/2002
Standard Workstations and Standard Software & Advance Workstations	G	ICB	1	0.33	SPN 8/2000	1. 9/2000 2. 10/2000	1. 12/2000 2. 1/2001 3. 1/2001	2/2001	12/2001
Standard Workstations and Standard Software & Advance Workstations	G	ICB	1	0.94	SPN 8/2001	1. 9/2001 2. 10/2001	1. 12/2001 2. 1/2001 3. 1/2001	2/2002	6/2003
Standard Workstations and Standard Software & Advance Workstations	G	ICB	1	0.94	SPN 8/2002	1. 9/2002 2. 10/2002	1. 12/2002 2. 1/2003 3. 1/2003	02/2003	12/2004
Comm. Network Servers/PBX/ Routers	G	ICB	1	0.51	SPN 8/2000	1. 9/2000 2. 10/2000	1. 12/2000 2. 1/2001 3. 1/2001	2/2001	12/2003
Comm. Network ATM Switch/ Routers	G	ICB	1	0.83	SPN 8/2001	1. 9/2001 2. 10/2001	1. 12/2001 2. 1/2002 3. 1/2002	2/2002	2/2005
Document Management/ Workflow	G	ICB	1	0.66	SPN 4/2002	1. 5/2002 2. 6/2002	1. 8/2002 2. 9/2002 3. 9/2002	10/2002	6/2003
Document Management/ Workflow	G	ICB	1	0.66	SPN 10/2003	1. 11/2003 2. 12/2003	1. 2/2004 2. 3/2004 3. 3/2004	4/2004	12/2004
Software Engineering Tools & Core Operational Software	G	Two Stage ICB	1	6.55	SPN 8/2000	1. 9/2000 2. 10/2000	1. 12/2000 2. 1/2001 3. 4/2001	2/2001	8/2004
Business management Software	G	ICB	1	1.03	SPN 8/2000	1. 9/2000 2. 10/2000	1. 12/2000 2. 1/2001	5/2001	8/2002
Database Licences	G	NBF		3.85					
Comm. Charges	G	NBF		1.60					

Medical Equipment									
1. Primary and Ambulatory Care Reform									
Medical Equipment	G	ICB	1	3.04	SPN 9/00	1. 9/2000 2. 10/2000	1. 12/2000 2. 1/2001 3. 1/2001	2/2001	12/2002
Medical Equipment	G	ICB	1	2.66	SPN 3/02	1. 3/2002 2. 4/2002	1. 6/2002 2. 7/2002 3. 7/2002	8/2002	12/2003
Medical Equipment	G	UNICEF	1	1.50		N/A	N/A	12/2000	12/2003
Equipment for Health Reform Investment Fund	G	NS	20	0.30		Through-out the life of the project			
Equipment for Health Reform Investment Fund	G	IS	10	0.52		Through-out the life of the project			
Equipment for Health Reform Investment Fund	G	ICB	10 (every 6 months based on proposals	1.70	First package: SPN 8/2000 Other subsequent packages will be carried out throughout the life of the project.	1. 9/2000 2. 10/2000	1. 12/2000 2. 1/2001 3. 1/2001	2/2001	Jun-01

2. Hospital Care Reform									
Equipment for Health Reform Investment Fund	G	NS	20	0.30		Through-out the life of the project			
Equipment for Health Reform Investment Fund	G	IS	10	0.50		Through-out the life of the project			
Equipment for Health Reform Investment Fund	G	ICB	10 (every 6 months based on proposals	5.20	First package: SPN 4/2001 Other subsequent packages will be carried out throughout the life of the project.	1. 5/2001 2. 6/2001	1. 8/2001 2. 9/2001 3. 9/2001	10/2001	Dec-01

3. Capacity Building									
PCU Office Equipment	G	NS	1	0.02		1. 7/2000 2. 7/2000	1. 8/2000 2. 8/2000 3. 8/2000	9/2000	11/2000
Backup Power Supply	G	ICB	1	0.28	SPN 8/2000	1. 9/2000 2. 10/2000	1. 12/2000 2. 1/2001 3. 1/2001	2/2001	5/2001
Staff Training Equipment/ Multimedia Center	G	ICB	1	0.74	SPN 8/2001	1. 9/2001 2. 10/2001	1. 12/2001 2. 2/2002 3. 2/2002	3/2002	8/2002
Vehicles	G	NS	1	0.05	Local 7/2000	1. 8/2000 2. 9/2000	1. 10/2000 2. 10/2000 3. 10/2000	10/2000	11/2000

CONSULTING SERVICES AND TRAINING									
1. Primary and Ambulatory Care Reform									
GP Management Training/ Curriculum Development	CS	QCBS	1	0.55		1. 9/2000 2. 10/2000	1. 11/2000 2. 12/2000 3. 12/2000	1/2001	4/2001
GP Management Training/ Delivery of Training	CS	QCBS	1	0.28		1. 2/2001 2. 3/2001	1. 4/2001 2. 5/2001 3. 5/2001	6/2001	6/2004
GP Management Training	CS	*	1	0.55		1. 2/2001 2. 3/2001	1. 4/2001 2. 5/2001 3. 5/2001	6/2001	6/2004
Health Promotion Training for GP	CS	*	1	0.11		Through-out the life of the project			
Health Promotion Training for Nurses	CS	*	1	0.17		Through-out the life of the project			
Primary and Ambulatory Care Reform Public Information	Technical Services	NCB	1	0.55		1. 8/2000 2. 9/2000	1. 10/2000 2. 10/2000 3. 10/2000	11/2000	6/2005
2. Hospital Care Reform									
Hospital Management Training/ Curriculum Development	CS	QCBS		0.19		1. 8/2001 2. 9/2001	1. 10/2001 2. 12/2001 3. 12/2001	1/2002	1/1900
Hospital Care Reform Public Information	Technical Services	NCB	1	0.55		1. 9/2000 2. 10/2000	1. 12/2000 2. 1/2001 3. 1/2001	2/2001	6/2005
Case mix/DRG Training	CS	*	1	0.83		Through-out the life of the project			

Hospital Accountants Training	CS	*	1	0.17		Through-out the life of the project			
Hospital System Administrators Training	CS	*	1	2.31		Through-out the life of the project			
3. Capacity Building									
Specialized IT Training	CS	QCBS	1	1.54		1. 8/2000 2. 9/2000	1. 10/2000 2. 11/2003 3. 11/2003	11/2000	3/2002
Core Operational Software	CS	QCBS	1	0.60		1. 4/2003 2. 5/2003	1. 6/2003 2. 8/2003 3. 8/2003	9/2003	12/2003
TA Legislative Review	CS	IC	1	0.07		1. 8/2000 2. 9/2000	1. 11/2000 2. 12/2000 3. 12/2000	1/2001	6/2201
TA - Information Systems Management	CS	QCBS	1	1.40		1. 8/2000 2. 9/2000 3. 12/2000	1. 2/2001 2. 2/2001	3/2001	6/2005
TA - Financial Management	CS	QCBS	1	0.40		1. 8/2000 2. 9/2000 3. 12/2000	1. 2/2001 2. 2/2001	3/2001	6/2005
TA - Dynamic Modelling	CS	QCBS	1	0.40		1. 8/2000 2. 9/2000 3. 12/2000	1. 2/2001 2. 2/2001	3/2001	6/2005
TA - Contracting Quality Assurance	CS	QCBS	1	0.85		1. 8/2000 2. 9/2000 3. 12/2000	1. 2/2001 2. 2/2001	3/2001	6/2005
TA - Labor Adjustment Strategy	CS	QCBS	1	0.30		1. 8/2000 2. 9/2000 3. 12/2000	1. 2/2001 2. 2/2001	3/2001	6/2004
TA - Investment Fund Development	CS	QCBS	1	0.40		1. 8/2000 2. 9/2000 3. 12/2000	1. 2/2001 2. 2/2001	3/2001	6/2004
TA - Training Program Development	CS	QCBS	1	1.45		1. 8/2000 2. 9/2000 3. 12/2000	1. 2/2001 2. 2/2001	3/2001	6/2003
Public Opinion Polling	CS	CQ	1	0.06		1. 9/2000 2. 10/2000	1. 10/2000 2. 12/2000 3. 12/2000	1/2001	6/2005
Media Campaign	Techni cal Servic es	NCB	1	0.79		1. 8/2000 2. 9/2000	1. 12/2000 2. 2/2001 3. 2/2001	3/2001	6/2005

Production of Publications	CS	QCBS	1	0.35		1. 1/2000 2. 2/2001	1. 4/2001 2. 5/2001 3. 5/2001	6/2001	6/2005
Staff Training	CS	*	1	0.07		Through-out the life of the project			
Journalists Training	CS	*	1	0.07		Through-out the life of the project			
Videofilm Production	CS	QCBS	1	0.23		1. 11/2000 2. 12/2000	1. 2/2001 2. 4/2001 3. 4/2001	6/2001	1/1900
International TA – Health Information Standards	CS	QCBS	1	0.88		1. 8/2000 2. 9/2000	1. 11/2000 2. 12/2000 3. 12/2000	1/2001	6/2203
International TA- Quality of Care/ Accreditation	CS	QCBS	1	0.13		1. 11/2000 2. 12/2000	1. 2/2001 2. 4/2001 3. 5/2001	7/2001	6/2004
Local TA- Health Information Standards	CS	IC	Various small contracts	0.53		1. 8/2000 2. 9/2000	1. 11/2000 2. 12/2000 3. 12/2000	1/2001	6/2003
Local TA- Quality of Care /Accreditation	CS	IC	Various small contracts	0.08		1. 8/2001 2. 9/2001	1. 11/2001 2. 12/2001 3. 12/2001	1/2002	6/2004
Study Tour	CS	*	1	0.70		12/2000			
Project Management Consultant	CS	QCBS	1	0.23		1. 8/2000 2. 9/2000	1. 10/2000 2. 10/2000 3. 10/2000	11/2000	6/2005
Procurement Consultant	CS	QCBS	1	0.18		1. 8/2000 2. 9/2000	1. 10/2000 2. 10/2000 3. 10/2000	11/2000	6/2003
Project Audits	CS	CQ	1	0.08		1. 8/2000 2. 9/2000	1. 10/2000 2. 10/2000 3. 10/2000	11/2000	6/2005
Monitoring and Evaluation	CS	IC	6	0.22		1. 11/2000 2. 12/2000	1. 2/2001 2. 4/2000 3. 5/2000	7/2001	6/2005

* Training will be concluded by selected institutions where staff will be sent for a specific training course/period. The Bank will review and clear the list of participants (along with their qualifications for selection of training courses), estimated cost, place of training, period of training, etc. on a six monthly basis.

[1] Thresholds generally differ by country and project. Consult OD 11.04 "Review of Procurement Documentation" and contact the Regional Procurement Adviser for guidance.

Disbursement

Allocation of loan proceeds (Table C)

Table C: Allocation of Loan Proceeds

Expenditure Category	Amount in US$million	Financing Percentage
1 Civil Works (a) Under Part A (2)	1.80	95%
(b) Under Part B (1) and D	0.22	95%
2 Goods (a) Under Part A(2)	1.90	100% foreign, 85% local
(b) Under Part B(1)	4.60	100% foreign, 85% local
(c) Under Part A(1)	6.00	100% foreign, 85% local
(d) All Other	26.50	100% foreign, 85% local
3 Consultant Services and Audit Fees	7.07	100%
4 Training	7.00	100%
5 Technical Services	1.93	100%
6 Incremental Operating Costs	1.50	90% until December 31, 2002, 80% thereafter
7 Unallocated	4.15	
Total Project Costs	62.67	
Front-end fee	0.63	
Total	63.30	

Use of statements of expenditures (SOEs):

While acceptable disbursement mechanism based on PMRs is not in place, disbursements will take place using the traditional disbursement mechanism. All disbursements against contracts for civil works and goods costing US$200,000 or more equivalent, services for consulting firms costing US$50,000 or more and individual consultants costing US$30,000 or more, as well as audit fees, training and incremental operating costs will be fully documented. Disbursements below these thresholds will be made against certified Statements of Expenditure (SOEs). This documentation will be made available for the required audit as well as to the Bank supervision mission, and will be retained by the PMU for at least one year after receipt by the Bank of the audit report for the year in which the last disbursement was made. The processing, disbursement and monitoring of the allocations of the proceeds of the Loan and Borrower counterpart financing would be managed by the PMU in coordination and consultation with the Ministry of Finance.

Special account:

To facilitate timely project implementation, the Government will establish, maintain and operate, under terms and conditions acceptable to the Bank, a separate Special Account denominated in US dollars to be managed by the PMU. The authorized allocation for the Special Account will be US$1.0 million. However, during the initial stage of the project, an amount limited to US$0.5 million will be deposited in

the Special Account. When the aggregate amount of disbursement realizes US$5.0 million, the amount deposited in the Special Account will be increased to the full authorized allocation of US$1.0 million. The minimum amount of each application should be 20% of the authorized allocation. Replenishment applications should be submitted by the PMU on a monthly basis or when about 33 percent of the initial deposit has been utilized, whichever comes first. The Special Account would be audited annually by independent auditors acceptable to the Bank.

Annex 7: Project Processing Schedule
BULGARIA: HEALTH SECTOR REFORM PROJECT

Project Schedule	Planned	Actual
Time taken to prepare the project (months)	12	6
First Bank mission (identification)	11/27/99	11/27/99
Appraisal mission departure	05/01/2000	04/30/2000
Negotiations	05/26/2000	
Planned Date of Effectiveness	09/30/2000	

Prepared by:

Bulgarian Ministry of Health (MOH) and National Health Insurance Fund (NHIF) working groups

Preparation assistance:

Boyan Doganov, Project Director, NHIF
Denitsa Sacheva, Chief of Staff, MOH
Dusan Ecimovic, Project Management Consultant
Alberto Neyra, Project Preparation Consultant

Bank staff who worked on the project included:

Name	Speciality
Dominic Haazen	Team Leader, ECSHD Financial Management Specialist
Laura Shrestha	Operations Officer, ECSHD
Peter Pojarski	Operations Analyst, ECSHD
Jan Bultman	Pricipal Health Specialist, ECSHD
Hong Chen	Operations Analyst, ECSHD
Leonardo Concepcion	Procurement Specialist, ECSHD
Antoniya Viyachka	Procurement Analyst, ECSHD
Craig Neal	Information Techonogy Specialist, ECSPE
John Langenbrunner	Senior Economist (Health), HDNHE (peer reviewer)
Armin Fidler	Senior Health Specialist, ECSHD (peer reviewer)
Jean J. De St Antoine	Principal Operations Officer, ECSHD (peer reviewer)
Gerald La Forgia	Health Specialist (LCSHH) (peer reviewer)
Nadejda Mochinova	Program Assistant
Maureen Law	QER Panel Chair, EASHD
Christopher Walker	QER Panel Member, HDNHE
Ioan Luculescu	QER Panel Member, AFTH2
Forest Duncan	QER Panel Member, USAID
Rohit Mehta	Senior Disbursement Officer, LOAEL
Alessandra Iorio	Senior Counsel, LEGEC

Annex 8: Documents in the Project File*
BULGARIA: HEALTH SECTOR REFORM PROJECT

A. Project Implementation Plan

B. Bank Staff Assessments

1. Country Assistance Strategy, April 1998
2. Identification Mission BTOR
3. Preparation Mission BTOR
4. Pre-appraisal Mission BTOR
5. Appraisal Mission BTOR

C. Other

1. Final Report for Health Sector Reform Support Project, Australian Health Insurance Commission, November 1999.
2. Health Care Systems in Transitions, Bulgaria, European Observatory on Health Care System, 1999.
3. European Standards in Health Sector, Bulgaria Health Insurance Fund, 2000.
4. National Human Development Report, UNDP, Bulgaria 1999.
   Volume 1: Trends and opportunities for regional human development.
   Volume 2: Bulgarian People's Aspirations.
5. Bulgaria: Consultations with the Poor, prepared for Global Synthesis Workshop, September 22-23, 1999, PREM, WB.
6. Information Technology Background Paper

*Including electronic files

Annex 9: Statement of Loans and Credits

BULGARIA: HEALTH SECTOR REFORM PROJECT

Project ID	FY	Borrower	Purpose	Original Amount in US$ Millions			Difference between expected and actual disbursements[a]		
				IBRD	IDA	Cancel.	Undisb.	Orig	Frm Rev'd
P008316	1993	Bulgaria	ENERGY	93.00	0.00	0.00	24.37	25.67	0.00
P033965	1998	Bulgaria	ENV. REMED. PILOT	16.00	0.00	0.00	15.56	10.85	0.33
P057927	2000	Bulgaria	ENV/PRIV. SUPPORT SAL	50.00	0.00	0.00	49.50	0.00	0.00
P008318	1996	Bulgaria	HEALTH SECTOR RESTRUCTURING	26.00	0.00	0.00	14.47	16.36	0.00
P008315	1996	Bulgaria	RAILWAY REHABILITATI	95.00	0.00	0.00	17.17	20.83	0.00
P055156	1999	Bulgaria	REG. INITIATIVE FUND	5.00	0.00	0.00	1.48	-0.34	0.00
P008323	1997	Bulgaria	SOCIAL INSUR. ADMIN.	24.30	0.00	0.00	10.35	8.25	0.00
P051151	1999	Bulgaria	SPAL (Soc. Protect. Adj.)	80.00	0.00	0.00	36.52	36.61	0.00
P008319	1994	Bulgaria	WATER COMPANIES REST	98.00	0.00	41.00	34.77	61.82	25.71
			Total:	487.30	0.00	41.00	204.19	180.05	26.04

BULGARIA
STATEMENT OF IFC's
Held and Disbursed Portfolio

In Millions US Dollars

		Committed				Disbursed			
		IFC				IFC			
FY Approval	Company	Loan	Equity	Quasi	Partic	Loan	Equity	Quasi	Partic
0	BAC Bank	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1999	Celhart	0.00	0.00	5.00	0.00	0.00	0.00	2.65	0.00
1999	Devnya Cement	13.90	1.50	0.00	0.00	13.90	1.50	0.00	0.00
1998	Euromerchant FND	29.16	0.00	0.00	0.00	22.58	0.00	0.00	0.00
1994	Interlease Inc.	0.00	5.00	0.00	0.00	0.00	4.50	0.00	0.00
1996	Sofia Hilton	3.21	0.30	0.00	0.00	1.71	0.30	0.00	0.00
1997		10.80	0.00	2.00	9.50	3.27	0.00	2.00	0.00
	Total Portfolio:	57.07	6.80	7.00	9.50	41.46	6.30	4.65	0.00

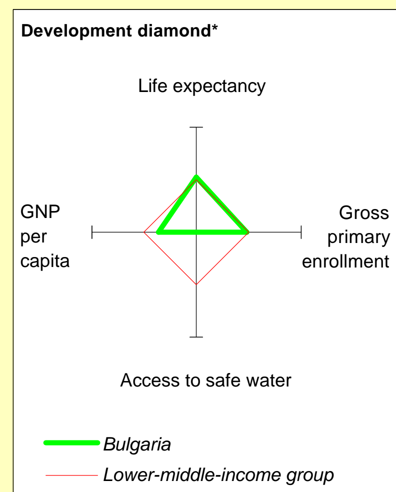
		Approvals Pending Commitment			
FY Approval	Company	Loan	Equity	Quasi	Partic
	Total Pending Commitment:	0.00	0.00	0.00	0.00

Annex 10: Country at a Glance

BULGARIA: HEALTH SECTOR REFORM PROJECT

POVERTY and SOCIAL

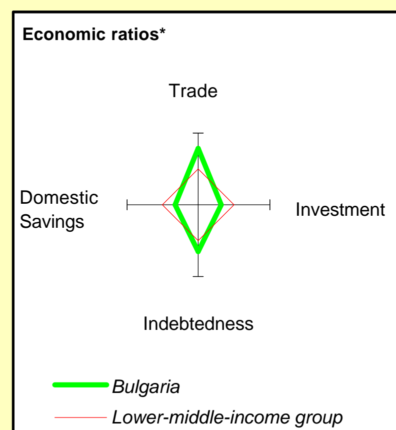
	Bulgaria	Europe & Central Asia	Lower-middle-income
1998			
Population, mid-year *(millions)*	8.2	473	908
GNP per capita *(Atlas method, US$)*	1,230	2,190	1,710
GNP *(Atlas method, US$ billions)*	10.1	1,039	1,557
Average annual growth, 1992-98			
Population *(%)*	-0.6	0.1	1.1
Labor force *(%)*	-0.6	0.6	1.5
Most recent estimate (latest year available, 1992-98)			
Poverty *(% of population below national poverty line)*	36	..	..
Urban population *(% of total population)*	69	68	58
Life expectancy at birth *(years)*	71	69	68
Infant mortality *(per 1,000 live births)*	18	23	38
Child malnutrition *(% of children under 5)*	..	..	..
Access to safe water *(% of population)*	..	..	75
Illiteracy *(% of population age 15+)*	2	4	14
Gross primary enrollment *(% of school-age population)*	99	100	103
Male	100	101	105
Female	98	99	100



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

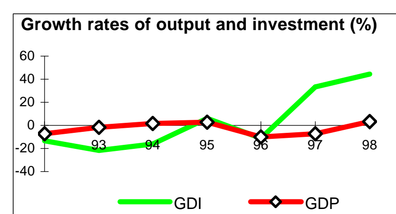
	1977	1987	1997	1998
GDP *(US$ billions)*	..	28.4	10.1	12.3
Gross domestic investment/GDP	..	32.9	11.4	14.7
Exports of goods and services/GDP	..	40.8	61.9	45.2
Gross domestic savings/GDP	..	31.1	16.9	13.7
Gross national savings/GDP	..	30.3	15.7	12.9
Current account balance/GDP	..	-2.5	4.2	-2.1
Interest payments/GDP	..	1.4	4.3	3.7
Total debt/GDP	..	29.1	97.2	80.8
Total debt service/exports	..	17.2	14.4	22.3
Present value of debt/GDP	..	..	92.2	..
Present value of debt/exports	..	..	143.6	..

	1977-87	1988-98	1997	1998	1999-03
(average annual growth)					
GDP	3.6	-4.0	-7.0	3.5	4.6
GNP per capita	3.5	-3.0	-5.9	4.8	5.6
Exports of goods and services	6.2	-12.2	3.1	-15.6	3.9

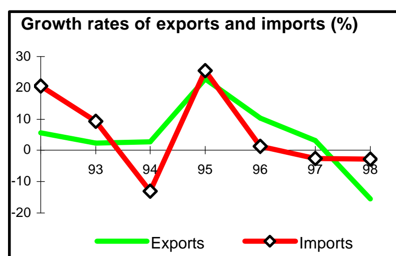


STRUCTURE of the ECONOMY

	1977	1987	1997	1998
(% of GDP)				
Agriculture	..	11.8	23.8	18.7
Industry	..	61.5	25.3	25.5
Manufacturing	..	..	16.8	17.0
Services	..	26.7	50.9	55.7
Private consumption	..	61.5	70.3	71.2
General government consumption	..	7.4	12.8	15.1
Imports of goods and services	..	42.6	56.4	46.3



	1977-87	1988-98	1997	1998
(average annual growth)				
Agriculture	-2.5	-2.1	32.9	1.4
Industry	6.4	-6.2	-11.3	4.3
Manufacturing	..	..	-14.9	6.5
Services	3.8	-2.0	-19.3	4.0
Private consumption	3.3	-4.9	-22.8	-4.7
General government consumption	8.6	-4.3	-1.4	4.0
Gross domestic investment	3.2	-7.7	33.1	44.3
Imports of goods and services	6.1	-16.3	-2.7	-2.8
Gross national product	3.7	-3.8	-6.6	4.4



Note: 1998 data are preliminary estimates.

* The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

PRICES and GOVERNMENT FINANCE

Additional
Annex No.: 11

Financial Management

General:

A review of Financial Management System was undertaken to (a) review the presence of the necessary elements for sound project financial management system such as internal controls, project accounting, project staffing and audit arrangements; (b) assess the project's capacity and readiness for the implementation of LACI; and (c) prepare a time-bound action plan for strengthening the financial management system to achieve compliance with minimum LACI standards.

***Project Management and Coordination and Staffing*:**

The Project Management Unit (PMU) will be directly responsible for financial management during project life. A Steering Committee will be established consisting of senior managers of the Ministry of Health and the National Health Insurance Fund to provide overall policy guidance to the PMU.

The PMU has recruited a full time project accountant who has advanced level training in finance and accounting, as well as experience with international projects finance. The project accountant would be responsible for financial management and control under the project itself and would report to the Project Director. Technical assistance is being made available to the PMU to assist in establishing the financial management and control systems. To ensure the appropriate segregation of duties, a second accountant will also be hired once the project becomes operational.

The overall operating budget for the PMU will be approximately $1,056,000 over the term of the project, with a capital of $90,000, and an additional $75,000 allocated for project audits. Procurement and Project Management technical assistance, and training for all staff is being provided to the PMU. These allocations cover the entire period of project implementation.

Accounting:

A project financial and accounting system has been selected, which is consistent with the software used in the first health project, as well as other PMU's in Bulgaria. The system as establishes has, *inter alia*, an accounting and internal control system with the capacity to record and retrieve in a timely manner, all financial and procurement transactions under the project. The system: (a) records and reports all assets, liabilities, and financial transactions and procurement activity of the project; and (b) provides reliable financial information for managing and monitoring project activities.

The accounting system (chart of accounts) is classified by component and category of expenditure, and is able to capture data by sub-component at the level of individual activities. It also reflects the various sources of funds. Furthermore, the system provides information on the receipt and use of funds and is able to produce financial reports comparing budget with actual expenditures at any given time. The system as established will provide financial data to measure performance when linked to the outputs of the project.

Financial Reporting:

Although an acceptable financial management system has been established, disbursements will start using traditional disbursements methods -- SOEs reimbursements, direct payments, etc. After the PMU has gained experience with the financial management system and reporting under project management reports (PMRs), and provided that the financial management system is reviewed and found capable of handling it, the project will move to PMR-based disbursements (expected June 30, 2001). The PMU will maintain accounts for the Project and will be responsible for preparing Project Management Reports (PMR -- see Annex 9 of the Project Financial Management Manual) on a quarterly basis, and furnish to the Bank not later than 45 days after the end of each calendar quarter, a PMR for such period, which:

(a) (i) sets forth actual sources and application of funds for the project, both cumulatively and for the period covered by said report, and projected sources and applications of funds for the project for the six-month period following the period covered by said report and (ii) shows separately expenditures financed out of the proceeds of the credit during the period covered by said report and expenditures proposed to be financed out of the proceeds of the credit during the six-month period following the period covered by said report;

(b) (i) describes physical progress in project implementation, both cumulatively and for the period covered by said report, and (ii) explains variances between the actual and previously forecast implementation targets; and

(c) sets forth the status of procurement under the project and expenditures under contracts financed out of the proceeds of the credit, as at the end of the period covered by said report.

Project Implementation Plan (PIP):

The Project Implementation Plan includes the financial management policy and procedures manual developed during the course of establishing the financial management system.

This manual includes (a) special emphasis on accounting and auditing policies, standards and internal controls; (b) the role of the financial management systems in project management and implementation; (c) the accounting arrangements required for project management, the format for and content of project financial reporting; and (d) the auditing arrangements that will be used during project implementation.

Auditing:

The PMU will be responsible for ensuring that the financial statement, Special Account, and SOEs are audited by an independent auditor, acceptable to the Bank, in accordance with standards on auditing that are acceptable to the Bank. The annual audit will be carried out in accordance with the *Guidelines for Financial Reporting and Auditing of Projects Financed by the World Bank (March 1982).* The audit report shall be in a format in accordance with the International Standards on Auditing promulgated by the International Federation of Accountants (IFAC). The audit report will include a separate opinion for SOEs against which disbursements have been made or are due to be made from the Credit and SOEs which will be included in the audit report accompanying the financial statements.

The audited financial statements of the special accounts, and SOEs of the preceding fiscal year, including a separate opinion by the auditor on disbursements made against certified statement of expenditures, will be sent to the Bank within six months of the end of the fiscal year.

The audit of the financial statement will include: (a) an assessment of the adequacy of accounting and internal control systems to monitor expenditures and other financial transactions and ensure safe custody of project-financed assets; (b) a determination as to whether the project implementing entities have maintained adequate documentation on all relevant transactions; and (c) verification that expenditures submitted to the Bank are eligible for financing, and identification of any ineligible expenditures.

The estimated overall budget for auditing under the project would be around $75,000, which appears to be reasonable, given the size and length of the project (5 years). Auditing services would be procured on a least-cost basis, and packaged as a recurring audit, with no requirement for a new engagement letter, except in the special circumstances. The PMU will prepare terms of reference and a short list for the audit and will obtain No Objection from the Bank, prior to Board presentation.

Bank FMS staffing and supervision:

The project was reviewed in detail by a Bank FMS during appraisal and a detailed action plan was developed to ensure that an adequate financial management system is in place prior to Board presentation. Because of the timing of the project preparation, it is recommended by the FMS that the project not use on PMR-based disbursement at this time. A time-bound action plan will be developed to ensure a move to PMR-based disbursement by June 30, 2001. During project life, an FMS will take part in supervision missions to monitor the FM of the PMU and ensure compliance with ongoing FM covenants.

Special Account:

To facilitate timely project implementation, the Government will establish, and will maintain and operate, under terms and conditions acceptable to the Bank, a Special Account, denominated in US Dollars. The minimum amount of the application should be 20 percent of the authorized allocation. The replenishment applications should be submitted at least every three months, and must include reconciled bank statements as well as other appropriate supporting documents. A conversion account (USD to Bulgarian Leva) may also be established, as well as separate accounts for Government contributions (USD and conversion).

The Government will be responsible for the appropriate accounting of the funds provided by the IBRD under the Loan, for reporting on the use of these funds, and for ensuring that audits of the financial statements or reports are submitted to the Bank. A computerized accounting system is being established at the PMU. Once trained, the Accountants at the PMU would maintain and prepare quarterly financial reports as part of Project Management Reports.

Accounting software and assessment of Y2K risks:

The project preparation consultant retained by under the Swiss grant has implemented the PAIS software system in other PMU's in which he is working. Having a number of PMU's in Bulgaria having the same software should provide a nucleus of staff who are conversant with the software and capable of supporting each other. Neither hardware or software purchased have displayed Y2K compatibility problems.

Conclusion:

Significant progress has been made on the project financial management system and related documentation,

the FM system fully satisfies the Bank's minimum financial management requirements.

Additional
Annex No.: 12

Social Assessment

Three analyses are included in this section: (a) an assessment and strategy for combating corruption in the health sector in Bulgaria, (b) a matrix which identifies and describes the interests of various stakeholders; and (c) an assessment of the how the proposed Bulgaria Health Reform Project will impact upon stakeholders, particularly vulnerable groups.

I. A Multi-Pronged Strategy for Combating Corruption
II. Identification of Stakeholders [matrix table]
III. Social Assessment of Poor and Vulnerable Groups

I. A MULTI-PRONGED STRATEGY FOR COMBATING CORRUPTION

The main form of corruption affecting the health sectors in Bulgaria is *administrative corruption.* This generally encompasses bribe payments or other private gains to public officials to alter the prescribed implementation of existing rules and regulations. Common types of administrative corruption include bribes to connect to public services, to be given priority in the provision of government services, and to gain licenses. At the root of this corruption is discretion on the part of public officials to grant selective exemptions, to prioritize the delivery of public services, or to discriminate in the application of rules and regulations. Though it occurs at all levels of the state and the economy, administrative corruption is rooted in poor mechanisms of control and accountability within the state apparatus.

Background: Perceptions of Corrupt Practices in the Health Sector in Bulgaria

While not specifically targeted towards the health sector, a number of initiatives are underway to monitor public perceptions of public corruption in Bulgaria. These monitoring initiatives, carried out by "Coalition 2000", seek to gauge public opinions with regard to corruption, rather than investigating or confirming the accusations made. Quarterly interviews are carried out with a nationally-representative sample of 1000 persons using a standardized questionnaire. In addition, in-depth interviews are conducted with political and business leaders.

Based on quarterly polling by "Coalition 2000", the public has consistently ranked custom officers to be the most corrupt occupational group in Bulgaria, followed by medical professionals and low-level traffic police. To more deeply explore perceptions of the health sector, one small-scale study was carried out in the town of Bourgas. More than 90% of respondents said that there is corruption within the health sector in their towns, while 65% reported that the majority of medical professionals take bribes. It is believed that these perceptions of the health sector are held nationally.

Forms of corrupt practices: three forms of corrupt practices were specifically identified:

1. Public-sector physicians direct clients to private practitioners where they have to pay for services rather than receiving the free public care. [This practice was reported by 75% of those interviewed];

2. Clients do not receive health care services in a timely manner unless the physician is given an "under the table" payment, a present, or favor. Physicians use tactics to postpone medical treatment until favors are received. [Reported by 61%];
3. Some physicians write prescriptions for imported medications that are too expensive and provided only at particular pharmacies. Often, the physician has a financial stake in those pharmacies. [Reported by 53%].

Public perception of why the physicians engage in corrupt practices were suggested: (1) the low-pay of physicians (cited by 2/3 of respondents), (2) the absence of measures against those who take bribes; (3) absence of clear norms to define the relationship between physicians and their patients; and (4) the health care reform itself (reported by only a small percentage of respondents).

Public perceptions of how corrupt practices can be stopped: Over 80% of respondents reported that corruption cannot be stopped, but that it can be severely limited. The proposed measures suggested include: (1) economic changes to ensure salaries for the physicians. The respondents reported that physicians need at least double their current salaries; (2) new regulations for the provision of health services; (3) directives to change the relationship between physicians and their clients; (4) implementation of the health sector reform; and (5) more vigorous measures against corrupt physicians.

Strategy for Combating Corruption under the Project

As public sentiment can affect the implementation of the health sector reform, the National Health Insurance Fund (NHIF) has been concerned about public perceptions that physicians engage in corrupt practices. While not clearly designated as an "anti-corruption" strategy at the time of its development, the NHIF has already developed and is implementing a multi-pronged approach to deter corrupt practices. These guidelines will affect all transactions covered by the NHIF, but will not address private transactions by physicians. While developed independently, NHIF's strategy is highly consistent with the recommendations of the citizen groups detailed above. Features of the strategy are highlighted below.

Codes of Conduct. It should be noted that it is within the national tradition to give presents to physicians as an expression of gratitude for services provided. The difficulty lies in differentiating between a bribe extorted as a pre-condition for the provision of medical services and a gift freely given as an expression of gratitude. Consistent with this distincition, the NHIF defines physician actions as "corrupt" when: (a) s/he requests a current or promised future gift or extra-payment prior to the provision of services; or (b) postpones treatment until a gift or extra-payment is received. Inexpensive gifts which are offered after services are provided are often perceived as allowable. To better define and demarcate between "gifts" and "bribes", the NHIF is developing and will disseminate "codes of physician conduct".

Payments for Health Services. A standardized "price list" which details reimbursement rates for physicians from the NHIF has been produced and is being widely distributed to both the medical community and to the general public. The NHIF seeks to widely inform the public about the maximum charges that will be reimbursed for services financed by the NHIF.

Under health sector reform, the nature of payments from patients to physicians has changed dramatically. Previously, patients often gave gifts to physicians for "free" services that were

financed by the Government. Under health care reform, employees are contributing premiums for health insurance. Officials believe that patients will perceive that "they have already paid" for the health care services and will be unwilling to provide additional contributions directly to the physicians.

Adequate Pay for Physicians. As described earlier, physicians have been grossly underpaid given their high level of education and experience. The labor adjustment strategy, coupled with the broader health sector reform, is designed to dramatically increase the base salary of physicians by reducing the total number of physicians employed and allowing part of the savings to be used for an improved pay scale for the remaining physicians. In addition, physicians will be awarded additional incentives to work in remote areas and to treat particular medical conditions.

Public Information. (a) a public information campaign is underway to inform both physicians and the general population about the health sector reform, including public rights and responsibilities under the reform; (b) departments in both the NHIF and regional health insurance funds have established "hot lines" to receive complaints from patients with regard to both the quality of services received as well as over-payments requested. Telephone numbers for these hot-lines are being widely published as part of the public information campaign using project funds for public information. Later, hot-lines will be established in all 120 local offices.

Accountability. (a) Medical audits will be carried out in 2% of practices every month, such that every practice will be audited about every four years; (b) a procedure has been established to investigate and impose punishment for complaints of corrupt practices. The case will be heard by an independent review panel, comprised of members of the regional health insurance fund and the Bulgarian Medical Association. If evidence of corruption is found, the panel will recommend suspension of that physician's contract with the National Health Insurance Fund for a period of 6-months to 2 years.

Project Monitoring and Evaluation: one of the key performance indicators for the monitoring of the Bulgaria Health Sector Reform Project is to judge whether public perceptions of corrupt practices among physicians is changing. The indicator will be regularly monitored using qualitative research methods. In addition, annual reporting to the Bank on progress in this area is a condition of implementation in the Loan Agreement.

II. IDENTIFICATION OF STAKEHOLDERS WHO WILL BE AFFECTED BY ACTIVITIES PLANNED UNDER THE HEALTH SECTOR REFORM PROJECT

Stake-holders	Their Interests	Degree of Support for Project's Objectives	How the Project Might Positively or Negatively Affect their Interests	Project Activities to Address Issues

The State; Govern-ment	• To ensure well-being of the population through improvements in health status; • Use of the state's (financial) resources in most efficient manner; • To be perceived as being responsive to the needs of the population.	Average to high	• If project objectives are met, the health reform will be guaranteed, effecting positive outcomes in both health status and in improved use of public financial resources; • Increased public support for Govt.	• Improved medical equipment; • Improved training of physicians; • Support to health insurance, thereby improving the use of financial resources; • Public information campaigns.
Ministry of Health & 28 Regional Health Care Centers	• To ensure accessibility and equity in health care delivery; • To ensue quality-of-care, sustainability, and efficient use of resources;	Very high	• Ditto. • Strengthening of public support for the Ministry of Health and for the National Health Insurance Fund	• Ditto.
Ntl Health Insuranc e Fund & 28 Regional Health Insuranc e Funds	• To ensure the maximum package of quality services to the population; • Cost containment; • Improved efficiency of health care system; • Better administration of the whole health care delivery system.	Very high	• Possibility to develop quality standards in out-patient and in-patient care and to introduce these indicators in the information system of the HIF and hospital information system; • Support for improvement of the efficiency of the system; • Increased public support for health insurance in general, and for the insurance funds in particular.	• Technical assistance to develop quality standards; • Improved hardware/software for the computerization of health insurance processes; • Public information campaigns for public awareness.

The Popul-ation	• To receive high-quality health services when needed, without geographical, economical, ethical, cultural, or other barriers.	Medium (awaiting "proof" that the reforms will work)	• If the project (`and especially the component on primary and ambulatory health care reform) is successful, the whole population would benefit as existing barriers to care would be removed.	• All project interventions.
Vulner-able Groups (the un-employe d, those with low incomes, ethnic minoritie s (the Roma), the aged, rural populatio n, etc.	• To receive high-quality health services when needed, without geographical, socioeconomic, ethical, cultural, or other barriers.	Medium (awaiting "proof" that the reforms will address their needs.	• Vulnerable groups are expected to benefit MORE from the project than the general population as: A. Reform legislation guarantees equitable access to health care services for the whole population (unlike in the past); B. The reform assures prioritization within the system on the basis of real health needs at the national and regional levels; C. Special incentives are being built into the reform to encourage physicians to practice in rural, under-served areas.	• A number of activities under the project are specifically designed to address the needs of the mentioned target groups: special public information and education materials and events, health promotion initiatives, etc. In addition, special studies (technical assistance) will monitor how the project is affecting specific vulnerable groups.
Medical Assoc-iations of Physicia ns and Dentists	• To keep job positions for their members; • To improve salaries and benefits of their members; • To raise the prestige (social position) of medical doctors and dentists; • To ensure professional satisfaction of their members.	Medium to High	• Many doctors will see improvements under the project in terms of (1) salaries/benefits; (2) professional growth/training opportunities; (3) quality of medical equipment and medical technology used; • However, there is currently an over-abundance of physicians, and jobs will be eliminated under the health reform.	• See next row.

<table>
<tr><td>Hospitals</td><td>• Lowering costs;
• Improving efficiencies in the provision of medical services;
• Heightened satisfaction of medical staff.</td><td>Mixed</td><td>• Pending: many hospitals are awaiting details of closures and plans for privatization.</td><td>• The project will provide better support for:
A. A better management system;
B. Quality assurance;
C. Information systems;
D. Resources for energy conservation, leading to lower costs;
E. Heightened opportunities for human resources development.</td></tr>
<tr><td rowspan="2">Physicians</td><td rowspan="2">• To be gainfully employed as physicians;
• To have sufficient income and benefits in their positions;
• To use better medical equipment and technologies;
• To have opportunities for continuous education;
• To have opportunities to use better information technology (hardware and software)</td><td>High</td><td>• Many doctors will see improvements under the project in terms of (1) salaries/benefits; (2) professional growth/training opportunities; (3) quality of medical equipment and medical technology used</td><td>• Provision of improved medical equipment and technologies;
• Professional development / training opportunities, especially for rural doctors; • Improved communications equipment;
• Better health outcomes for patients due to improved standards of care;
• Improved standards of living (indirect benefit)</td></tr>
<tr><td>Very Low</td><td>• Jobs will be eliminated for some physicians, as there is currently an over-abundance; potential for increased unemployment
• Will likely lead to some social and professional conflicts between medical professionals.
• These health professionals will have negative impressions of the health reform, and could act to discredit the rationalization effort.</td><td>• Severance payments for unemployed medical professionals (to be financed by Government funds);
• Retraining activities;
• Seed money for establishment of entrepreneurial pursuits (still under discussion).</td></tr>
</table>

Nurses	• To be gainfully employed as nurses; • To increase opportunities for higher qualification and training; • To increase professional prestige.	High	• The importance of many nurses will be heightened with expansion of primary health care (PHC), and these nurses will benefit from more training and professional development opportunities.	• *to be discussed*
		Very Low	• Many nurses will be worse off, as: A. The number of nursing positions will likely drop as physician jobs are cut; B. Practicing nurses and feldshers currently working in rural areas will be replaced by physicians; C. Possible conflicts could arise between doctors and nurses.	• *to be discussed*
Local Health Authoriti es (262 muni-cipalities)	• To contribute to the well-being of the local population through supporting the invest-ments in health services provided at local level; • To financial resources of municipality in most efficient manner; • To be perceived as being responsive to the needs of the local constituency.	Mixed (some respon-sibilities, and their financial subsidy, have been removed, while new, as yet unfunded, respon-sibilities are emerging)	• Successful reform will improve the image of local authorities; they will be perceived to be responsive to local needs; • If health financing reform is successful, health insurance will efficiently remove the fiscal burden from the municipalities;	• All project interventions
Med. Univ. (5)	• Increase the prestige of the academic institutions;	Medium, outcomes are still speculative .	Reform offers opportunities to strengthen the role of medical universities in both capacity building and training (of physicians);	• No direct interventions.

III. Social Assessment of Poor and Vulnerable Groups

Introduction. The project development objective is to support the Government of Bulgaria in implementing the reform of its health sector, designed to improve access to health care services and to ensure on-going financial and operational sustainability. Implementation of the project must be viewed within the framework of the economic and social context that has evolved over the past decade in Bulgaria. The transition towards a more market-oriented economy began in November, 1989. The economic transition that has been occurring since that time has been difficult, characterized by the emergence of previously-unknown unemployment, falls in real wages, and substantial increases in wage inequality. Unemployment is of long duration. The ranks of low-paid workers have grown, and their relative wage status has substantially deteriorated. Poverty in Bulgaria tends to be a result of both low (relative) wages and low household labor supply. However, work does not keep families out of poverty -- the "working poor" account for one-third of all poor. Moreover, poverty incidence is quite high, even among families with two earners. Thus, Bulgaria does not conform to the usually observed pattern whereby two earners effectively protect against poverty.

Bulgaria began the transition with a well-developed, albeit inefficient, health infrastructure and good health indicators in many respects. However, as economic conditions deteriorated, health indicators stopped progressing and even declined in some instances. Indicators show rising infant mortality, rising incidence of tuberculosis, epidemics of communicable diseases, etc. In keeping with the transition to a more market-oriented economy, the country has been moving from a highly-centralized, public sector health system toward a more diverse and decentralized system. However, the fast pace of decentralization of the health care delivery system and the unregulated emergence of private health care providers pose a real threat to the quality of health care. With the assistance of the World Bank and other partners, the Ministry of Health and the medical community are wrestling with the most complex, and often controversial, issues such as the introduction of health insurance, the allocation of resources in a decentralized setting, and the means to encourage greater efficiency and improved quality of health services.

Methodology of the Social Analysis

This social analysis seeks to: (1) identify key stakeholders who will be impacted by the proposed Health Reform Project; (2) identify poverty-stricken and marginalized groups within the population to ensure that they are protected under the project, and (3) ensure that the proposed project appropriately identifies and addresses the needs of both the key stakeholders and vulnerable groups.

The analysis is based on:

- "Consultations with the poor", i.e. recent participatory focus group sessions that were carried out with the poor to inform the World Development Report 2000/01. These surveys were carried out in three villages, three towns and three cities in Bulgaria. Special attempts were made to interview the poor, as well as ethnic minority populations;
- A review of the written literature; and,
- Interviews with informed parties, including Government officials, medical doctors, nurses, and representatives of NGOs (including CEGA ("Creating Effective Grassroots Alternatives), the leading NGO working with the Roma.

Identification of Key Stakeholders for the Health Sector Reform Project

This section seeks to identify key stakeholders who will be impacted by the proposed Health Sector Reform Project and the nature of how they will be impacted. The following table identifies the stakeholders, identifies their interests, estimates their degree of support for the project, suggests how the project might affect their interests, and finally identifies specific project activities that were designed to address their issues. In sum, there are four groups of stakeholders that were considered:

1. The Borrower. In this case, the Bank's most immediate client is the Government of Bulgaria and the agencies responsible for project implementation: the Ministry of Health and the National Health Insurance Fund.

2. Project Beneficiaries: the Government's immediate clients are those who will benefit from improved delivery of health services and heightened efficiencies in the financing of these services:
• The whole population of Bulgaria (including minority and rural populations).

3. Affected Groups: those individuals, families, communities or organizations who are not direct beneficiaries (or specifically targeted to receive specialized interventions), but who may be affected and who might need to be protected or monitored under the project.:
• Physicians (who continue to work as physicians), physicians who leave medical service, nurses, etc.,\;
• The majority Bulgarian population;
• Minority groups (Roma, Turks, Pomaks);
• Urban and rural populations.

4. Other stakeholders: others with vested interests, including donors, non-governmental organizations (NGOs), religious and community organizations, private sector firms, etc.
• The Bulgarian Medical Association'
• Local governments.

The table in II above outlines the expected impact of the project on each of these groups.

Ethnicity and Social Exclusion:

This section considers whether particular ethnic groups might be vulnerable to exclusion under the Health Sector Reform Project. We begin with a description of ethnic groups within Bulgaria, and detail special efforts under the project to ensure that the needs of these vulnerable groups are sufficiently addressed.

According to Bulgaria's most recent census (4 Dec. 1992), ethnic Bulgarians account for over 85% of the total population, with sizable minority populations of those of Turkish descent (9.7%), Roma (gypsies, 3.4%), Pomak (Bulgarian Muslims) 0.8%, and other (including Madedonian, Armenian, Russian, other) 1.1%. Independent demographic analyses suggest that that the Roma population may have been significantly under-enumerated, with the correct proportion of Roma being in the 6-8% range.

Ethnic Groups in Bulgaria
(according to the Census of 4 December 1992)

Group	Total Population	Per Cent
Total	**8,472,724**	**100.0**
Bulgarian	7,206,062	85.1
Turkish	822,253	9.7
Roma (Gypsy)	287,732	3.4
Pomak (Bulgarian Muslims)	65,546	0.8
Other	91,131	1.1

By minority ethnic groups:

The recent *Voices of the Poor study* found that there are three sub-groups of Bulgarian society with are socially excluded -- the Roma, the disabled, and the Pomaks (Muslim Bulgarians) -- but the situation is worst in the case of the first two groups. Significant discrimination against the Turks was not identified.

The Roma are segregated, walled-off -- they live in particular places, in specific neighborhoods, ghettoes, which are literally walled-off into something like inner cities with their own infrastructure. Local residents who participated in the focus groups expressed that "we're excluded as if we were lepers; we've been left here to die".

Unlike the Roma, who are socially excluded, the disabled are excluded because of inaccessibility. They are often confined to their homes by the absence of elevators, high steps in public places, inconvenient transportation, etc. Even polyclinics often have no conveniences for wheelchairs. "For the disabled, the world is inaccessible; for the Roma, it is unattainable."

The Roma

The Roma (an ethnic group often referred to by the pejorative names of "Gypsies" or "Tsigan"), who arrived in Bulgaria in the 13th and 14th centuries, are the country's most visible minority group. The number of Roma in Bulgaria varies according to different estimates, from about 300,000 (1992 census) to 600-800,000 (various sources). The Roma in Bulgaria, like those around the world, are not a united and homogeneous community. Rather, they are heterogeneous in terms of religion (some Muslim; Orthodox, Protestant); language (Roma dialects, Turkish, Bulgarian), and types of traditional crafts and way of life.

While there are exceptions (such as the socially-integrated town of Kalofer), the status of the Roma in Bulgaria is similar to that of the Roma in many other countries in Central and Eastern Europe: all of the components that produce poverty and despair are prominently displayed. Unemployment in many Romani communities approaches 90 percent. Education beyond the grade-school level is a rarity. Basic services (adequate housing, running water and sewage, adequate health care) is virtually non-existent.

Social exclusion is common, and the Roma face open discrimination. In the work place, Roma, who previously had worked in state-owned industrialized segments of the economy doing the lowest-paying and menial jobs (hauling coal, mixing the cement), became the first to be laid-off or fired with the closing of the factories. Unemployment rates amongst the Roma have now reached 80-90% (compared with 16% among Bulgarians as a whole). The situation was made worse by inflation, which had reduced the value of

the social welfare payments. Housing is generally very poor, often in areas where municipal services (including sanitation services) are vastly inferior to those provided in other areas. Most Roma attend segregated schools, where the graduation rate has dropped from 60% in the 1980s to about 30% now.

As elsewhere, the Roma are often considered by the rest of the population to be dirty and lazy people who are prone to crime. That some Roma are active in the black market and prostitution, and have a disproportionately high crime rate, perpetuates this stereotype. However, to some extent, the stereotype is self-perpetuating, as poor economic status is partially due to these prejudices and to a great extent is responsible for the high crime (especially theft) rate. Of course, the Roma do not agree with this characterization, and reported that they too had had the same living standards as the other people prior to 1990. They too had belonged to the “average” economic class. The economic hardship caused by unemployment and the dwindling value of public assistance has necessitated petty theft and begging to avert hunger in the family.

The *Voices of the Poor* study highlights the stigmatization of the Roma. As reported in that study,

The Roma were frequently discussed as a group apart. For example, while discussing the percentage of different categories of people in the community, the total was made up to 100%, and then some extra 30-40% were added for the Roma, because they "don't count" or "they are in a class of their own". In contrast, Roma [mostly] discussed all social groups in the community without drawing a distinction between Roma and Bulgarians. The Roma also identified different sub-categories within their community. The extremely poor among them are those who have no electricity, running water, toilets. "here's a widow who doesn't even have a door at her shelter; just a blanket."

What strategies and activities would best meet the needs of the Roma? The Government argues that, in order to improve the social and economic situation of the Roma, and thereby reduce crime amid economically disadvantaged groups, a comprehensive strategy of encouraging and promoting projects dealing with the problems of the Roma, such as improving Roma education and encouraging education in Roma language is required. While the Government has adopted such a strategy, the implementation of such projects is difficult, constrained not only but also by competing needs for state resources, but also by the lack of coordination amongst Roma groups in identifying and communicating their needs to Government.

One qualitative survey conducted by the Roma-Lom Foundation in the late 1990s tried to identify the most urgent needs. Roma in Lom identified their three biggest problems as: (1) unemployment, (2) low educational level and low levels of school attendance, and (3) the poor condition of the infrastructure in their neighborhoods. These results are consistent with what was learned from the *Voices of the Poor* study.

It should be noted that, while the Roma did not identify health care as one of the most pressing of their needs, disturbing inequalities between the Roma and the majority population are seen with respect to health. The Roma-Lom Foundation reports:

The low living standard of the Roma has a destructive influence on their health. The mortality rate has been rising in recent years. Only five percent of the Roma reach retirement age, whereas for the rest of the population the corresponding figure is 35 percent. One of the most serious problems is tuberculosis. Recently, the Roma-Lom Foundation tested 70 children from one of the neighborhoods for tuberculosis; forty of them tested positive.

Pomaks (Bulgarian Muslims).

The Pomaks are a Slavic people who live in the Balkan region of southern Europe. They are usually considered to be a type of Bulgarian since they speak a Bulgarian dialect, have Bulgarian features, and have cultural practices similar to the ethnic Bulgarians. They are distinguished, however, by their non-Bulgarian names and their devotion to Islam, rather than to Orthodox Christianity. Although most of the world's Pomaks live in Bulgaria, small clusters are also found in Greece, Macedonia, and Romania. The Pomak economy is based on agriculture, and raising animals (cows, goats, and sheep) is also important. Most Pomak farmers live in two-story dwellings in rural villages that are surrounded by their fields and pastures.. Pomak women are renowned for their weaving abilities. Many Pomaks also earn income as migrant workers.

Some sentiments expressed in the *Voices of the Poor study* suggest that there is a disparaging attitude toward Pomaks by both ethnic Bulgarians and by ethnic Turks, because they are alien to both groups. Pomaks voluntarily exclude themselves from both groups and live separately in small communities.

The Turks

The Turks, over 800 thousand people of Turkic ethnicity who live in scattered pockets in contemporary Bulgaria, are descendants of the Rumelian Turks of the Ottoman Empire which dominated the lower Balkans until the late 19th century. .Of the estimated 7 million Rumelian Turks who had lived in the Balkan region at the turn of the century, most have emigrated to Turkey, leaving only about 1.5 million in all of the Balkan states.

During Communist rule in Bulgaria (from 1947 to 1989), the Muslim Turks, with their "outdated" religious customs, were considered an obstacle to a modern industrialized society. From 1985 to 1990, the expression of any aspect of Turkic culture was unlawful. During this period, according to Bulgarian state authorities, there were no Turks in Bulgaria; there were only "Islamicized Bulgarians". These people, however they were referred to, were systematically discriminated against. They were relegated to the performance of the least-skilled jobs, and were effectively barred from political access. The Communist government carried out a much-publicized campaign of forced "Bulgarianization" of the ethnic Turks in Bulgarian culminated in 1984-85 with the decreed issuance of Slavic names to replace Islamic ones on the mandatory identity cards. This decree was met with considerable, and sometimes violent, resistance.

Since 1989, the Turks have enjoyed greater freedom and the Muslim community has returned to some of its old customs. The Turks now have full political, cultural, and religious rights, and have considerable influence in Bulgaria's government. There is no official discrimination of Bulgarian Turks. *The Voices of the Poor study,* when considering socially excluded groups, considered the Turks to be socially integrated.

The core problem of the ethnic Turks in Bulgaria is very similar to that of the majority ethnic Bulgarians at present: the poor economic situation. This group has experienced severe economic pressures because of their traditional occupation as agriculturists and their social immobility. However, some discrimination by the Bulgarian populace remains. There is workplace discrimination, with most of the supervisory positions being given to Bulgarians. Though the situation has improved, the legacy of being denied university education also hurts their economic status. There are few Turkish officers in the Bulgarian military.

Vulnerable Groups: the Poor

This section considers whether "the poor" might be vulnerable to exclusion under the Health Reform Project. We begin with a general description of poverty in Bulgaria.

Who are the poor? Estimates of the number of poor people varies according to different research methods. National statistics for 1997 estimate that poverty is pervasive -- 69.5% of Bulgaria's population is characterized as "poor". The most disadvantaged are identified as the ethnic minorities discussed above: the Roma, the Pomaks, and the Turkish minority. Most of the poorest have low educational levels, and often have many children. The poor also include the long-term unemployed, single mothers, the disabled, and some retired people. Poverty is estimated to be slightly higher in urban areas, though the lowest level is reported in Sofia.

The informal focal group discussions carried out for the *Voices of the Poor study* identified the following socioeconomic groups within society. (Note that estimated percentages in each category are indicative only as they were not scientifically estimated).

1. The Rich, 5%. Many in this category are perceived as to have their fortune by dishonest means. "Nothing has changed -- those who were well off before are well off now too, and those who were poor still are." "The means by which mobility is achieved have remained the same: politics -- party commitment; shady dealing and corruption; and connections." However, there is also the new recognition that some newly wealthy achieved wealth through high education and "being smart".
2. "Normally-living" people: 15%. Normally-living is defined as having steady employment and salaries, being able to afford holidays and not to worry about the future;
3. "Us", the poor, 70%, the overwhelming majority, who can barely make ends meet. Haven't starved to death, but each day is unpredictable because of job insecurity and lack of money; Generally, poverty in Bulgaria is not characterized by real hunger, but rather by cutbacks in consumption and a loss of previous status associated with job and income security.
4. The Roma, 8%, an intermediate group who are poorer than the poor, but are not really destitute and social outcasts. Characterized as having exceptionally high unemployment.
5. A small group of the destitute or people living in extreme poverty (2%), who are excluded from the community -- people who have no food and no shelter. These persons have to rummage in garbage cans and cannot cope by themselves. In addition to the socially marginalized (drug users), the category also includes sick elderly people, some disabled, and orphans.

Focus group discussions with "the poor" highlight that respondents do not associate "well-being" with wealth. They note that the rich have money, but don't necessarily have security nor the respect of the community. "Ill-being", however, is identical with poverty, and most focus group respondents reported the state of ill-being to be their is to "our situation." Poverty, and all of its related problems, is perceived as a recent problem in Bulgaria -- having emerged shortly after the political change in 1989. It is widely felt that unemployment and the collapse of the social safety net (which is associated with the availability of jobs and social security) are the driving forces behind all other current problems. A commonly expressed sentiment was that: "even though people were underpaid back then too, they nevertheless had a sense of security." It was further noted that many of the currently poor were in the "middle-class" a decade ago, and that their current status was not the result of their own decision or choice. They were victims of the social transformation.

In identifying their greatest concerns, the poor listed: (1) stable employment and steady wages; (2) food security, especially amongst the Roma; and (3) social cohesion, as opposed to the social exclusion and discrimination faced by the Roma.

The Health Reform Project will not target interventions towards "the poor" as a vulnerable group. As evidenced by the above description, the majority of the population is characterized as poor. The most vulnerable (the poorest of the poor) are identified as the ethnic minority populations who will be monitored under the project. Finally, it should be noted that many families count on their welfare payments (unemployment, child benefits, and welfare for socially disadvantaged and disabled people). Notwithstanding the common complaints about delayed welfare payments and shady dealing at the welfare office, these are recognized as a safety net though "if we were to depend only on the welfare payment, we'd starve to death."

Institutions

Which institutions are important in people's lives? According to the *Voices of the Poor* study, the labor office, the municipality (often personified as the mayor), the police, and the welfare office are the most important. The school and different types of health care institutions (hospitals, polyclinics, health care centers) were consistently mentioned, but were not considered most important, in both rural and urban settings. At the same time, the most important official state institutions, except for schools and health institutions, are on the whole evaluated negatively in terms of mistrust and inefficiency. Non-governmental organizations (NGOs) are popular in large urban areas, but are virtually unknown of in rural sites and small towns.

The municipalities have significant vested interests in the health sector reform. Until now, local governments have been one of the major agents channeling resources into the health care system at the local level, including both out-patient and hospital care. Under the old system of health care financing, about 1/3 of municipal finances went towards health care. Municipalities were responsible for funding and managing all polyclinics (previously the main instrument of group primary health care) and municipal hospitals. Municipal authorities were viewed by the local population as the institution responsible for the status of the health sector and health services in the area, and it is likely that this perception will continue even after the introduction of the general practitioners, and later on, of the insurance financing of hospital care. With the introduction of the national health insurance, local authorities will: (a) be relieved of their responsibilities for the PHC sector, except on the level of managing/renting out facilities to the GPs, and (b) be relieved of the burdens of financing the local PHC system.

However, at the same time, the municipalities will: (a) continue, for some time period, to be viewed as the local custodian of the health service sector, and will continue to suffer the consequences of any problems with the new system; (b) lose a large part of their central subsidy as they are supposed to cease having expenses for the PHC. However, some municipal budget deficits and indebtedness may occur as there is not direct correspondence between the loss of subsidy and the loss of responsibilities; and (c) assume a number of new responsibilities brought about by the new system. Examples include: providing administrative structure and mechanisms for renting out facilities, for collecting payments from the GPs, for negotiating contracts with the GPs for use of facilities and equipment, etc.

Health care

Focus Group Concerns about Health Care

The interviews with the poor and with minority populations that were carried out for the *Voices of the Poor study* covered a wide-variety of issues and concerns. In ranking those that caused the greatest concern, participants were clearly most concerned about the effects of unemployment and the loss of steady wages. They believed this to be the root problem that caused all other major concerns. In prioritizing the "list of greatest problems" affecting the poor and minorities in rural sites, 16 topics were mentioned; health was not included. In the urban sites, only 4 groups mentioned health concerns. Specific health-related concerns mentioned during the focus groups are detailed below.

Heightened Disease Burdens due to the Transition:

A small number of respondents were concerned about heightened risk-seeking behavior (widespread heroin and alcohol abuse in the Roma population in Varna) and increased disease burdens as a result of economic transition. While many of the city groups mentioned that a major personal impact of poverty is disease (and specifically mental disorders such as anxiety and depression), a surprising omission is that participants did not report current conditions of ill-health. It is known, for instance, that certain sub-groups of the children within the Roma population are suffering from tuberculosis, but these concerns were not discussed during the sessions.

Costs of Health Services and Medications:

Many participants were reminiscent for the pre-transition days when everyone was employed and protected by a social safety net. There was a clearly-expressed desire to have sufficient income (or Government intervention) to cover what are considered to be the essentials of daily life -- food, health care services, medicines, heating, and education.

- *How do you make ends meet with only a small pension, high taxes, high bills for utilities, and high-priced medicines?*
- *A paid leave, free health care, a holiday in a sanatorium. And, when they recover, they will find their jobs waiting for them and even a welcome party organized by the colleagues. While now a sudden illness will bring ruin to the family and, at the end, you will be kicked out by your employer.*
- *The "rich" are not afraid of accidents because they can afford their hospital treatment;*
- *Before 10 Nov 1989, life was better, there was greater security because the prices of foods and medicines were low and stable (pensioners, Sofia);*
- *Medicines are no longer free-of-charge; that's why it's harder to be ill now;*
- *Even if the doctors diagnose your case and write out a prescription, drugs are so expensive. That's why I asked the doctor to explain the diagnosis to me and then made inquiries about the herbs recommended by traditional medicine for that illness.*

Access for the Disabled:

- *There are no lanes for wheelchairs, not even in polyclinics where they are supposed to turn up every three months in order to get the successive certificate of disability.*

Corruption

Corruption was frequently mentioned, particularly by the Roma population, who perceived that their access to health care services would be limited or eliminated if they did not pay bribes to the physicians.

- *Corruption is virtually everywhere -- that's how you place orders at the factory; that's how you make*

sure that your child gets decent medical treatment;

- *They'll let you die unless you grease their palm. (older Roma men from Filipovtsi, Sofia);*
- *Doctors won't even look at you unless you give them something;*
- *We used to [prior to the collapse of the social security safety net] have doctors, and every time a baby was born in the neighborhood, they came here and made you give the baby medicine. If you didn't, you were scolded by the doctor. Now, the doctor won't admit Gypsies even in critical condition unless you pay a bribe.*

Access (see also Quality of Care)

The following comments refer for physical access to health care facilities in terms of accessibility of services, transportation options, etc. Discussion of access in terms of discrimination is covered in the sections on corruption and quality-of-care.

- *The collapse of the transport infrastructure has made access to health services very difficult. The medical auxiliary who used to commute to the village seldom comes nowadays. For both humans and animals, the villagers have now begun to rely on traditional practices -- herbs, midwives, even witchcraft;*
- *The collapse of the infrastructure raises specific female problems. Young mothers complained about the closure of the health care center in the villages of Sredno Selo and Kalaidzhi and the need to travel to Zlataritsa for check-ups and advice. Since the capabilities of the unit in Zlataritsa are also very limited, patients are usually sent to Elena, especially for obstetric help. All this adds up to some 45 km and, given the limited bus services, poses serious problems. Several women told how they had given birth at home with the help of "old women". One woman said that she had given birth in a car on the road to Zlataritsa.*

Quality of Care / Discrimination

Participants were asked about the quality of care in the various types of health care facilities (hospitals, polyclinics, etc.). Most were ambivalent regarding the types of facility --- rather, what's important is the humane attitudes of the people employed in a particular institution that makes a big difference. If doctors treat people with respect, the health care institution is evaluated highly. If not, just the opposite. The hospital is clearly a main problem for the Roma groups. "They treat us like dogs."; "Once they see that we're Gypsies, they throw us out like dogs" were common expressions from all of the Roma groups who participated in the focus groups in all sites.

The Health Sector Reform Project within Bulgaria's Social Context

The Health Sector Reform Project, and the National Health Insurance Fund more generally, have developed a strategy to ensure equal access to health care. Components of the strategy are detailed below:

Guarantees for Equal Access to Health Care Services.

Legislation. With ratification of the "Health Care Establishments Act", the Government is trying to ensure that the new health system will provide full access and coverage to all citizens of Bulgaria, including the vulnerable groups. This is achieved through a legislative and regulatory reform that addresses the issue from the perspective of both the provider and the recipient. Special efforts were written into the law to ensure that geographically rural areas are included.

Provision of Services. Under the Act and under NHIF regulations, health care provision was planned for and distributed on a territorial principle, based on the development and implementation of National and Regional Health Maps. The maps were created on the basis of: (a) the geographical, infrastructure, demographic, and health status features of the regions; (b) the existing health care institutions and their potential for providing medical care; (c) requirements for emergency, primary, and specialized out-patient care, including needs for facilities and medical equipment, and (d) regional health priorities.

Special Efforts for the Provision of Services in "Undesirable" Locations. A set of measures was developed to attract physicians to remote or less desirable locations. According to the National Framework Contract, "less desirable locations" are defined as: those that are a long distance from emergency medical services and hospital centers, places with undeveloped infrastructure, mountainous area, environmentally undesirable areas, etc. The NHIF will pay the practitioner additional salary of up to BGN 25 per month for each of the listed disadvantages in the location. The MOH, supported by the first and second health projects, is also giving these areas high-priority status for refurbishing and equipping.

Full Coverage of Insurance Premiums for Vulnerable Groups. The National Health Insurance Fund seeks to register every citizen in Bulgaria for health insurance, regardless of his ability to pay. For employed workers, contributions of 6% are currently being made to the NHIF, of which 80% is paid by the employer and 20% by the employee. The employer:employee proportion will change with time until the contribution proportion is equalized at 50%:50%. For workers who have been unemployed for up to one year's duration, the Ministry of Labor and Social Policy (Unemployment Office) is contributing the premiums on behalf of the citizen. For those who are long-term unemployed or receiving public assistance, premiums are paid by the municipalities through the Ministry of Labor and Social Policy.

Recognizing that registration for health insurance has only been a recent event, NHIF estimates that there are 500,000 to 700,000 persons who have not been identified and for whom premiums are not yet being collected. These are largely persons who work part-time in the agricultural sector. Attempts are being made, with the assistance of the Ministry of Agriculture, to develop a register of such persons.

Even in the absence of having been officially registered in the health insurance system, patients will not be refused services by a general practitioner. Upon receipt of services, they will be newly registered in the health insurance system. Attempts at cost recovery will be made for the current services either through direct payments by the patient or from the Unemployment Office or through the municipalities, as appropriate.

Public Education Campaigns. The Public Information Office of the National Health Insurance Fund has developed public information campaigns to inform the general population about changes that are occurring as a result of the introduction of health sector reform in the country. Some of the messages include: (a) how to register for health insurance; (b) patient rights and responsibilities under the health reform; and (c) advertisement of the correct, reimbursable prices for services. Special messages have been developed to target particular sub-groups of the population. With project funding, discussions are underway with NGOs such as CEGA ("Creating Effective Grassroots Alternatives") to investigate how to best inform and work with communities such as the Roma, who often don't speak or write in Bulgarian language.

Hot-Lines. Special telephone lines will be set-up in the National Health Insurance Fund (already operational), the 28 Regional Health Insurance Funds, and eventually the local offices to provide guidance for citizens to report physicians that refuse to provide services, offer mediocre services, or who request "under-the-payment" payments from their clientele. Procedures to deal with such issues have been

established.

Study Plans and Project Conditionalities A small number of key indicators will be used to monitor and evaluate the performance of the Bulgaria Health Sector Reform Project. Specific indicators were selected, and will be reported on regularly by the PMU, to address whether the Roma population truly have access to the health care services. This information will be gathered using qualitative research methods. In addition, one of the loan conditions states that "the Government of Bulgaria will report annually to the Bank (by April 30 for the previous calendar year) on progress that has been made towards ensuring uniform access to health services for all ethnic, economic, and geographic groups, as well as the level of health insurance coverage for these groups and the population generally."

Additional
Annex No.: 13

Monitoring and Evaluation

Decision Tree and Logframe. A decision-tree which highlights how the World Bank-financed project is expected to contribute to health sector objectives in Bulgaria was developed as follows:

1. Program Goal: to stop deterioration in the health status of the population while gradually improving to Western European standards.	
↓	
2. Project Development Objective: to support the Government of Bulgaria in implementing reform of its health sector, designed to improve access and to ensure on-going financial and operational susteinability.	
↙	↘
3A. PDO, sub-objective: To improve access and effectiveness of health care and health promotion in Bulgaria.	**3B: PDO: sub-objective:** to ensure on-going financial and operational sustainability of the health sector.
↓	↓
Output 3.A.1: to ensure **access** to a basic package of well-functioning health services for all members of the population, including vulnerable groups and the rural, through a newly-designed network of GPs and hospitals	**Output 3.B.1**: to ensure **financial sustainability** of health insurance system by funding a **labor adjustment strategy** to transition surplus physicians out of the health sector and to improve provider payment mechanisms.
Output 3.A.2: to heighten **quality of health services** through provision of better equipment and supplies, improved service standards for quality assurance, and increased incentives to provide high-quality care.	**Output 3.B.2**: to implement **new National Health Insurance**, ensuring funding at central and regional levels.
Output 3.A.3: to improve **capacity of providers** through training in use of upgraded equipment, regular conduct of medical audits, and availability of Investment Funds for locally-selected upgrades of facilities and equipment.	**Output 3.B.3:** to improve **information flows** through provision and use of information systems in GP offices, hospitals, & the National Health Insurance Fund.
Output 3.A.4: to better **inform public** about the implications and benefits of the health reforms.	

As its project development objective (PDO), the Health Sector Reform Project will support the Government of Bulgaria to implement a fundamental reform of its health sector, designed to improve access and to ensure on-going financial and operational sustainability. This objective, when combined with other non-Bank financed interventions, is expected to contribute to improvements in the health status of the Bulgarian population. While the Bank loan can influence both the development objective and the larger sector goals, the Bank will not be able to claim success or failure at the level of health status changes as these are affected by a wide range of interventions and external factors. Specific outcomes expected from the project, which the project can be held directly accountable for producing, are highlighted in the decision tree as Outputs.

Indicators: within the decision-tree framework of project aims and objectives, a specific set of "key indicators" has been established for the purposes of project monitoring and evaluation. The indicators selected, as well as methods for collection and critical assumptions are provided in Annex 1. The selected indicators are linked to specific project activities, which are directly tied to the Government's objectives. While not designed to capture every change which is likely to occur as a result of the health sector reform, or from the project more specifically, the indicators *are* designed to provide strong indications of whether the project is achieving its objectives in each of the key areas of the project design. While the Government *has* chosen to monitor a broader range of indicators than those chosen as key indicators, the Bank will only regularly monitor the set that are identified in Annex 1.

Methods for Monitoring and Evaluation, including Supervision Reporting: the Project Management Unit will:

1. Prepare **quarterly Project Management Reports (PMRs),** which detail project financing needs and sources for the subsequent quarter of project implementation, and describe the financial situation of the project in terms of actual versus planned expenditures for each project activity;

2. Prepare an **annual Implementation Progress Report (IPR)**, with the first report due on 30 April 2001 (for activities through 31 December 2000). An indicative outline of the structure and contents of the report format follows. The format will be evaluated during a future supervision mission, after the first report has been submitted and finalized:

Format for the annual Implementation Progress Report:

a. Executive Summary. This section will provide a brief summary overview of project progress up to 31 December, including: (i) summary of project activities, (ii) financial status; (iii) project successes/achievements, (iv) problems encountered and suggested actions; and (v) major issues still outstanding.

b. Project Activities during Previous Year: this section will provide a short description of project activities carried out during the previous year, with accompanying tables showing progress relative to targets/plans for the period and to total project targets/plans (e.g. equipment procured, training activities completed, studies underway, etc.). Results of any major surveys, studies, or evaluative activities which analyze or impact upon the health sector reform will be briefly described. In addition, any major achievements or successes during the previous year will be highlighted. Any problems or delays will be described and explained, together with proposed remedial actions.

c. Planned Activities for Next Year: this section will include a brief description of activities planned to be completed during the next year (January 1- December 31), with accompanying tables showing the relationship of planned activities to project targets/plans;

d. Budget and Financial Status. This section will summarize progress in project expenditure (by component, sub-component, and activity) during the previous year relative to amounts budgeted for that period and the overall project cost tables. Explanations for over- or under-spending will be provided. Progress on claims, reimbursements, and audits will also be described, with comments provided on any delays or problems encountered and suggested remedial action. This activity will be closely linked the quarterly report submission but will be done on an annual basis.

e. Project Management Status. This section will describe problems or issues relating to project

management, if any, with suggested remedial action.

f. Key Indicators. This section will provide available information on trends in the defined indicators, relative to project goals, accompanied by appropriate comments. Quantitative values are required on an *annual* basis for the following indicators: (i) all indicators that are based on administrative records of the state, the MOH, the National Health Insurance Fund, or other Government agencies, (ii) indicators to measure trends in ensuring access to all ethnic, economic, and geographic groups; and (iii) indicators to measure trends in anti-corruption activities. The latter two sets are specified in the loan conditions. Other qualitative indicators will be required only at baseline, mid-term review, and at the end of the project.

g. Status of Covenants. This section will provide information on the status of project arrangements;

h. Major Issues. This section will provide an analytical description of all major issues in project implementation arising in any of the aspects listed above. It will also lay out for discussion the suggested actions for addressing them on the part of both Government and the IBRD. Any issues with regard to the relationship between Government and the IBRD will also be highlighted here.

3. **Mid-Term Review:** the PMU will have drafted a mid-term review by April 30, 2003 (reporting on progress through 31 December 2002. The mid-term review will follow the format of the annual reports of above, but will highlight progress towards ALL agreed upon indicators (including those based on focus groups and opinion polls) and implementation progress and constraints. In addition, the report will consider whether any adjustments need to be made to the original project design for the remainder of the implementation period. This report will be used as the basis for a joint MOH-NHIF-Bank mid-term review mission in June-July 2003.

4. **Nationally-representative sample surveys** will be conducted at the beginning and end of the project for the purpose of evaluating whether significant health status changes are occurring within the Bulgarian population. An over-sampling of vulnerable ethnic and geographic groups will be conducted. While the project cannot be held wholly responsible for changes in these indicators, as health status is affected by a wide range of variables, it is important to gauge whether significant changes are occurring in important disease and mortality patterns in the country. Planning for the specific topics to be covered in the sample surveys should begin immediately, as these details need to be finalized before effectiveness.

Additional
Annex No.: 14

Progress on Health Reform

The **Legislative Reform** started with the adoption of three fundamental Acts of Parliament that set up the overall framework for radical changes in the health sector: (i) the Health Insurance Act, (ii) the Act on Professional Associations of Medical Professionals and Dental Surgeons, and, (iii) the Health Care Establishments Act.

Health Insurance. The Health Insurance Act was passed by Bulgarian Parliament in June, 1998, with technical assistance/policy input from the Bank. Initially, this law provided for the collection of insurance premiums to commence on July 1, 1999, and for the health insurance financing to begin operations by January 1, 2000 for ambulatory care services and by January 1, 2001 for hospital services. Collection of premiums started as scheduled. However, the latter was postponed by 6 months, and is now scheduled for July 1, 2000 for ambulatory care and July 1, 2001 for hospital services. This rescheduling is giving the Government needed time to prepare for the start-up of the new payment mechanism.

In connection with the above, a National Health Insurance Fund (NHIF), and 28 regional offices, were established. As part of this process, significant investments in infrastructure (e.g., facilities, computers, and related training) were made as part of the overall implementation process. Modifications to the premium rates for social security and unemployment insurance were made to provide the fiscal room for the introduction of the health insurance premiums. Health insurance premiums, amounting to 6% of personal income (currently divided 80:20% between employers and employees), are being collected at this time by the National Social Security Institute, under an inter-agency arrangement with the NHIF.

With the introduction of the national system of health insurance in the areas of primary and specialized care, all insured Bulgarian citizens are guaranteed to have access to a package of health services, irrespective of their income and property status. As part of this new financing system, a number of free or highly discounted pharmaceuticals will be available to patients will certain illnesses.

There has been a great deal of activity by the NHIF preparing for the July 1, 2000 implementation date for the coverage of ambulatory care services. This has included the specification of the information systems, ordering of equipment, acquisition and renovation of facilities, design of organizational structures and hiring of staff, specification of the package of services and payment mechanisms, and the design of training and public information strategies. Completing any one of these activities by itself in less than a year would be a major achievement; completing all of this work with the limited number of staff available is remarkable.

The information technology strategy is one area that has experienced rapid development over the past year. A great deal of work had already been done by the time the Australian Health Insurance Commission (AHIC) team financed under the PHRD Grant arrived in Sofia, and changes have taken place since they completed their assignment. While the NHIF staff working in this area are both dedicated and knowledgeable, there is a significant need for improved project management skills among the members of the management team, as well as an immediate need for outside expertise with both project and general management experience to assist the NHIF in planning and implementing the necessary information systems. Swiss grant funds are being used to address these needs.

Status of Health Establishments under the Restructured Health Care Sector. There are two major types of health institutions that will change in terms of their property and privatization status as a result of the health reform: hospitals and polyclinics. Per recent legislation and the Government's program, the status of these institutions regarding ownership and privatization is as follows:

- *Privatization, control, and ownership of hospitals*

Re-registration of all hospitals into commercial companies will be completed by September 1, 2000. With respect to ownership and privatization status, there will be three basic types of hospitals:

1. Municipal hospitals (the current municipal hospitals)
2. United Regional Hospitals (the current 28 regional hospitals)
3. University Hospitals and National Centers (about 20 in number)

After re-registration, the ownership of Category 1 hospitals will be 100% municipal. Only Category 1 hospitals can be privatized - either by the medical staff or by an external investor through normal privatization tenders. Internal privatization by staff (a kind of worker-manager buy-out) is only allowed if 50%+1 of the medical staff wants to privatize the hospital. It is expected that no more than 10% of these hospitals will be privatized between 2001 and 2005, as investor interest is expected to be limited during the health reform transition period.

Ownership of Category 2 hospitals will be 51%: state and 49%: municipal. These hospitals will not be privatized.

Category 3 hospitals have a special status, with some privatization possibilities. While the majority of these hospitals will remain state-owned, a small number could be privatized. They are being re-registered into commercial companies for the purpose of allowing them to hold contracts with the NHIF and other possible sources of financing such as funds for voluntary health insurance, insurance companies, employers, etc.

- *Privatization, control, and ownership of polyclinics*

Polyclinics are, and will continue to be, 100% municipally owned after the end of re-registration. As long as they remain, their owners (the municipalities) will be obliged to ensure the funding for capital investments of the polyclinics. However, if municipalities wish to introduce improvements to benefit their populations, municipalities can buy equipment as long as an investment totals more than BGL 10,000 (approximately USD$5,000) or as long as it is a specific medical or health care program.

The polyclinics can be privatized. It is expected that privatization will occur at a quicker pace for polyclinics, given their smaller size, and the fact that the re-registration of the polyclinics is currently more advanced than that of the hospitals. As opposed to hospitals, polyclinics will be available for piece-meal privatization - i.e., GPs or specialists will be able to buy separate offices and specific equipment (rather than being obliged to buy the entire polyclinic).

Municipalities will have contracts with all users of the polyclinics' space, and will rent office space and medical equipment to them. The payment of salaries and supervision of the medical activities will be covered respectively by the NHIF and the NHIF/BMA (Bulgarian Medical Association), and will not be under the control of the municipalities.

Introduction of General Practitioners (GPs). For the first time, the concept of the "General Practitioner"

as a family doctor is being introduced, which is expected to lead to improvements in relationships between doctors and patients, and will provide more efficient access to primary health care. The first positive changes regarding the quality of medical care are expected as early as the end of the year 2000.

The introduction of contractual relations between health care providers and the NHIF, and the combination of the social and the free-market principles in health care provision, will allow for annual updates of the benefits package for the insured people and for a stable balance of the doctors' and patients' interests. Medical professionals will receive fair and adequate payment based on the quantity and the quality of their work. The primary health care sector currently includes over 5000 general practitioners, more than 6000 specialists, and a large number of nurses, midwives, rehabilitation therapists, laboratory assistants, and other personnel.

The Basic Package of Medical Services for General Practitioners in PHC was published as Ordinance 28 in the official Gazette (106) on January 12, 2000. This very detailed package covers not only diagnostic and curative services, but also health promotion activities (including targeted disease-prevention campaigns, vaccination, and mother-child care). The detailed formulation of the package also acts as a reference for both the GPs and the patients as to what might be expected in terms of services. With reference to this package, the contracted doctors will be responsible for the delivery of services around the clock. They can organize this together with other GPs in their own and adjacent municipalities. This development should replace the Emergency Medical Services with respect to home visits and eliminate the PHC activities from the EMS. The implementation of the PHC package is expected to begin on July 1, 2000.

The payment mechanisms selected and the proposed package of services (the National Framework Contract which will formally establish the package of services was recently ratified), appear to represent "best practice" proposals, which should provide the correct incentives for general practitioners to deliver needed, high quality services. In particular, the proposal is aiming to ensure that services are provided to those who need them, and that appropriate attention is paid to health promotion and disease prevention by using the following mechanisms:

- the use of an age adjusted capitation formula for general practitioners: for enrolled patients between 18 and 55 years of age the general practitioner gets 1 x the capitation fee per enrolled patient, under 3 years of age, it is 2x; between 3 and 18 years of age it is 1.5 x; and above 55 years the GP will get 1.75 x the basic capitation fee.
- giving bonuses for preventive care, and management of persons with chronic diseases: cardiovascular diseases (especially hypertension), stroke, diabetes, kidney failure, chronic obstructive pulmonary diseases and Parkinson's disease are the conditions for which the GP gets a 15% bonus (calculated over the basis fee) per patient belonging to this category. The GP will only get paid for one disease category per patient. The GPs are going to use the "episode of care" reporting system. The Health Insurance Fund will use physician profiling systems and statistical methods as well as more in-depth medical audits to control the use of this bonus system. Clinical guidelines are prepared for all these conditions, using a consensus method.
- if the doctors are organized to deal with urgent care/ calls outside normal office hours and have submitted a plan prior to concluding a contract, then the GP might get 15% of the basic fee for all the enrolled patients
- if doctors are working in poor conditions (mountainous/ bad road conditions; villages more than 50 kilometers from the office of the doctor; poor communication systems with only 1 or 2 telephones available), then the GP gets 15 % for all the enrolled patients living in this area,
- in the future the GPs may receive a bonus for attending continuous medical education and for mentoring new physicians.

The proposed medical audit function will cover 2 percent of the physician services each month, and will examine adherence to the conditions of the contract, and the appropriate use of practice guidelines and rational prescribing practices. This function should ensure that material deviations from accepted practice are discovered and corrected.

Similarly, the use of global budgets for specialty services with allowances for the capacity to adequately use higher-cost diagnostic equipment, and reduced payments for services provided beyond the specified amounts (digressive system), should provide income security for the physicians and high quality services for patients, as well as help in cost containment. There are three levels of specialties, ranging from specialists with very basic equipment, via medium level specialists (3 different specialties) getting 1.40 x the basic fee to specialists working in a so-called diagnostic center getting 2 x the basic fee. For 12 visits of patients/day the specialist gets the basic fee, from 12 to 20 visits per day 0.55 x and for visits over 20 per day 0.45 x the basic fee. The fees are based on an average duration of 20 minutes per visit and include also the investment and depreciation/interest costs as well as the costs for auxiliary personnel.

All of this is supported by regional per capita allocations based on the national health care map, with appropriate allowances for geographic and other peculiarities. The diagnostic centers are expected to deal with 70 % of the cases (only 30% will be referred to hospital) and will have to be accredited. The foreseen accreditation will also include a review of the equipment and the contracting mechanism will include an assessment of the needs for specific expensive equipment. One area of concern, mentioned in the AHIC report (see section 2.6), was the capacity of the physicians themselves to be ready to contract with the NHIF and deliver services in accordance with the signed contracts. The NHIF needs to work with the physicians to address this issue. Some of the funds under the Swiss grant (see section 2.6) will be directed toward this activity.

The training and public relations strategies also appear to be well thought out and seem to have benefited greatly from the input of the AHIC Consultants working under the PHRD Grant.

Additional Components of the Government's Strategy in Health. In addition to the details highlighted above, the Government will continue its role in organizing, managing, and financing emergency medical aid, state sanitary control, epidemic prevention and control measures, blood transfusion services, hospital psychiatric care, health promotion, and disease prevention measures. The Government will also continue to be responsible for the overall management of the health care system and for guaranteeing health care security through direct financial investment and supporting organizational changes, as appropriate.

By the end of its mandate, the Government will have started the implementation of 12 national health programs which are of vital importance to certain groups of the population suffering from the highest incidence illnesses in the country. A number of activities beyond the health insurance scope are envisaged as well that are related to prevention, health promotion, and efficient treatment, and that have a direct impact on the improvement of people's health.