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ВОЗМОЖНОСТИ ДЛЯ РАЗВИТИЯ МОДЕЛИ МЕДИЦИНСКОГО СТРАХОВАНИЯ В БОЛГАРИИ

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OPPORTUNITIES FOR DEVELOPMENT OF THE HEALTH INSURANCE MODEL IN BULGARIA

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АННОТАЦИЯ

Развитие и совершенствование модели медицинского страхования в стране является насущной необходимостью для улучшения состояния здоровья населения. **Целью** статьи является обзор возможных изменений в модели медицинского страхования в стране. Указываются положительные стороны и ожидаемые проблемы для системы введения конкуренции между финансированием фондов здравоохранения (демонополизация фонда медицинского страхования) и строительством второго (возможно, третьего) уровня медицинского страхования. Был использван документальный метод. **Выводы**: На сегодняшний день наиболее широко принятым и поддерживаемым государством вариантом является построение двухуровневой модели медицинского страхования, включающей обязательный базовый пакет медицинских услуг, финансируемых за счет медицинского страхования, и дополнительный пакет добровольного страхования в сочетании с демонополизацией медицинского страхования. В **заключение**, предстоящие изменения в модели медицинского страхования требуют глубокого экспертного анализа, общественной поддержки и консенсуса.

ABSTRACT

Improvement of the existing health insurance model in the country is urgently required in order to achieve better health status of the population. **The objective** of this paper is to review the possible changes of the healthcare system and improvement of the health insurance model, which will undoubtedly increase patient satisfaction. The positive aspects and expected challenges for the system resulting from introducing competition between healthcare funds (health insurance fund demonopolization) and establishing a second (and possibly, a third) pillar of health insurance have been outlined. Documentary **method** used. **Conclusion**: At present, the best perceived and publicly supported option is the option of building a two-pillar health insurance model, including a mandatory basic package of medical services funded by health insurance contributions and an upgrading voluntary health insurance and/or insurance package, combined with the demonopolization of the health insurance fund. In **conclusion**, it is stated that the forthcoming changes in the health insurance model would require extensive expert analysis, public support and non-partisan consensus.

Ключевые слова: демонополизация фонда медицинского страхования, базовый пакет медицинских услуг, модернизация модели медицинского страхования, второй и третий столпы медицинского страхования.

Key words: health insurance fund demonopolization, basic package of health services, health insurance upgrade, second and third pillar of health insurance.

INTRODUCTION: Improvement of the existing health insurance model in the country is urgently required in order to achieve better health status of the population. Healthcare requires changes, with the top priority being to increase the efficiency of financial and other resources. Increased financial resources for Bulgarian healthcare is a necessary though insufficient condition for improving the quality of medical care and health indicators, respectively. Financial and medical control should be raised to a new level by introducing a package of organizational, regulatory and financial measures.

THE OBJECTIVE of this paper is to review the possible changes of the healthcare system and improvement of the health insurance model, which will undoubtedly incease patient satisfaction.

TASKS: Indicate the positive aspects and possible risks for the healthcare system from introducing insufficiently though-out health insurance fund demonopolization and health insurance upgrade.

DISCUSSION: Before proceeding with the selection of a new health insurance model, it is necessary to make a thorough and truthful analysis of the organizational, financial and resource issues. Their complex solution will prepare the successful reform of

the system. Specific measures should be applied by the legislative and executive authorities, without delay, some of which are related to [1]):

- **Complete electronization** of the healthcare system and establishment of a national unified information system among the stakeholders – a key instrument for the effective functioning of healthcare, ensuring transparency and control over the operation of the healthcare system.
- Improve the overall organization of the system in order to achieve **effective functionality between all levels** of healthcare.
- Regulate and implement **medical and financial standards, indicators of medical activity quality** in its various aspects – structure, activity, results, enabling the authorities to exercise control; Stimulate contractors to provide quality services and participate in long-term medical training.

Remove the NHIF (National Health Insurance Fund**) budget from the state healthcare budget;** return the separate account to which insurance amounts are transferred in order to achieve transparency regarding the amount of funds collected from health insurance contributions.

- **Increase public healthcare resources** in accordance with the required scope and quality of medical services according to the needs by **increasing the GDP (Gross domestic product) rate; increase the collection of health insurance contributions; promptly transfer the full amount of health insurance contributions to the NHIF** by the state for certain categories of people.
- **Valuate the medical services**, including the work of medical specialists.
- **Increase the budget for outpatient medical care** in order to increase the possibilities for prevention of chronic noncommunicable diseases and timely diagnosis and treatment of diseases.
- Create a regulatory platform for the **actual implementation of some medical activities, such as outpatient procedures, which will be performed within the scope of the Specialized outpatient medical care** (approximately 30% of the clinical pathways) in order to reduce the financial pressure on the system by the increased amount of hospitalizations.
- Introduce **diagnostically-related groups in hospital treatment**.
- Regulate a **pro-generic policy in prescribing medication** to control the high rate of growth in the drug product costs.
- Regulate **incentives for work in remote settlements**, isolated in terms of transport from big cities where medical services are provided, by creating a Special State Fund, and municipalities' participation in facilitating the establishment and maintenance of hospital healthcare provider practices in the populated areas where these are lacking (provision of offices, housing, assistance for utility costs, assistance from the municipality for repair works, etc.).

The implementation of these regulatory, organizational and financial measures will provide stakeholders with sufficient and objective information about the healthcare system needed to make the crucial decision related to the further financing of the health insurance model.

The public's expectations are to democratize and liberalize the medical services market, which will play the role of an engine for better and more effective healthcare services. Free competition on the healthcare market will positively affect the quality of the medical service and the effect of the healthcare on the population not only at the level of healthcare providers, but also between funding institutions (NHIF, health insurance/insurance funds). **NHIF demonopolization** may change the healthcare system by creating conditions of competition between the funds and the possibility for more effective control on payments to the healthcare providers, however without guaranteeing an automatic positive change in the quality of the medical services. Restricting or removing the monopoly is a desirable solution by some politicians and experts, with the idea of eliminating the process of nationalizing the health insurance fund and providing the patients with the right to choose a fund to which they with provide their health insurance.

The incorrect and unprofessional implementation of the long-awaited demonopolization of the health insurance fund imposes a number of risks in the field of economic and social relations. Free competition may cause fault practices and defects in the delivery and use of medical services. Some of these are related to the conscious selection of a healthcare fund primarily for younger patients in good health and solvency; most often performing costly medical activities and other activities related to risk elimination. There is a risk that the financing funds may direct and concentrate patients primarily in their own healthcare institutions, thereby limiting the choice of a healthcare provider. All of these will undoubtedly increase patients' dissatisfaction.

A matter of debate and in-depth analysis is the choice between complete demonopolization of the health insurance fund and a partial demonopolization concerning only additional health insurance/insurance. Stakeholders that do not agree to this change refer to the experience in European countries where there is a large number of health insurance funds, and point to some weaknesses, such as:

- higher risk of bankruptcy for some health insurance funds;
- increased administrative burden on contractors in terms of reporting the medical care to a number of health insurance funds;
- reduced actual public funds from the health insurance contributions for medical services as a result of spending approximately 40% of each healthcare fund for administration and allocation of funds for establishing a guarantee fund;
- risk selection by means of patient selection, etc.

Removing the monopoly of the health insurance fund is a very complicated process that will take place over an extended period of time and will affect all participants in the healthcare system, which is why the decision FOR or AGAINST requires a highly specific expertise and serious preparation of the society.

The main pillar of health insurance cannot provide adequate medical care to health insured persons, which compromises the basic constitutional right of citizens to guaranteed access to free healthcare. The inconsistency between the healthcare package and its funding is a major problem for the system and prevents voluntary funds from developing. Populism for "free healthcare" has collapsed under the pressure on the health insured patients to make substantial extra payments in order to use medical care.

In this connection, the question of increasing the funds in the system is increasingly being discussed. The mismatch between the healthcare package and its funding necessitates a clear definition of a basic healthcare package of goods and services funded from mandatory healthcare contributions, based on reliable information and actuarial assumptions analysis.

The basic package must be tight and lasting in time, balanced between the desired health outcome and financial burden of expenditure, provided from the mandatory health insurance contributions, available to every Bulgarian citizen [2], in line with the demographic characteristics and statistics of socially significant diseases. The volume of goods and services in the basic healthcare package should include those that are absolutely necessary; these should be effective and efficient, and impossible to be provided by any individual.

Specification of the scope and coverage of medical activities included in the basic package will allow for **upgrading by different health insurance packages offered by additional health insurance and/or insurance entities.** These packages will cover additional medical services not included in the basic package funded by the health insurance contributions. They may provide direct access to some specialists in the outpatient care, hospital supplies not covered by the basic package; application of innovative methods and medications, etc. These health services must be provided by licensed insurance and health insurance companies. In order to ensure the financial stability of the companies, as well as the rights and interests of insured/health-insured persons, the funds should meet high requirements imposed by the state.

Despite some resemblance between the insurance and health insurance, it should be noted that these are different forms of social protection including the corresponding advantages and disadvantages. Healthcare insurance provides continued solidary receipt of medical services involving a number of activities, such as prophylactic examination, medical and diagnostic examinations and/or consultation with a specialist at the discretion of the physician in the event of health risks, monitoring of chronic disease progression, hospital treatment, etc. Social insurance funds administer the costs, primarily by controlling the provision of medical services. Health insurance covers the damages in the event of a specific risk, i.e. a serious illness or incident endangering the life of a person, or disability. In such events, the insurance fund pays for the entire treatment or a part thereof, taking into account the amount of the contracted compensation. The insurer manages and reallocates the risk of occurrence of the insurance events included in the package of medical services.

Due to the low social status of a large part of the population, it is essential that the cost of the additional health insurance packages should be the same and not high for all insured persons, while the insurance packages should have different coverage (the amount for which the person is insured) and premiums depending on the risk of illness, age, health, family burden, lifestyle of each insured person, etc.

Those who have not made a choice of the form of supplementary insurance or health insurance, are expected to pay for the medical service over the basic package in cash, at prices determined by the healthcare institutions.

It is a subject to discussion whether the supplementary insurance and health insurance should be voluntary and/or mandatory, irrespective of the number of upgrading pillars of the system. According to some experts, the change in the health insurance model should include the existence of three insurance pillars:

The first pillar of the mandatory health insurance provides all insured persons with a basic package of medical services in line with demography, population structure and priorities, such as prevention and prophylactics of socially significant and chronic diseases, child and maternal healthcare, emergency care. Funding will take place through health insurance contributions and state transfers accumulated in the NHIF.

The second pillar of the mandatory health insurance provides an additional package of health services not included in the basic pillar, mostly highly specialized, innovative techniques and medication, free consumables. Funding will take place through additional insurance contributions accumulated by the competing health insurance companies.

The third pillar of voluntary health insurance provides services not included in the first two pillars. Every person will choose a package of health services offered by the health insurance companies.

Each of the proposed three-pillar health insurance model has its advantages and disadvantages. The positive effect is the creation of a real market of health services and effective competition, and conditions for high quality medical services, as well as increasing the funding for the system and the effectiveness of the control over the spending of the funds. The disadvantages are related to the determination of the amount of the health contribution, the stability of the financial institutions and the risk of bankruptcies, the need for a grace period for accumulation of sufficient financial resources, etc.

If the health insurance is mandatory, the financial burden falls only on the people who pay and free riders go 'free' and the risk of low collection of insurance/health insurance contributions remains. In fact, mandatory health insurance represents a mechanical increase in the healthcare contribution and makes it unnecessary to create a second pillar. Given the fact that under the current health insurance model, the number of users of medical care is almost twice as

high as the regular health insurance payers, the predominant public opinion is that the upgrade packages should be voluntary.

In addition to the actual development of health insurance on the vertical axis, a positive effect on the system will be the demonopolization of the health insurance on the horizontal axis, through the development of substitute health insurance by the health insurance funds that are the NHIF competitors. [9] The development of the NHIF implies the possibility of offering packages of medical services from the second pillar of the system.

CONCLUSION: At present, the best perceived and publicly supported option is the option of building a two-pillar health insurance model, including a mandatory basic package of medical services funded by health insurance contributions and an upgrading voluntary health insurance and/or insurance package, combined with the demonopolization of the health insurance fund.

Healthcare sector is extremely delicate, requiring thorough analysis and expertise in different spheres of social and economic life. Decisions on the future of the health insurance model should have a horizon of not less than 25-30 years. A key success factor for the upcoming changes in the health insurance model is the formation of a new attitude by each individual and the society as a whole, to health and lifestyle.

How and in what way the health insurance model in the country will be changed is a fundamental conceptual issue requiring broad discussion and support by the whole society, political will and non-partisan consensus. Healthcare should become a real political and financial priority, through the implementation of which the citizens' and society's efforts will be supported in order to achieve a higher level of health status and quality of life.

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ХАРАКТЕРИСТИКА ВИРУСНОГО ГЕПАТИТА А НА ФОНЕ ХРОНИЧЕСКОГО ВИРУСНОГО ГЕПАТИТА С

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АННОТАЦИЯ

Цель. Охарактеризовать клинические проявления вирусного гепатита А на фоне хронического вирусного гепатита С.

Методы. Исследование проведено за период 2016–2019 гг. в Харьковской областной инфекционной больнице. Методом случайной выборки выполнен ретроспективный анализ 259 медицинских карт стационарного больного с диагнозом «гепатит А». Этиология заболевания подтверждена обнаружением маркёров к вирусам гепатитов А, В и С методом иммуноферментного анализа.

Результаты. Этиологическая структура гепатита А-микст: сочетание гепатит А + хронический вирусный гепатит С — 73,0%, гепатит А + хронический вирусный гепатит В + хронический вирусный гепатит С — 11,0%, гепатит А + хронический вирусный гепатит С — 9,0%, гепатит А + хронический гепатит неустановленной этиологии — 7,0%. Выявлены возрастные различия в группах пациентов с гепатитом А: моно- и микст-инфекция (35,5±11,74 и 40,7±13,72 года соответственно; p=0,026). Гепатит А протекал в среднетяжёлой форме вне зависимости от инфицированности другими гепатотропными вирусами, однако тяжёлое течение болезни у 1 пациента с хроническим вирусным гепатитом В с исходом в цирроз печени закончилось летально.

Клиническая картина гепатита А в виде моно- и микст-инфекции характеризовалась типичной симптоматикой. Изменения в биохимическом анализе крови при микст-инфекции отличались более высокой цитолитической активностью, гипоальбуминемией, меньшим снижением уровня мочевины.

Вывод. В этиологической структуре микст-гепатита доминировало сочетание вирусного гепатита А и хронического вирусного гепатита С; в большинстве случаев гепатит А протекал в среднетяжёлой форме, однако при суперинфицировании возможно более тяжёлое течение заболевания — вплоть до летального исхода.