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Assessing Needs of Care in European Nations

THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN BULGARIA

**LUDMILA MINCHEVA
AND GALINA KANAZIREVA**

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The Long-Term Care System for the Elderly in Bulgaria

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Ludmila Mincheva and Galina Kanazireva*

1. The long-term care system of Bulgaria

1.1 Overview of the system

As laid down in a number of important policy documents, the philosophy of the system of long-term care (LTC) in Bulgaria is ostensibly based on the principle of solidarity, equity and access of all clients in need. Its objective is to improve the quality of life of disabled children and elderly people with impaired activities of daily living (ADL) and instrumental activities of daily living (IADL) by means of providing conditions for effective exercise of their right to independent living and social inclusion and for reduced dependence on institutional care.

The EU definition of long-term care is the basis for the different services provided in this area, and although there is no specific legislation for long-term care only, the issue is addressed in a number of policy acts – the Social Assistance Act (and the Regulations for its implementation), the Disabled People’s Protection, Rehabilitation and Social Integration Act (and the Regulations for its implementation), Ordinance No. 4 on the Terms and Conditions for Social Service Provision, the Ordinance on the Criteria and Standards for Social Service and the Health Insurance Act, which provides a basis for the services rendered as part of the national mandatory health insurance system.

Depending on the specific case, LTC is provided by the state (through the systems of health and social welfare), the municipal authorities and private providers through the systems of social insurance and social welfare. The system is multifaceted depending on the type of provider involved; it is in a transition phase and reform aimed at strengthening the processes of decentralisation, focusing on the needs of the individual care recipients.

The main targets of long-term care are people with impairments (disability) and elderly people (65+). Services are provided in residential institutions (for old people, and people with disabilities), at home, or in an environment that is close to the family.

Formal LTC is provided in public institutions (the number of elderly people listed as residing in such institutions was put at 5,373 on 31 December 2008), private institutions and mixed property institutions in the form of services in residential institutions, community-based and home-based services.

Informal LTC provided by family members is more widespread due to a variety of reasons: inadequacies of the formal care resources, difficult procedures of access, etc. Thus, most elderly people in need of ‘informal’ LTC rely on their family members. Informal care givers generally do not receive any payment or other benefits in return for care giving. In recent times, however, as a result of the ongoing reform efforts of the government, some unemployed family members

* Galina Kanazireva (galky@yahoo.com) is Co-Founder and Board Chair of the Index Foundation in Sofia, Bulgaria. Ludmila Mincheva (lucymincheva@yahoo.com) is Founder and Executive Director, Index Foundation. For more information on Index Foundation, see the penultimate page of this study.

may be hired as personal assistants to disabled members of their family, provided they meet a number of criteria and requirements and complete an appropriate training course.

Private care givers may also be hired by the family to provide home-based LTC, but their fees are rather high and only affordable to relatively few families.

All eligible disabled and elderly people whose ADL and IADL disability exceeds a set limit (the so-called ‘level of disability’) are entitled to receive LTC. The extent of disability is established by a medical panel based on the specific health problem and extent of disability induced by it, following an application on the part of the client along with a referral by the family physician.

The permanent disability is indicated in an expert decision of a medical panel certifying the nature of permanent disability, its extent (in percentage terms above 50%, based on the overall status of health) and the period for which it is established.

The reform of the social services systems in Bulgaria has gathered pace in the period after 2002 when the Council of Ministers adopted a new Strategy for Social Policy, highlighting the priority of reducing the number of people placed in social welfare institutions and of developing social services for the most vulnerable groups of the population. The accent was placed on the transition from institutional care to community-based services and services provided at home in a family environment. This focus was reiterated in the National Report on the Strategies for Social Protection and Social Inclusion 2006-2008 and the National Strategic Reports for Social Protection and Inclusion 2008-2010 (the last one was submitted to the European Commission in September 2008).

1.2 Assessment of needs

There is no national definition of “need of care”; instead, specific eligibility criteria are defined in the different pieces of legislation for the different types of services.

Assessment of needs is individual and normally based on an application to the respective welfare service. The applicant is assessed on a number of criteria. The criteria vary depending on the type of service. Generally, the minimum eligibility criteria are defined in the legislation (the Regulations for the implementation of the respective law) and they are nation-wide and binding. These may include the applicant’s income, property status, family status, potential care providers (friends or relatives), type and severity of the disability, etc. The severity of disability is assessed by independent bodies. In the case of disabled children below the age of 16, for example, these are the Regional Expert Consultative Panel, and the Central Expert Consultative Panel (Ordinance 19, MoH), and for adults – the Territorial Expert Consultative Panel and the National Expert Consultative Panel. The level of disability is established in percentages in line with a methodology described in a special Ordinance. Several groups of disability are defined i.e. Group I – Disability degree above 90% (grave); Group II – disability degree 71-90% (medium); and Group III – disability degree 50-70% (mild). The methodology is based on broad descriptions of functions, thus allowing for some subjective interpretations.

The major eligibility criteria for placement in residential institutions include:

- Disability degree above 70%, or 2nd group disability;
- Impaired ADL and IADL (and absence of income to hire an assistant);
- Absence of close relatives (parents, spouse, children who have come of age, guardians and trustees), or impossibility of these relatives to take care of him/her (due to advanced age, caring for other disabled people, bad relations, etc.);
- The applicant should not have turned over any immovable property in exchange for the obligation to be looked after and supported.

Once placed in residential institutions, the recipients of care have to pay a fee for their stay specified in a contract with the manager of the respective establishment. In most cases the amount of the fee is 70% of the monthly income received. If however, an applicant is placed who does not meet the above eligibility criteria, then relatives must pay a fee matching the real costs of their support.

1.3 Available LTC services

LTC services are provided in different forms and in different settings.

Care at home can be received by persons who are unable to take care of themselves without external assistance due to their health state, functional impairments or old age.

Social care at home is defined as a complex set of social services provided in the home of the clients by the respective municipal departments and includes provision of meals, maintenance of personal hygiene, cleaning, assistance with the supply of technical means and devices needed by the disabled clients, daily living services, etc. These services are intended for people with different kinds of disabilities whose health constraints lead to their isolation and/or inability to organise their own daily activities; single people living alone who, due to different health reasons, are unable to organise their daily lives or keep their home clean.

The eligibility criteria for these services include being over 60 years of age, being unable to care for oneself, having no relatives and not having signed a contract for ceding property in return for financial support and/or care. (Ordinance No. 4 of 16 March 1999). In the majority of cases, however, priority is given to people over the age of 75, particularly if they are living alone or have an income below the social pension.

Next to the social care at home, (which is the most widely available home-based LTC service), LTC home-based services are also provided under various **national programmes** and include such forms as:

- **Social assistant:** a person providing a set of services focused on social work and counselling to the clients (persons with permanently impaired working capacity to the extent of 90% and over, entitled to “assistance of other people”; children with 50% and over impaired social adaptation ability entitled to assistance by other people; severely ill single elderly people experiencing autonomy difficulties, certified by a Medical Expert Board Protocol; adults or children leaving specialised institutions for disabled people), and such needs as leisure time organisation and social contacts. Included in the set of services are meals, shopping, maintenance of personal hygiene, cleaning, assistance in the provision of administrative and other services, social contacts, etc. As a rule, the social assistant is a trained unemployed person hired under this National Programme. In as much as that type of service is intended for a very high risk group such as severely disabled people, it plays an important role in reducing the risk of institutionalisation.
- **Personal assistant:** according to the legal definition – this is a person providing permanent care to a child or elderly person with some kind of a permanent disability or to an elderly person with a permanent disability, or to a severely ill person for the purpose of meeting that person’s everyday needs. Among the beneficiaries of this kind of service are persons with a permanently impaired disability of and above 90%, entitled to “assistance of other people” or, where their autonomy is not possible; children whose social adaptation ability is reduced by 50% and over and who use assistance from other people; persons or children checking out of a specialised institution for disabled people. This service is very important for the provision of adequate permanent care at home to people with the highest degree of disability. A policy is followed with the aim of extending its scope and improving the quality of care.

- **Home helper:** the home helper is a person who provides services at home, focused on the maintenance of hygiene in the home, shopping and cooking, washing and other everyday activities. These services are intended for people with different kinds of disability (regardless of age) whose health constraints lead to their isolation and/or inability to look after themselves and organise the everyday activities; single people living alone who for different health reasons are unable to organise their everyday lives and keep their homes clean. These services include regular cleaning, personal hygiene, feeding, small repairs at home and/or assistance in their execution; daily living services – buying food, medicines and vital items with money provided by the recipient of the services; paying electricity and phone bills, water supply bills, taxes etc. with money provided by the recipient; small technical repairs, etc. As with the other two kinds of services, they are intended for people facing a higher risk of social isolation and institutionalisation; therefore the competent national institutions envisage their expansion. The service has been introduced since the beginning of 2009 as part of the **National Programme “Social Services in a Family Environment”**.

Home helpers differ from social assistants in that the social assistants are Agency for Social Assistance (ASA) employed trained professionals providing LT integration services to disabled people, whereas home helpers are usually unemployed and registered at the Employment Agency, hired to provide help to disabled people with impaired ADL and IADL against minimum payment and after a short training course.

- **Companion:** the companion helps people with a severe disability in domestic chores and social services. In most cases he/she is in fact a relative or a close friend of the disabled person. The relationships between the two are based on social rather than economic principles. The needs of the disabled person are met to the extent that the companion is prepared to do that. No official statistics exist as to the number of employees engaged in these different categories or the number of users in the different services.

A distinction is also made between **community-based services** and **services in residential institutions**. The community-based services are social services rendered in the environment that is usual for the person (family environment), while services in residential institutions involve the person's removal from the family environment and being placed in everyday care at the establishment where they are accommodated.

Services outside the habitual home environment are provided in different homes for the elderly. Placement in such homes implies a longer period of time and covers full board and lodging:

- Homes for elderly people – HEP;
- Homes for disabled elderly people;
- Shelters;
- Temporary placement homes.

The homes for elderly people are most widespread among the institutions providing a set of social services to persons who have reached the age and acquired the right to an old age pension in compliance with the Social Security Act, including persons with impaired working capacity certified in an expert assessment by a medical panel.

The main activities performed in the homes are aimed at supporting and enhancing the capacity of the people placed there in order to enable them to lead an independent life. The aim is to satisfy their everyday needs (shelter, food, health care, assistance in using administrative and other services), to create conditions for social contacts and opportunities for social integration; to support people who have retired and withdrawn from active life in overcoming psychological

barriers which make them feel that they are not needed anymore and to provide conditions for their mutual assistance.

That type of specialised institutions have an important role to play in the provision of long-term care in view of the firmly established adverse demographic trends and the growing need for such services.

Community-based services are provided by the following institutions:

- Social service office – SSO;
- Social Care at Home SCH ;
- Day care centres;
- Centres for Social Rehabilitation and Integration – CSRI ;
- Temporary placement centres;
- Crisis centres;
- Family-type placement centres;
- Protected homes;
- Public kitchens.

Depending on the type of service provided the establishments providing LTC services may be categorised:

- According to type of ownership – state, municipal, private and mixed;
- According to the period for which services are provided – daily and all year round;
- According to type of service provided – service in the community and outside it.

All services are provided in kind. Generally access is not means tested, but the income is taken into consideration in calculating the fee for the service.

There are no services or cash benefits for informal care givers.

1.4 Management and organisation (role of different actors/stakeholders)

Social services are provided by (a) the state ; (b) the municipalities; (c) Bulgarian natural persons registered under the Commerce Act and legal entities which may provide social services only after being registered in the Register of the Agency for Social Assistance.

The Agency for Social Assistance (ASA) keeps a Register of Natural and Physical and Legal Entities providing social services under the Social Assistance Act. Social services can be provided in a joint venture based on contracts between the government, the municipalities and physical and legal entities registered in the ASA Register. The entities listed in the register are commercial companies or NGOs. The register includes the providers only and not the services provided by the state and the municipal bodies. The mayor of the municipality may assign the management of the specialised institutions, of the social services provided in the community and of the residential type of social services.

All activities in the field of social services are provided after a call for tender or through contracting with a sole applicant while observing the standards and criteria established in the Regulations on the Implementation of the Law and the Ordinance on Standards and Criteria for Social Services adopted by the Council of Ministers. The mayor of the municipality may assign the management of social services after holding a call for tender or competition. Participants in

the competitions may be providers of social services registered in the Register of the Agency for Social Assistance. The competition is conducted by a panel assigned by order of the mayor of the municipality.

Persons who wish to use social services submit a request in writing to (a) the director of the Directorate for Social Assistance in their permanent place of residence for social services as government-delegated activities; (b) to the mayor of the municipality – for social services as municipal activities; (c) the management body where the provider is a physical person registered under the Commerce Act, or a legal entity. Attached to the request are an ID card, a copy of the personal medical record, if any; a copy of the decision of the Local Medical Experts Board, the Territorial Medical Experts Board and the National Medical Experts Board, if any. On the grounds of the submitted request and attached documents the relevant bodies make a social assessment of the needs of the applicant for social services, which results in a report and proposal for provision of social services.

The placement in specialised institutions and the provision of social services in the community as government-delegated activities take place by order of the director of the Directorate for Social Assistance, issued on the grounds of the social assessment report. The placement in specialised institutions and provision of social services as municipal activities take place by order of the mayor of the municipality concerned.

There are also some local initiatives for public-private partnerships. NGOs play an active role in the provision of long-term care (mostly private initiatives establishing homes for terminally ill patients).

There are a number of requirements to the providers of social services: to draw up an individual plan of services following a needs assessment for each client and the formulation of the objectives to be reached; to keep a register of the persons placed; to observe location and facilities standards, meals and food quality standards; health service standards; standards on the level of information, on the organisation of leisure time and contacts for socialising; number of specialised staff, etc.

The social services provider is obliged to submit to potential clients a draft contract for the provision of social services and information in writing as: description of the social services to be provided; the experience of the provider in the provision of social services and in staff training; terms and conditions of service use; complaints procedure.

The provider of social services concludes a service provision contract with the user and/or with his/her legal representative. It is obligatory for the contract to include: the rights and obligations of the parties to the contract; a description of the activities; the amount of the fees for social services; period, terms and conditions and contract termination procedure.

The providers of social services draw up an individual plan after an assessment of the needs of each client and the formulation of objectives to be achieved. The plan should include activities for the satisfaction of daily health, educational and rehabilitation needs; leisure time and needs for contacts with family, friends, close relations and other persons.

The individual plan for the clients of social services in specialised institutions includes measures enabling them to leave the institutions and to achieve social inclusion. The providers of long-term social services assess the implementation of the plan and, if necessary, update it every six months.

1.5 Integration of LTC

Currently, LTC services in Bulgaria incorporate two tiers – of medical and social services, and each tier is regulated by different bodies and legislation. At the same time the respective

legislation also targets other categories of people, and there is no clear framework with respect to the LTC system only, which makes it difficult to integrate the services needed by the recipients of LTC. It would normally be the GP or the social worker who plays an important role in this process through referrals and recommendations. Additional efforts are needed to improve interaction and coordination. It is stressed in the National Report of Bulgaria on the Strategies for Social Protection and Social Inclusion that the integration of services is particularly important for persons with impairments. A Framework Contract was signed between the Ministry of Health and the Ministry of Labour and Social Policy for strengthening the coordination of all agencies to improve the situation of people with learning disabilities placed in residential institutions. It defines the areas of cooperation and the specific commitments of the two ministries, as well as their concrete responsibilities.

2. Funding

The financial resources for social services development and support are provided from three main sources: the state budget, the local budgets and the incomes of the beneficiaries.

Social services are financed by the state budget with the help of different mechanisms:

- Targeted transfers to the municipalities towards the support of the services which are delegated as state activity; these transfers are determined (since 2003) on the basis of the so-called “financial support standards per one place” (since 2008 these standards are unified, i.e. they cover the total support and salary costs);
- Targeted national programmes fully financed by budget means (for example the Programme “Assistants for People with Disabilities”, which also has the characteristics of a subsidised employment programme);
- The Social Assistance Fund under the Ministry of Labour and Social Policy, funding a small number of low-budget projects of municipalities, natural persons, and legal entities registered in the Register of the ASA;
- grant schemes for the delivery of social services within the framework of the Operational Programme “Human Resources Development”.¹

The municipalities provide funds from their own revenues (i.e. within the framework of their budgets) for local social services (social services at home, public kitchens, and pensioners’ and disabled people’s clubs). That means that the local authorities determine the amount of funds allocated to finance the individual types of social services. The limit for the development of local services is the amount of own revenue in the municipal budget.

The clients of social services are obliged to pay fees covering a minimal part of their costs. The social service fees funded from the national budget are set in a tariff approved by the Council of Ministers. The social service fees funded from the municipal budget are paid in compliance with

¹ Since 2007 some grant schemes have been launched within the framework of this specific Operational Programme under the National Strategic Reference Framework (NSRF) for the implementation of the EU Structural Funds in the period 2007-2013, (mainly financed by the European Social Fund and national co-financing) to ensure broader supply and delivery of the services of ‘personal assistant’, ‘social assistant’ and ‘home helper’. These schemes/programmes are: “*Care in family environment for the independent and dignified life of people with different kinds of disabilities and people living alone*” (for the development of such services/activities as ‘social assistant’ and ‘home helper’) with a total budget of €14,8 million and “*Refining and improving the service of personal assistant to people with different kinds of disability and people living alone*”, with a total budget of over €6,1 million.

the Local Taxes and Fees Act. The payment for social services provided by physical persons registered in compliance with the Commerce Act as well as by legal entities is effected in accordance with the agreements.

The services of a personal assistant is completely free for clients, with all costs thereof being covered under the National Programme “Assistants to People with Disabilities”.²

The service of home helper is also financed from the national budget.

The service of social assistant is partially covered by the clients.³ The larger part of these costs are at the expense of the state budget, which also funds the National Programme “Assistants to People with Disabilities”. However, the municipalities also have certain financial obligations to cover part of the costs per one hired person not financed by funds from the central budget in compliance with the arrangements for the Programme (mainly social security contributions payable by the employer). Thus the Social Assistant service is provided on the basis of the principle of co-financing on three levels: state budget, municipal budget and user fees.

The service “Social services at home” is a service provided by the local authorities and financed from the respective municipal budget. With a view to extending its scope and improving the quality of services it is now being developed not only as a typical local activity, but also as an element of the National programme “Social services in a family environment”. Thus resources towards the achievement of that objective are provided from the central budget too.

The 2001 census data show that 45% of those who need to take medication have to pay 25 leva per month (12.5 euro), 39% have to pay between 36 and 55 leva per month (18 to 27.5 euro), 13% - between 56 and 100 leva per month (27 to 50 euro) and for 3% the payments are above 100 leva (50 euro) per month. These co-payments may be considered rather high relative to the income of people in need for LTC. In most cases the latter rely on social support or on pensions since few of them are able to work and have any opportunities for employment. The disability pension is the main source of subsistence for 72%, 8% rely on another person for their support, on a job or old age pension.

3. Demand and supply of LTC

3.1 The need for LTC (including demographic characteristics)

The assessment of needs is mostly based on demographic data and on some data on the morbidity of elderly (people aged 65 and over) indicating a possible demand for medical and social care. In general, the planning of long-term care facilities is not based on any structured assessment of the needs of the population. Community (municipal) bodies do not perform the

² The services “Personal assistant” and “Social assistant” are actually components of the National Programme “Assistants to People with Disabilities”. It is financed from the national budget and enjoys broad public support. Its objectives are (1) to guarantee employment to unemployed persons and to alleviate the situation of families with a disabled member in need of continued care or to satisfy certain daily living needs, organise the leisure time of people with permanent disabilities or very sick people on their own and implement activities designed to facilitate their social inclusion; (2) to guarantee quality care in a family environment and to help reduce the number of permanently disabled and severely sick solitary people placed in institutions.

³ To use this service in a fixed number of hours per week one has to pay a minimal fee fixed by the law and for the time exceeding the established limit the client has to pay a higher fee, which however is affordable for his/her budget.

assessment of needs for the population in their area. They work mostly on a reactive mode and the planning is mainly based on historical practice.

In recent years Bulgaria has had one of the slowest population growth-rates in the EU. Negative population growth has occurred since the early 1990s due to economic collapse and high emigration. According to the National Statistics Institute, in 1989 the population comprised 9,009,018 people while as of 31 December 2008 the population was 7 606 551.⁴ Population projections according to Eurostat methodology show that the country's population will be 7,137,000 in 2020 and 5,475,000 in 2060.⁵ Bulgaria faces a severe demographic crisis: the fertility-rate is 1.48 children per woman (for 2008) and the population annual growth rate for the period 1990–2007 is -0.8%.⁶ Females outnumber males in the population and the share of the urban population is 71%. A major problem of the country's demographic development is the high mortality rate at a young age.

Overall, according to data from the National Health Strategy published in 2001, the share of persons with impaired health had increased as compared with 1996 from 50.7% to 59.5% for persons aged 45-64, from 71.8% to 76% for persons aged 65-74 and from 79.5% to 82.4% for persons aged over 75 years. Theoretically, in the absence of specific studies, this may provide some general indication of the potential needs for LTC.

Based on the demographic data, it is possible to gain a rough idea of the demand for LTC services for people at the age of 65 and over. However, information on the health status of this population group is required for an estimate of the demand for LTC services.

According to NSI data, in 2006-2007 the share of pensions and children's allowances in the structure of household incomes decreased by 0.5% and 0.2% respectively while social benefits increased by 0.4%. In the period 1999-2008 a pronounced trend was observed towards an increase in the healthcare costs in the structure of total household expenditures from 2.9% to 4.8%. Indirectly that may be an indication of the growing demand for LTC.

3.2 The role of informal and formal care in the LTC system (including the role of cash benefits)

As already mentioned, the philosophy of the system of long-term care in Bulgaria is based on the principle of solidarity, equity and access of all clients in need. Its objective is to improve the quality of life of elderly people and children with impaired ADL and IADL by means of providing conditions for the effective exercise of their right to independent living and social inclusion and for reduced dependence on institutional care. At present the system of formal LTC is being overhauled to meet this objective.

Formal LTC services in the country are operating and regulated by Bulgarian legislation (see below.) Although their role is likely to grow significantly due to the process of population ageing and demographic crisis, their scope and range are far from adequate and they often operate in conditions of severe constraints in terms of equipment and financing, which affects the quality of services. Control mechanisms are in place, but so far no independent research has been conducted to assess the quality of formal LTC services and the actual possibilities for positive change.

⁴ http://www.nsi.bg/ZActual_e/PopByAge08.htm

⁵ http://www.nsi.bg/Population_e/Population08.htm; published on 30.03.2009

⁶ http://www.unicef.org/infobycountry/bulgaria_statistics.html

Benefits are provided to all disabled and elderly people meeting certain specific criteria, i.e. incomes below a certain minimum level, or 70 to 100% disability. These benefits are however for strictly defined purposes – to cover heating, transport and some other costs. LTC services are not included in this type of benefits – they are only provided in kind.

In analysing informal care in the LTC system, it is important to note the very strong impact of the national psychological specificities and cultural and national traditions. The cultural traditions in Bulgaria encourage care for elderly people to be provided by family members, who are not trained professionally, but accept that responsibility out of a sense of family duty. The LTC in this case is considered to be a family matter. According to the National Representative Survey report by Prof. Lilia Dimova, Head of Agency for Social Analyses in 2002 (N = 1 160), 61,6 % of the adult population (over 18 years old) are convinced that “it is the responsibility of children to look after their elderly parents”.⁷

Thus, informal care is not regulated by legislation and it is not legally recognised or financially encouraged within the system of LTC services. No cash benefits are envisaged for informal care. Yet, for example, one of the placement requirements of LTC institutions for the elderly is that the clients should not have any family members capable of providing care for them.

One positive development in recent times has been the possibility for unemployed family members to apply and, following training, start work against minimum pay as personal or social assistant to a disabled family member, including elderly members.

The impact of dynamic change in the social models today should also be taken into account. Traditional family values are changing and the intensive economic, urbanisation and migration processes lead to a higher demand and increased role of formal LTC services. This has already emerged as a lasting trend. Here again no research has been conducted in the country to measure and appraise the significance and implications of these developments.

3.3 Demand and supply of LTC care

As already indicated, there is no systematic assessment on a national or local level of the general demand for LTC, nor the demand for LTC among the elderly for all types of services. While information is generally available for community-based care and care in residential institutions, there is no aggregated information about the needs of medical care at home, or the need for care provided under the different national programmes (social assistant, personal assistant, etc.)

Data is shown in the tables below on the supply of LTC in the country in 2008, by types of services and categories of clients with respect to community-based care and care in residential institutions (source: National Statistical Institute):

⁷ Dimova, L. & M. Dimov (2004), National Background Report for Bulgaria, Social Assistance in Bulgaria, Eurofamcare Consortium, University Medical Centre Hamburg-Eppendorf, Institute for Medical Sociology, Hamburg, Germany.

Table 1. Community-based social services in 2008

Community-based social services in 2008 (number)					
	Institutions	Number of persons who used social services	Number of people who received services		
			By the end of the year		
			total	men	women
Community-based social services - total	646	1 33 066	72 979	33 931	39 048
Home social patronage ²	-	57 884	46 947	22 148	24 799
Day care centres (including day care centres for elderly)	43	4 057	1 315	411	904
Day care centres for mentally handicapped elderly people	31	1 612	666	392	274
Day centres for physically disabled elderly people	15	978	468	152	316
Centres for social rehabilitation and integration	241	48 659	13 453	5 743	7 710
Day care centres for children and youth	82	3 685	2 810	1 807	1 003
Temporary placement homes	20	1 428	641	312	329
Crisis centres	18	621	149	28	121
Family-type placement centres	18	322	304	177	127
Protected homes	83	603	566	279	287
Shelters	8	175	71	39	32
Mother and child units	11	258	84	17	67
Social support centres	55	11 242	4 687	1 939	2 748
Centres for street children	12	775	190	103	87
Vocational centres	9	767	628	384	244

Table 2. Specialised institutions for the provision of social services outside the community in 2008

Specialised institutions for the provision of social services outside the community in 2008 (number)							
	Institutions	Number of persons					
		In the beginning of the year	Registered	Left of diseased	At the end of the year		
					total	men	women
Specialised institutions for the provision of social services outside the community - total	299	17 554	4 765	5 066	17 253	8 077	9 176
Including children under 18 years of age		5 652	1 182	1 482	5 213	2 980	2 233
Of these:							
Homes for elderly people	100	5 160	2 400	2 220	5 340	1 955	3 385
Homes for children and youth with intellectual disability	26	1 568	106	172	1 502	831	671
Including children under 18 years of age		1 105	96	106	1 032	577	455
Homes for physically disabled elderly persons	27	1 510	567	547	1 530	748	782
Homes for elderly persons with intellectual disability	58	4 442	541	582	4 401	1 972	2 429
Homes for people with sensory disability	5	127	45	38	134	57	77
Homes for children deprived of parental care	82	4 676	1 096	1 495	4 277	2 477	1 800

One source of information about the demand is the data on the waiting lists for some services. According to information provided by staff of the Agency for Social Assistance, the waiting list for placement in specialised institutions (30 June, 2009) included:

1983 people waiting for placement in homes for elderly people

869 people waiting for placement in homes for elderly with mental health problems

357 people waiting for placement in homes for elderly people with intellectual disabilities

303 people waiting for placement in homes for elderly people with physical disabilities

631 people waiting for placement in homes for elderly people with dementia

19 people waiting for placement in homes for elderly people with a sensory disability

The total number of elderly people waiting for placement in specialised institutions in June 2008 was 4,162.

4. LTC policy

4.1 Policy goals

Bulgaria's priorities in the field of social services as a component of the long-term care development policy are:

- To extend the range of services targeted specifically at elderly people and people living alone, people with disabilities and others and improving their quality of life;
- Transition from institutional care to services permitting such people to live in their community and family environment;
- Reduce the number of people using services in specialised institutions for social services delivery and reduce the number of the institutions themselves through the development of a modern network of community services.
- Create incentives for informal carers by providing financial support and replacements for certain periods of time.
- Strengthen the capacity of the LTC system by providing education and training of staff and involving young people.

Currently the de-institutionalisation of people placed in specialised institutions is achieved through the provision of social services in the community. To achieve real de-institutionalisation it is necessary to build up a network of different types of services serving as an alternative to placement in specialised institutions.

4.2 Integration policy

The integration policy for health and social care services in Bulgaria is realised through the concerted activities of the medical staff/family physicians working for the National Health Insurance Fund and the social workers subordinated to the Agency for Social Assistance. The family physician is responsible for the initial examination and monitoring of the health status of the elderly. In case of impaired health and the need for LTC, the elderly patient is referred to the relevant health institutions and medical nursing care is arranged if needed. The arrangements for any medical services, medical nursing care included, are made by the family doctor. Where necessary, the doctor alerts the social services.

Upon receiving an application from the elderly patient or his/her family physician, friends or relatives, the local unit of the social services makes an initial assessment of the situation and decides on the LTC measures and programme to be applied in each specific case.

At first sight, this system seems to be well-integrated and work well, but in reality its operation is often compromised due to inadequacies in human resources and relevant facilities or due to systematic objectives and subjective impediments. In particular, this is so in the remote regions and villages in the country, which are often left to cope on their own because family physicians or social workers usually live and work in town and are unable to respond quickly to emergencies or organise regular home-based LTC. Occasionally long periods of time elapse before such patients can even be placed in specialised public institutions; LTC arrangements are often impossible, so such clients usually have to stay and receive LTC in hospital. In most cases the hospital authorities show understanding for their plight, but nowadays this is becoming increasingly difficult due to financial constraints and the inability to account for such hospitalisations to the financing institution, namely the National Health Insurance Fund.

4.3 Recent reforms and the current policy debate

Reforms are based on the updated legislative framework. Yet, there is no single act covering all the issues related to LTC, which creates complications in understanding the planning and implementation of the policy.

Perhaps with the exception of the regulations cited above, the legislative acts treat the disabled en bloc and do not make clear distinctions between the different groups. The issues of the elderly as a separate category are not addressed in a specific focused manner, especially as far as LTC is concerned; the legislative texts relating to them are too vague and general and the requirements and criteria for access – too strict. Many policy documents are more focused on what needs be done in the future, rather than strictly prescribing what must be done now. LTC inadequacies with regard to the elderly are not dealt with explicitly. The entitlement procedures seem too bureaucratic and difficult to follow and the elderly in need are unable to cope with them, especially if they live alone. LTC in the remote parts of the country is often simply unavailable or at best comes too late in the form of hospitalisation for a period of time, after which there is not much choice left. The system is not focused on the active identification of elderly in need; instead many procedures seem designed to discourage elderly seekers of LTC.

The debate is focused on strengthening the care provided in the community (day care, home care, etc.). To date, the debates about informal care and implementation of possible incentives for informal carers are not very active or intensive. The only measures officially put forward that seek to stimulate informal care and make it become more motivated are associated with alleged employment policies rather than with real effective solutions. Still, they probably constitute a step forward.

In late 2009 the political debate on LTC intensified. The initiative was undertaken by the NGO sector and the National Social Security Institute (NSSI). LTC was for the first time defined as “a social risk” also in terms of social insurance. It was suggested that the solution to the problem should be sought along the lines of establishing special schemes for social security (through the system of social and health insurance). Awareness raised that “Bulgaria needs a new concept for LTC, legislative and institutional solution, as well as financial provisions, bound with the state budget, the social insurance funds and the social programmes.”⁸ Some of the measures proposed include: LTC to be integrated in the social security system as a mandatory social security risk; establishment of an independent LTC fund; financing LTC from public funds, or an insurance fund and fees from the families of persons in need; increase of the health insurance fee so that LTC and palliative care are covered, etc.

For the first time the European Charter for Family Carers was promulgated in Bulgaria, too.

4.4 Critical appraisal of the LTC system

At the end of 2007, Bulgaria’s population numbered 7,640,000 people, 2,270,000 of whom were pensioners. Against that background the formal and informal LTC services seem highly inadequate. In most cases the care for elderly sick parents is an immeasurably heavy burden on their offspring, especially for those working in strenuous jobs. In such cases the only way out for them is either to place the parent in a home for the elderly or in a hospice, or hire a care professional. Some elderly people are abandoned to their fate and meagre pensions and live alone without proper care or help. Placement in an institution is often difficult or very expensive, if the institution is private. Currently the number of available public homes for the

⁸ Slavova, Zoya (2009), “LTC – An Element of the State Social Security System”, Head of the Department “Analysis and Strategic Planning” NSSI, Bulletin of the NSSI, issue 6.

elderly in the country is quite inadequate, considering the growing number of elderly people increasingly dependent on LTC. In the best case there is a wait of at least half a year for placement in a home. The situation is aggravated by deteriorating health due to the long time-span without care. Most elderly people cannot afford to pay for care as their pensions are well below the poverty threshold. Thus, thousands of elderly people in Bulgaria are compelled to live in sickness and poverty. More than 330,000 pensioners live alone in Sofia (which has a population of about two million), but there are only 6 homes for the elderly and only one municipal establishment providing meals and some limited care at home, serving some 1,900 people over the age of 60 or people with 71% disability.

A major problem in the critical appraisal of the LTC system in Bulgaria is the lack of credible developed research instruments, research surveys and needs assessments. Thus, in many instances the LTC inadequacies are more than obvious to the many elderly people who have had the chance (or mischance) to experience them. Yet on paper these services look quite good in terms of their range, variety and organisation.

Despite the government's announced measures and strategies, there has been no significant improvement along these lines. The existing national programmes fail to meet the growing demand for LTC services or for improvement of their quality, largely due to the limited financial resources for their implementation (especially at local level). While the community-based forms of LTC are hailed with enthusiasm as a major vehicle of de-institutionalisation, in fact their efficiency and accomplishments have not been studied in depth. Moreover, they seem ridden by a lack of resources and staff problems.

Another missing element in the puzzle is the lack of an operating LTC system linking the different units of the system and permitting the efficient exchange of data and information. There are also criticisms that the use of LTC in the homes for social services is by default impossible unless one is socially weak. The people who do not meet the criteria for social assistance have no chance to benefit and use the public finances, despite the contribution they and their families have made.⁹

Urgent measures are needed to establish a viable network of different types of LTC services as an alternative to the expensive placement in specialised institutions and treatment in hospitals instead of in proper LTC facilities, on the basis of well-defined and developed quality standards and efficient central and local mechanisms of supervision. The key to the solution of this problem is to develop mechanisms for the provision of types of service that are considerably less expensive than hospital and specialised institutions. To that end the informal long-term care givers should be formally recognised and supported. One way to maintain the supply of care givers at the level required is to resort to the introduction of both benefits in cash and kind in the care of elderly people.

So far the integration of the efforts of the health and social systems has been regulated by legislation only in general terms. The expectations for the improvement and transformation of the social system have been linked with local, citizen and professional initiatives.

⁹ Op. cit., Zoya Slavova.

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About Index Foundation

Index Foundation is a not-for-profit organization working in Bulgaria's social sector. A special focus of the Foundation's activities in the past 12 years has been health care and social service delivery. Index Foundation enjoys the support of the international donor community and its project and research activities are sponsored by a wide range of institutions like the European Commission, the US Congress, USAID, Georgetown University, Open Society Institute, World Learning, Bearing Point, London School of Economics (LSE), London School of Hygiene and Tropical Medicine, British Academy of Sciences, etc. The endeavours of Index Foundation also extend beyond Bulgaria. It is a member of the Bulgarian Platform for International Development (BPID) and implements projects in countries from the Eastern Neighbourhood region – Moldova, Ukraine, etc.

ANCIEN

Assessing Needs of Care in European Nations



FP7 HEALTH-2007-3.2-2

L launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

- 1) How will need, demand, supply and use of LTC develop?
- 2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (<http://www.ancien-longtermcare.eu>).