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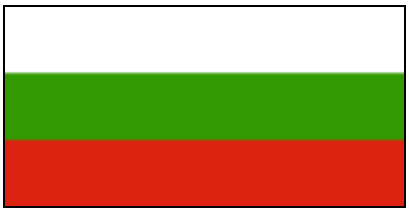
Study on the Social Protection Systems in the 13 Applicant Countries

Bulgaria
Country Study



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Social Protection in Bulgaria

1. INTRODUCTION: ECONOMIC, FINANCIAL, SOCIAL AND DEMOGRAPHIC BACKGROUND

1.1 Main Influencing Factors for Social Protection

1.1.1 Economic and Financial Indicators

Over the past several years Bulgaria's macroeconomic performance has strengthened considerably and the country has made important progress in implementing market reforms. After a nearly full-blown crisis of late 1996 and early 1997 financial stability was rapidly achieved, following a radical shift in economic and structural policies that included as a centrepiece the introduction of a currency board system in mid-1997. The subsequent prudent macroeconomic management resulted in strong fiscal consolidation, low inflation and interest rates and rising foreign exchange reserves. Improving policy performance also reflected major advances in the process of structural reforms and provided a stable environment for the rebound of economic growth. After having fallen by a third between 1989 and 1997, real GDP recorded an aggregate increase of 11% during 1998-2000. Despite the success in stabilisation and a pronounced strengthening of confidence during 1998-1999, major concern continued to be raised by the dynamics of several key economic indicators. After an initially sharp jump in output that followed large previous contractions GDP recovery became rather sluggish by mid-1998, exports slid into decline, the process of privatisation and industrial restructuring showed some signs of losing impetus. To a great extent these developments were attributable to the prolonged series of external shocks that the economy had been experiencing since the crisis in Asia and the wars in former Yugoslavia. However, they also reflected internal difficulties due to adverse initial conditions, problems in policy implementation and co-ordination, as well as a weak institutional environment.

The inflation was among the main reasons that caused the impoverishment of the population. The main inflationary factor till the middle of 1997 was the variation of the exchange rate. That is why inflation dropped down significantly during the first year of the Currency Board, (Table 1.1). From the view point of social policy, the low inflation rate is the main positive implication of the stabilisation policy, which allowed a significant increase of the income in real terms in 1997-2001 period (Figure 1.1).

Fiscal policy is amongst the main influencing macroeconomic factors for social protection policy. A critical factor for the management of budget expenditure was the absence of a clear and consistent vision of mid-term fiscal policy until 1997. This resulted in a huge accumulation of internal debt, mostly by the transformation of the bad debts of the banks into government debt. Under the conditions of the Currency Board the budget was transformed from an instrument of allocation into an instrument of economic stabilisation. The considerable reduction of the basic interest rate had an extremely favourable impact on the deficit. At the end of 1997 the deficit was only 3.6% and the trend of decrease continued in the next years. Next to this, the improvement of tax collection and the low level of interest rates allowed to implement a more active social policy. A large part of the budget freed due to the fall of interest rates was used for social payments, wage adjustment, as well as for extra wages and pensions at the end of the year.

The 2000 consolidated budget deficit had slightly exceeded 1% of GDP compared with the targeted 1.5%. Preliminary estimates pointed even to a lower outcome in 2001. The adopted 2002 budget aims at maintaining the achieved macroeconomic stability, while allowing for some further lowering of the profit and income tax rates to support the ongoing output recovery. It was framed around the underlying assumptions of 4% GDP growth and an average inflation rate of 4.2%. The budget deficit under the consolidated program was set at 0.8% of this year's GDP. This fiscal target is a precondition for securing a future agreement with the International Monetary Fund.

1.1.2 Demographic Indicators

The demographic trends have been subject to unfavourable changes during the years (Table 1.2). The age structure of the population deteriorates and the age pyramid gradually turns upside down. The birth rate decreases simultaneously with the increase of the sickness rate and the death rate. Another negative trend is the strong emigration flow after the beginning of the 90s, in which more than 170,000 people (mostly young and educated people) left the country. These data are registered for the period of 1992-2001 by the last population census. For the period of 1989-2001 the total emigration flow is estimated at 300,000 people or at 10% of the labour force.

These trends caused a considerable depopulation of large areas from the country - mainly the underdeveloped, frontier and mountain regions. The coefficient of natural increase of population in such municipalities is much below the average for the country: for example Makresh municipality (-39%), Trekliano municipality (-35%), etc.

The unfavourable demographic processes are accompanied by deteriorated health status. The child mortality rate is one of the major indicators for the level of health care in a country. The values of this indicator in Bulgaria have been very high during the recent years – over 13 per 1,000 children born alive up to 1 year of age (in the West-European countries it varies between 3.5 and 9). The life expectancy at birth is another important indicator. According to this indicator the position of Bulgaria is also unfavourable as the high mortality rate of the 40-49 age group shows. The quality of the health service is the main reason for the relatively low values.

The *ethnic structure* of the population also should be pointed out as a demographic characteristic, which refers to the social protection policy. According to the last population census in 2001, there are 365,000 Bulgarian Gypsies which account for 4.6% of the population. They have a distinct demographic behaviour. Early marriage is typical – 40% are married before the age of 16 and 80% before the age of 18. After the marriage they do not continue their education. Their birth rate is the highest of the country. Bulgarian Turks and Bulgarian Muslims (Pomaks) form another large minority group, including roughly 757,000 persons (9.5% of population). In 1984-1989 a forced integration policy has been initiated. Bulgarian Turks and Bulgarian Muslims had to change their names and speaking Turkish in public places was forbidden. This policy has been stopped after the abolishment of the socialist regime in 1989 and has been publicly criticized. These ethnic groups live in rural and backward areas of the country. They still suffer from the loss of the most qualified persons who emigrated to Turkey after the liberalisation.

The results of the last population census in 2001 differ from the structure in 1992, when the Turks represented 9.4% of the population and the gypsies 3.6%. The differences are due to the mass emigration of Turks from Bulgaria to Turkey in the middle of 90s and the faster increase of the Gypsy population with its comparatively higher birth rate.

1.1.3 Social Indicators

Employment and Unemployment

During the last ten years of transition, total employment decreased by more than one million people or one fourth of the pre-transition levels. However, official statistics did not cover employment in the shadow economy which accounts for an estimated 20% of the reported GDP.

Employment statistics indicate an increase in the share of people employed in agriculture over the 1995-2001 period which is explained by the restitution of agricultural land which is owned mostly privately today. Employment declined by one third in mining and by 50% in construction.

The business services sector started to develop after the transition. This sector employs mainly young people with high qualifications. The acceleration of the privatisation process and the relative increase of the private sector enlarged its impact on the employment. About two thirds of the employed (61% in 2001) work in the private sector. Due to the new technologies, it is a less labour intensive industry.

Table 1.3 presents data on the labour force participation rate. Formally, statistics do not confirm the hypotheses for the unequal position of women at the labour market. The economic activity of women is traditionally high and the female labour force is well educated and trained. However, the research identifies a mismatch between the higher qualification of women and their unfavourable position at the labour market, e.g. an employment in low paid jobs, a small share among the self-employed, a growing number of women working as unpaid family workers etc. (UNDP, ILO 1998, Women in Poverty). Because of the low real value of pensions, the economic activity of pensioners has been relatively high, particularly for the lower age group between 55 and 59 years.

At the beginning of the transition process, the number of unemployed was rather symbolic – less than 2 per cent of the work force was unemployed. With the production decline, the level of unemployment increased and rose above 10 per cent in the end of 1991. This tendency continued during the transition, interrupted by short periods of temporary stabilisation at the labour market. The lowest level of unemployment was seen in June 1996. After that, following the financial crisis, the situation on the labour market deteriorated (Table 1.3).

The most important factor for unemployment is the reorganisation of main state-owned branches of economy. The reduction of the number of employed was most significant in the electrical engineering and machine building industries that are the branches with the highest decline of output.

Since the beginning of 1998, the prudent monetary policy, the restricted access to bank credits and the lack of investments had a negative impact on the labour market with the consequence of deteriorating employment. Next to this, the accelerated economic restructuring led to new waves of mass layoffs. The rate of unemployment increased significantly and reached 19.5% at the end of 2001.[1]

This is the highest rate of all the candidate countries for EU accession, except Slovakia. Unemployment could be defined as one of the most important problems for the social protection policy mainly because of its durable character (60% of the unemployed population are long-term unemployed). At the same time, there are structural characteristics that impede integration at the labour market (e.g. mismatches between demand

[1] Labour Force Survey, National Statistical Institute, December 2001

and supply of qualified labour force, youth unemployment, regional discrepancies etc.). The unemployment rate of villages was twice the one of towns. The uneven territorial distribution of jobs persists and the unemployment rate in half of the municipalities is higher than 20%.

In addition, unemployment affects the disadvantaged groups of the population such as the young, the disabled and minorities to a greater degree. Unemployment of people with secondary and lower level of education prevails.

Income and poverty

The high rate of inflation over continuous periods of time normally leads to a reduction of the purchasing power of income and a decline of consumption. During the period of 1995 to 1997, the real income of households followed a tendency of decline which was dramatic in 1997 (Figure 1). Unlike the previous years, an increase of the incomes was observed in the 1998-2001 period. The average monthly salary increased by nearly 50% in real terms while the total cash income per person in the households increased by 44%.

Despite the positive changes and the recorded economic growth, Bulgaria remains the country with the lowest GDP per capita among the 13 candidate countries for EU accession. Table 1.4 presents the income levels in EURO equivalent. The average wage is about 140 EURO which is the lowest among the countries candidates for EU accession.

The purchasing power of the main types of social incomes (pensions, benefits related to the minimum wage and the Guaranteed Minimum Income) increased significantly after 1997. However their purchasing power is still below the pre-reform period (Table 1.5).

The income of the population is extremely low compared to the absolute poverty line as estimated by the experts from the government and the trade-unions (Table 1.6).[2] In the last years poverty rates measured under the absolute line is above one third of the population. The relative poverty line used for the poverty assessment of the World Bank (66% of average gross households expenditures) also reveals a high level of poverty. The results show a significant improvement of the living conditions between the last two panels of the World Bank survey (1997 and 2001), but at the same time, there is still an overall decline in living standards since 1995.

The price of growing poverty has been paid in most of the countries in transition. However, in Bulgaria the effect was a rising polarisation between poor and non-poor, rather than an improvement of the welfare of the average strata and incentive promotion among the largest groups of the

[2] For more details on the applied poverty lines see item 4.1.2

population. Lorenz curves presented in Figure 3 illustrate the extent of income differentiation in the last years. Under these circumstances the income stratification of the population outpaced the capacity of the state to promote social cohesion. Apart from that, the choice of appropriate measures is limited under the pressure of fiscal restrictions. This complicates additionally the efforts for adequate social protection of vulnerable groups of population, exposed to the risk to become poor or excluded from the society.

A large part of the population is affected by poverty, including pensioners, minorities, long-term unemployed and households from peripheral rural areas. Poverty continues to generate problems not only in terms of social marginalisation and isolation of individuals (e.g. difficult access to health cares, education and other services), but also in terms of physical survival. The structure of households' expenditure can be interpreted as an additional indicator for impoverishment. The relative share of households' expenditures for food continues to be extremely high – over 40 per cent, and 9% is spend for energy and heating. Individual strategies such as clandestine employment and in-kind consumption from small households' plots continues to dominate.

Changes in Family

Family status is one of the most important characteristics of population and an important resource for social development. The last population censuses show a tendency towards a decrease of married couples (Table 1.7). The rising number of unmarried individuals above the age of 30 is among the unfavourable changes. The delay of marriage leads to increase of the average age of birth and has a negative impact on the reproductive behaviour. This trend could be explained with the limited resources and lack of housing rather than with higher education or carrier development which are positive developments in itself. At the same time, the data points out a stabilisation of family institutions. The marriage rate is relatively stable (4.3 per thousand during the last years) and the downward trend from the beginning of the 90s has been overcome. The divorce rate decreased from 1.5 in 1992 to 1.3 in the last year. Despite the fact that the family is affected by some processes characteristic for most European countries such as low marriage rates and an increase of informal marriages, as a whole, the families with their opportunities for mutual help are preserved and their social prestige is fairly high.

The main social problems of the family are connected with children. The average number of children per family is decreasing persistently to 1.3 in 2001. The largest number of families have one child - nearly 30%. Families with three or more children account for less than 3%. (Table 1.9).

The reduction of the birth rate is characteristic for most of the European countries and it is preconditioned by common factors such as higher levels of education, professional career plans, increased cares and responsibilities for upbringing children. However, economic crisis of the transition have produced additional motives for decreasing the number of children in the family.

The high number of abortions is one of the serious problems for family planning despite an decreasing abortion rate during the last years (from 47.2% in 1995 to 35.8% in 1999). The number of children of unmarried mothers is growing too – in 1999 they are more than one third of all births.

Incomplete families are a specific risk category because the average level of income in the country does not allow to support a dependent member of family. Single parents find it more difficult to get jobs that allow to reconcile family and job responsibilities. The data leads to the conclusion that special protection is needed for the young families taking into account the right to choose reproductive behaviour and the necessity to combine professional and household's duties in order to ensure appropriate living standard for the children.

The census data shows an increase of the number of single households which are also affected by the risk of poverty, particularly those of the elderly and the disabled. In 2001 there are 663,000 people living in single households (Table 1.10). Social protection policy should envisage the needs of these persons in terms of targeted benefits for heating, home services and relevant measures for poverty prevention.

1.2 How Does the Described Background Affect Social Protection?

1.2.1 Forecasts and Projections

The unsteady economic development of the country during the last years impedes the analysis of the macroeconomic impact on the social protection system, as well as the development of economic projections. Despite the existing constraints, there is an Actuarial Report prepared by the government which comprises long-term prognoses for the 2000-2049 period and a short-term actuarial model for the 2000-2003 period. (National Social Security Institute 2001).

The assumptions for the long-term prognoses are based on demographic and economic forecasts prepared by the National Statistical Institute, the Ministry of Finance and the Agency for Economic Analyses and Prognoses. The main demographic factors included are fertility and mortality rates, migration, longevity, expected changes in family patterns, invalidity rates etc. The economic factors are GDP growth, inflation, the labour force participation rate, the income structure of the active population etc. All these

factors have a different impact on revenues and expenditures of social security funds. The prognoses comprise assumptions of elasticity.

Bearing in mind the economic instability and the dynamic of transition, the long-term projections have been developed in three scenarios regarding the effect of revenues and expenditures on social security funds: optimistic, average and pessimistic. The ”average” economic assumptions are presented in Table 1.11 and the long-term demographic prognoses in Table 1.12. At the same time, the long-term prognosis takes into account the implementation of the reforms in the pension system, e.g. the gradual increase of the retirement age which is supposed to be completed until 2009 and the reallocation of about one fifth of all contributions to private pension funds. The contribution for complementary pension insurance in the fully funded system is expected to increase from 2% in 2002 to about 5-7% in the next years, thus helping to redistribute demographic and inflation risks between the active generation and the pensioners.

The short-term prognosis for the 2000-2003 period is based on the actuarial model which was developed according to the current legislation. It includes data 1) for the expected number of insured persons by categories, e.g. employees and self-employed and 2) for their average insurance income (Table 1.13). The projections for insured persons are based on the assumptions of decreasing unemployment and a significant increase of the number of employees. The number of self-employed persons remains limited at 9% of the total number of insured persons. The compliance rate among these persons is particularly low and their involvement in the official economy is an important challenge for the financial stabilisation of the social insurance system. The second factor of the actuarial model – average insurance income – is defined at 3.5% annual inflation and 9% wage increase in the 2002 to 2003 period. The same parameters are included in the macroeconomic framework for the preparation of the government budget.

At the same time, the budget projections are oriented towards a decrease of the contribution rate. The minimum target is to reduce the overall contribution rate in the state social insurance from 36.7% to 30%.

1.2.2 Influences of Economic, Demographic and Social Developments on the Social Protection System

The worsening social and economic indicators observed in Bulgaria since the beginning of the transition process raise concerns about the impact of these changes on welfare and social cohesion. At the same time, the negative social consequences endangers the labour force development and the economic competitiveness. That is why the social protection system should be envisaged not only as a resource-consuming sphere but also as a prerequisite for economic growth.

The process of social protection adjustment to the economic, demographic and social realities has two sides: revenue and expenditure.

Effects on the revenue side

The Bulgarian labour market in transition is characterised by a parallel decrease of the number of employed and of the real wage rates, thus reducing the fiscal bases for performance of adequate social protection policy. Combined with the unfavourable demographic development, this factor inevitably leads to an increase of contribution rates and of the rising fiscal burden imposed on the active population. This trend influences in a negative way the economic initiative and the competitiveness of the Bulgarian economy and creates preconditions for further narrowing the financial capacity for social protection.

According to the statistical surveys, the shadow economy in Bulgaria provides 20% of the GDP and includes more than a quart of the economically active population. Most of these persons are self employed and are not registered therefore and not included in the social security system. The negative impact of this phenomenon has two dimensions. On the one side it lowers the compliance to contribute and consequently destroys the financial balance of the system. On the other side the people engaged in the shadow economy have no access to social protection and are exposed to higher risks of poverty and social exclusion.

In 2001, the government declared a general intention to decrease the fiscal burden of the contributions for the small businesses. However, bearing in mind the restrictions on the budgetary policy imposed by the Currency Board in Bulgaria, the short-time realisation of this goal will be difficult.

Effects on the expenditure side

Until 1997, the social security system aimed to redistribute the minimum amount of resources available to keep the broad eligibility for and the amount of benefits, the inherited pre-reform legislation provided for. The gradually increasing deficit has been subsidised by the state budget. It has contributed to the increasing state debt and inflation process. After the implementation of the Currency Board the bank re-financing of the state budget is not allowed, thus implying the need to re-estimate some acquired social rights and to reduce the broad access of non-employed people to the social security benefits. Most of the reforms of the social protection system aim at restricting the social rights and re-establishing the financial balance.

It is difficult to restrict social rights that have already been granted, but the case of Bulgaria offers a good example of the growing costs of hesitation and prolongation of the reforms. The recent amendments to the social laws include an increase of the retirement age, the implementation of health

insurance and the abolishment of the generous non-contributory schemes paid by the social insurance funds.

Since the goal of the reform is to target limited public finances to those who are most affected by the risk of exclusion, the shift from universal non-contributory benefits towards means-tested benefits seems to be an effective instrument for income redistribution. The income support of the groups concerned by the restrictive reforms in the social security system should be provided by the social assistance system, which at present covers a relatively limited share of the population.

Potential risks are mainly connected to the income and labour status of the individuals. That is why the most efficient way for their alleviation is an active labour market policy that would help to allocate the limited financial resources rationally and would straighten the redistribution potential of the social protection system as well as the development of people's own capacity to overcome social risks.

1.3 Annex to chapter one

Table 1.1: Macroeconomic and Financial Indicators (1995-2001)

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001***
GDPa)							
Total GDP at current prices in 1000 Million EURO	10	7.8	9.2	11.4	12.2	13.7	15.2
Annual growth rate in constant prices – percentage change on previous year	2.9	- 10.1	- 5.6	4	2.3	5.4	4
GDP per head in PPS (Eurostat)	-	5400	5400	5700	6000	6500	7100
Inflation rate (Interim HICP for all items) - annual average rate of change in %b)	62.1	121.6	1058.4	18.7	2.6	10.3	7.4
Public social expenditure as % of state budget							
Health care	8.4	7.2	9.4	9.3	9.4	8.6	9.9
Social expenditures - including:c)	24.6	20.7	24.6	29.1	29.5	33.2	33.3
Pensions	18.7	16.0	16.0	20.8	19.7	22.2	22.3
Social benefits	4.8	3.7	6.8	6.5	7.4	9.4	9.0
Other social expenditures like programs for employment growth etc.	1.2	1.0	1.8	1.9	2.3	1.7	2
Social expenditure as percentage of GDP							
Health care	3.6	3.1	3.6	3.6	3.9	3.7	4.0
Social expenditures – including	10.6	9.0	9.5	11.3	12.3	14.2	13.6
Pensions	8.0	6.9	6.2	8.0	8.2	9.5	9.1
Social benefits and remunerations	2.1	1.6	2.6	2.5	3.1	4.0	3.7
Other social expenditures	0.5	0.4	0.7	0.7	1.0	0.7	0.8

Note: * Preliminary data for all figures except for HICP

Sources:

a) 1995/1996 - Statistical yearbook on candidate and South-East European countries
1997 -Jarko Pasanen. "The GDP of the Candidate Countries" in Statistics in Focus, Theme 2 – 28/2002.

b) 1995/1999 - Statistical yearbook on candidate and South-East European countries
2000 - National Statistical Institute, August 2002, available at www.nsi.bg

c) National consolidated fiscal budget, Official gazette (Republic of Bulgaria)

Table 1.2: Demographic indicators

	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Population (thousands)	8,384	8,340	8,283	8,230	8,190	8,149	7,891
Male	4,103	4,077	4,045	4,014	3,991	3,967	3,841
Female	4,281	4,263	4,238	4,216	4,199	4,182	4,049
Proportion of population less than 15 years (%) a)	17.7	17.2	16.8	16.3	15.9	15.5	15.0
Proportion of population aged 60 years and more (%) a)	21.4	21.5	21.6	21.7	21.7	21.8	22.4
Proportion of pop. aged 65 years and more (%) a)	15.2	15.3	15.6	15.9	16.2	16.3	16.9
Natural increase (per 1000 pop)	-5.1	-5.4	-6.9	-6.4	-4.8	-5.1	-6.4
Gender ration (female per 1000 male) b)	1,043	1,046	1,048	1,050	1,052	1,054	
Age dependency ratio	48.9	48.3	47.9	47.4	47.2	46.8	46.8
Fertility:							
Birth rate (per 1000 population)	8.6	8.6	7.7	7.9	8.8	9	8.6
Fertility rate	1.23	1.24	1.09	1.11	1.23	1.27	1.2
Net reproduction rate	0.59	0.58	0.52	0.54	0.60	0.60	0.57
Death rate (per 1000 pop) b)	13.6	14.0	14.7	14.3	13.6	14.1	
Male	-	-	-	16.0	15.0	15.5	
Female	-	-	-	12.7	12.3	12.8	
Child death rate (per 1000 population live births) b)	14.8	15.6	17.5	14.4	14.6	13.3	
Life expectancy at birth – total b)	70.6	70.6		70.5*		71.7**	
Male	67.1	67.1		67.1*		68.2**	
Female	74.9	74.6		74.3*		75.3**	
Life expectancy at age 60/65							
Male	12.5	12.3		12.6*		12.8**	
Female	15.2	15.1		15.2*		15.6**	

Notes: * Data for 1997-1999; ** Data for 1998-2000

Sources: a) Yearbook *Population and demographic processes*, National Statistical Institute – Bulgaria; b) Statistical Yearbook (1996-2001)

All other indicators:

1995/1999 - Statistical yearbook on candidate and South-East European countries

2000 -Yearbook *Population and demographic processes*, National Statistical Institute – Bulgaria

Table 1.3: Employment and Unemployment (1995-2001)

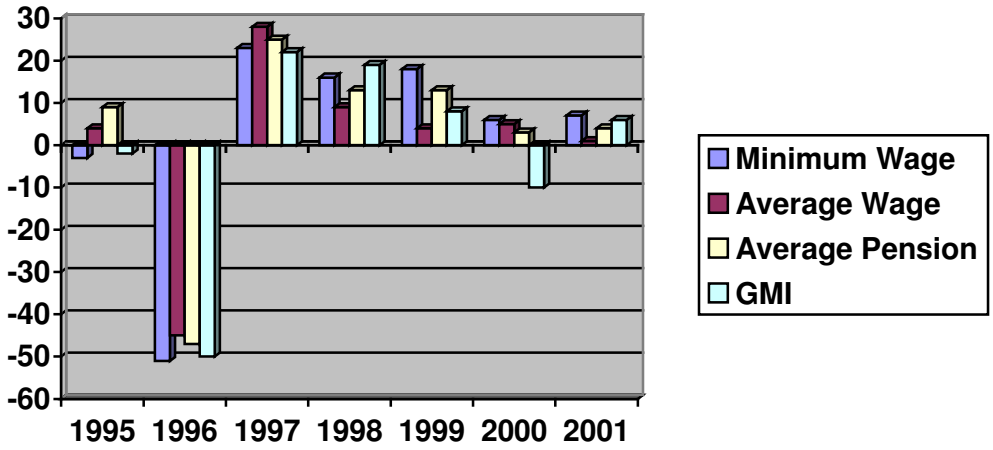
	1995	1996	1997	1998	1999	2000	2001
Unemployment rate	15.7	13.5	13.7	12.2	14.1	16.3	19.4
Male	15.5	13.5	13.9	12.6	14.0	16.7	20.2
Female	15.8	13.4	13.5	11.8	14.1	15.9	18.4
Labour force participation rate –total	52.2	52.5	51.9	51.6	50.2	49.8	50.4
Male	56.8	57.4	57.1	56.9	55.3	55.3	55.0
Female	47.9	48.0	47.0	46.7	45.4	44.7	46.1
Age 55-59	34.8	37.1	38.2	41.7	38.0	38.8	35.1
Age 60-65	8.5	7.9	8.7	9.2	9.1	11.3	11.3
Labour force structure (%):							
Employers	1.9	1.8	1.8	1.8	2.1	2.4	3.6
Employees	88.2	87.8	86.3	85.7	86.2	83.1	84.3
Self-employed	8.5	8.7	9.7	10.4	9.9	12.3	10.0

Source:

1995 /1999 - Statistical yearbook on candidate and South-East European countries

2000 – Quarterly bulletin *Employment and Unemployment*, National Statistical Institute – Bulgaria

Figure 1.1: Real Income Indexes (1995-2001)



Source: Ministry of Labour and Social Policy

Table 1.4: Income Levels in EURO equivalent (1995 – 2001)

	1995	**1997**	**2001**
Minimum Wage	38	26	50
Average Wage	114	100	140
Minimum Pension	23	22	20
Average Pension	36	35	40
Maximum Pension	56	66	80
Child Allowance	7	5	4
Guaranteed Minimum Income	21	15	20

Table 1.5: Purchasing Power of Main Income Categories

	Minimum Wage	**Average Pension**	**Guaranteed Minimum Income**
Bread (kg)			
1991	259	168	137
1995	151	135	86
1997	50	43	28
2001	130	123	62
Yoghurt (0,5 kg)			
1991	286	186	151
1995	117	105	67
1997	84	74	48
2001	154	145	73
Cheese (kg)			
1991	26	17	14
1995	12	10	7
1997	11	9	6
2001	23	22	11
Meat (kg)			
1991	23	15	12
1995	10	9	6
1997	6	5	3
2001	14	12	6

Source: Ministry of Labour and Social Policy

Table 1.6: Poverty Lines (1995-2001)

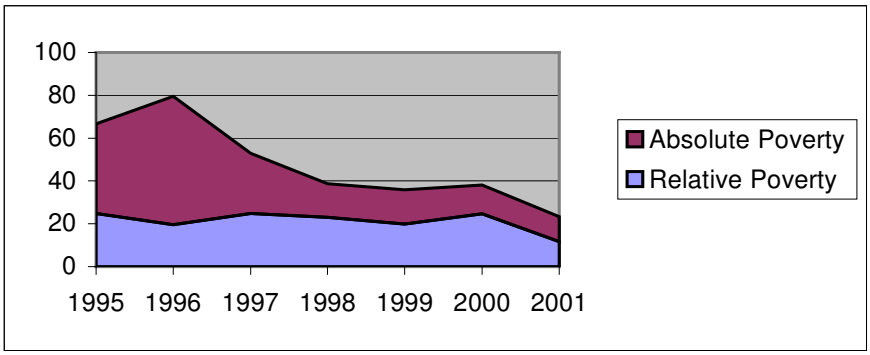
	1995	1996	1997	1998	1999	2000	2001
Absolute poverty line (BGN)*	4.9	10.1	78	81	88	97	105
Absolute poverty rate %	66.8	79.4	52.9	38.7	36.0	38.1	
Relative poverty line (BGN)**	2.5	4.4	54	66	71	76	61
Relative poverty rate %	24.7	19.6	24.8	23.0	19.9	24.6	11.7

Notes: *Minimum consumption basket calculated by MLSP until 1997 and after by the trade unions

**Relative poverty line applied by the World Bank equal to 66% of households expenditures

Source: Households Budget Survey, NSSI

Figure 1.2: Poverty Rates Dymanic (1995 – 2001)



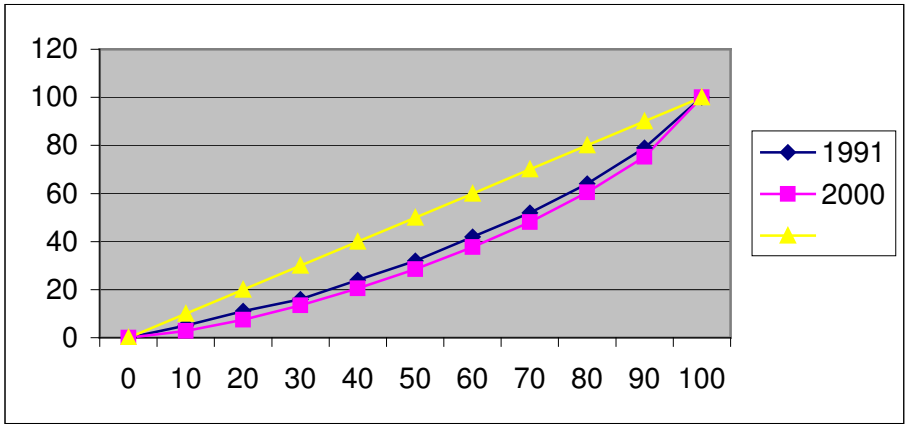
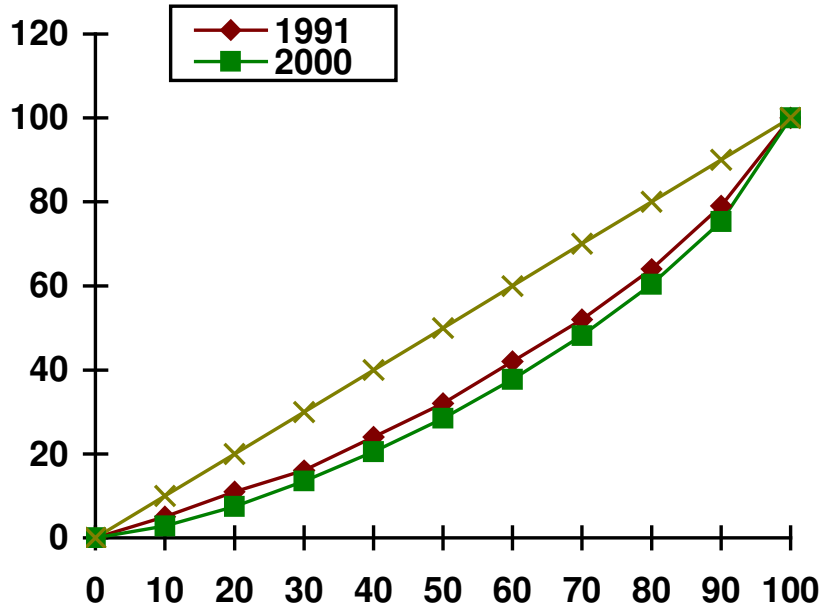


Figure 1.3: Deviation of Households' Income - Lorenz Curves



Source: Households Budget Survey, NCI

Table 1.7: Main Trends in Family Statistics (1995-2001)

	1995	1996	1997	1998	1999	2000	2001
Marriage rate (per 1000 population)	4.4	4.3	4.2	4.3	4.3	4.3	
Divorce rate (per 1000 population)	1.3	1.2	1.1	1.3	1.2	1.3	
Average age :							
of population	38.9	38.8	39.2	39.4	39.6	39.9	
of mother at 1st birth	22.2	22.4	22.7	22.9	23.0	23.5	
of mother at birth	23.9	24.1	24.3	24.4	24.6	24.9	
Average age at first marriage:							
Male	26.0	26.3	26.5	26.6	27.1	28.1	
Female	22.6	23.1	23.4	23.5	23.8	24.7	
Average age of divorce							
Male	37.3	37.6	37.4	37.7	37.8	38.0	
Female	34.0	34.3	34.0	34.2	34.3	34.8	
Share of births to unmarried mothers	25.7	28.1	30.0	31.5	35.1		

Source: Statistical yearbook, NSI, 2001

Table 1.8: Changes in Family Status of Population (1992-2001)

	1992 (number)	**1992 %**	**2001 (number)**	**2001%**
Population	8,487,317	100	7,973,673	100
Unmarried	2,876,849	33.9	2,850,941	35.8
Married	4,659, 392	54.9	4,052,888	50.8
Divorced	256,036	3.0	322,502	4.0
Widowed	686,559	8.1	746,977	9.4

Source: Population census, NSI 2001

Table 1.9: Families by Number of Members (1992-2001)

	1992 (number)	**1992 %**	**2001 (number)**	**2001%**
Families – total	2,547,016	100	2,392,062	100
2 members	1,134,719	44.6	1,099,130	45.9
3 members	683,633	26.	711,908	29.8
4 members	630,053	24.7	513,370	21.5
5 members	75,831	3.0	51,206	2.1
6+ members	22,780	0.9	16,448	0.7

Source: Population census, NSI 2001

Table 1.10: Households by Number of Members (1992-2001)

	1992 (number)	**1992 %**	**2001 (number)**	**2001%**
Households – total	2,964,577	100	2,956,558	100
Single	583,348	19.7	663,671	22.4
2 members	830,211	28.0	844,342	28.6
3 members	603,504	20.4	634,343	21.5
4 members	605,263	20.4	532,319	18.0
5 members	193,220	6.5	175,545	5.9
6 members	100,337	3.4	69,701	2.4
7+ members	48,694	1.6	36,637	1.2

Source: Population census, NSI 2001

Table 1.11: Average Economic Assumptions (2000-2049) (as per cent)

Years	Inflation	Increase of Ave. Insur-ance Income	Increase of pensions	Interest rate	Unemploy ment rate	Complian ce rate
2000	7.9	18.1	24.8	5.1	18.0	84.3
2010	3	6.2	3.1	5	11	86.6
2020	2	4.8	2.6	5	6	88.6
2030	1.5	3.7	2	4.5	5	90
2040	1.5	3.8	2.1	4.5	5	90
2049	1.5	4.3	2.5	4,5	5	90

Source: National Social Security Institute, 2001

Table 1.12: Average Demographic Assumptions (2000-2049)

Years	Fertility rate	Net migration	Annual decrease of death rate (%)
2000	1.3	-15,000	0.33
2010	1.65	0	0.33
2020	1.8	0	0.33
2030	1.9	0	0.33
2040	1.9	0	0.33
2049	1.9	0	0.33

Source: National Social Security Institute, 2001

Table 1.13: Short-Term Actuarial Projections (2000-2003)

	2000		2001		2002		2003	
	Insured persons (thousands)	Average Income BGN	Insured persons (thousands)	Average Income BGN	Insured persons (thousands)	Average Income BGN	Insured persons (thousands)	Average Income BGN
Total Insured	2,230	212	2,357	242	2,366	263	2,390	287
1.Employ ees	1,927	211	1,954	242	1,982	263	2,008	287
2.Officers	80	435	83	524	61	570	46	620
3. Civil servants	5	375	12	360	12	391	12	427
4. Self-employed	185	155	247	170	261	186	272	201
5. Other contracts	32	142	50	143	50	157	52	170

Source: NSSI, 2001

2. OVERVIEW OF THE SOCIAL PROTECTION SYSTEM

2.1 Organisational Structure

2.1.1 Overview of the System

The Ministry of Labour and Social Policy (MLSP) develops, co-ordinates and implements the state policy in the sphere of labour market, vocational training, incomes and living standard, industrial relations, health and safety at work, social insurance and social assistance. The MLSP ensures the implementation of the state policy by its specialised structures: the National Employment Service, the National Social Assistance Service, and by its territorial structures (Figure 1).

The main functions in the sphere of **labour market and vocational training** are as follows:

- Evaluation and anticipation of the development of the labour resources, elaboration and co-ordination of the state policy on insurance against unemployment and promotion of employment;
- Regulation of the activities of labour market institutions on national and regional levels;
- Implementation of the state policy in the sphere of training and re-training of labour force (either independently or in co-operation with other organisations);
- Development and implementation of instruments for the regulation of labour migration and for protection of the national labour market;
- Supervision of the usage of special funds for protection against unemployment.

The competence of MLSP in the sphere of incomes and living standard is:

- Analysis and evaluation of the incomes levels, living standards and poverty thresholds and their social protection;
- Elaboration and proposition of the policy and instruments related to wages and other types of income;
- Drafting legislation in the field of income regulation and indexation.

In the sphere of **social assistance** the Ministry:

- Elaborates programs for poverty relief;
- Regulates the activity of social assistance institutions;
- Promotes and supports charity and humanitarian activities;

- Promotes and controls the provision of social services and the development of social institution networks by public not-for-profit organisations.

The **National Social Security Institute** (NSSI) is a public organisation which, on the basis of the Code for the Obligatory Public Insurance, guarantees the citizens' rights on pensions and benefits. The Institute provides for quality services and manages the funds of the state social security in an effective and transparent way. NSSI administers the mandatory insurance programs for disability, old age and survivors' benefits, sickness and maternity, work injuries and occupational diseases as well as collection, control and information services for all obligatory contributions.

The Ministry of Health is the main actor in the sphere of health care. The health insurance system is designed as a state responsibility. The state has exclusive right to impose mandatory health insurance and to guarantee the observance of the insurance rights in respect of all citizens .

The Health Insurance Act (1998) established the **National Health Insurance Fund** (NHIF) as a public organisation and set principles defining the relationship between NHIF and the health care providers. The NHIF is responsible for the development, operation and management of the compulsory health insurance scheme in Bulgaria.

The compulsory health insurance is a system for social health protection of the population, which guarantees a package of health-related services. It is administered by the National Health Insurance Fund and carried out by its territorial divisions – the 28 Regional Health Insurance Funds.

2.1.2 Centralisation /Decentralisation of the System

The social insurance system is part of the responsibilities of the central government. At the same time the new social legislation has established autonomous social insurance institutions run on tripartite bases. The Supervisory Board is the highest management body of the NSSI. The Board comprises representatives of the state and of the national representative organisations of workers and employers. The NHIF is also managed by a Supervisory Board with representation of the state and the social partners.

The trend towards decentralisation of the system can also be seen in the development of voluntary insurance which is carried out by corporations that are registered according to the Commercial Law.

The social assistance system is part of the responsibilities of local governments. The central government through the MLSP has a supervisory and control function. The dual subordination of the system complicates its administrative structure, which is decentralised and located in the 280 municipalities of the country (see item 4.2.9.).

2.1.3 Supervision

The **MLSP** exercises the state control over the legislation in the sphere of industrial relations, health and safety at work, employment, unemployment and vocational training, remuneration, social insurance and social assistance as well as the implementation and compliance with international agreements in the field of labour market, social policy and social insurance.

In the sphere of social insurance MLSP has the following functions:

- Participation in the elaboration of basic parameters of social insurance and related payments;
- Preparation of projects and creation of conditions for the implementation of bilateral and multilateral agreements in the sphere of social insurance;
- Participation in the elaboration of basic parameters of social insurance and related payments;
- Promotion of the establishment and participation on the control over the activities of public and private funds for social insurance.

The **State Insurance Supervision Agency** (SISA) is an administrative structure under the Council of Ministers responsible for licensing and supervision of supplementary pension, health, and unemployment insurance companies. The status of the Agency is regulated in the Supplementary Voluntary Pension Insurance Act, the Mandatory Social Insurance Code and the Rules of Operation of the SISA.

2.2 Financing of Social Protection

2.2.1 Financing Sources

The financial organisation of social protection includes three different subsystems: State Social Insurance, Health Insurance and Social Assistance

State Social Insurance

State Social Insurance Fund has been separated form the state budget in 1995. Later in 1999 the Code for Compulsory Social Insurance implemented a comprehensive reform by establishing separate social insurance funds run by the NSSI:

a) Pension Fund; b) Sickness and Maternity Fund; c) Labour Injury and Professional Disease Fund

With the last amendments in 2002 the **Unemployment Fund** was removed from the Ministry of Labour and Social Policy to the NSSI thus becoming part of the state social insurance system.

Each fund is financed by a targeted contribution defined on the bases of actuarial models and prognoses. The state budget participates with targeted transfers for non-contributory benefits, e.g. child allowances and social pensions. Next to this, the state budget provides subsidies for compensation of the deficit which may be caused by low compliance, by redistribution of revenues to the supplementary pension insurance funds or by other reasons.

The separation of the social insurance budget from the state budget led to greater fiscal transparency and increased public confidence. Contribution compliance increased to 85% of the due contributions. Compared to the level in 1996, this is an increase of 10–12 percentage points.

Health Insurance

After 1950 the state health system in Bulgaria copied the Soviet ”Semashko” health system model that was financed by common tax incomes.. The contemporary mandatory health insurance system was implemented by the adoption of the Health Insurance Act in 1998 as a response to the heavy problems of the tax financed system of healthcare and as a continuation of the historical tradition of health insurance which existed in the country before the planned economy .

The NHIF is funded by pay-roll taxes which are the main source for health care financing. During the second half of the year 2000, the allocated budget of the NHIF for health insurance payments amounted to BGN 187 million. This corresponds to GNP/health expenditure ratio of 4.5%. Between 1994 and the first half of the year 2000, the ratio was between 3%-4,3%. This improvement was accompanied by a more realistic financing of the curative establishments for outpatient care. Another source for financing of the healthcare providers is the consumer tax according to Art. 37 of the Health Insurance Act that amounts to 1% of the minimal wage and that is payable with each visit to the doctor. Municipal and state owned hospitals profit from a third source of financing: they receive targeted subsidies and transfers from the state and municipal budgets. These funds are supposed to cover expenditures for investment, the execution of national and regional programs and other activities according to the Health Insurance Act and the Hospital Establishments Act.

Social Assistance

The social assistance system is financed by the municipal budget, block subsidies and earmarked transfers of the central government. The rehabilitation and social integration fund of the Council of Ministers provide targeted subsidies for non-contributory benefits of the disabled. A detailed description of the social assistance financing is presented in section 4.2.9.

2.2.2 Financing Principles

Despite the different sources of financing, the social protection system in Bulgaria is based on common principles:

- compulsory and comprehensive participation;
- solidarity;
- equality of members;
- tripartite management.

Mandatory social insurance is financed on a pay-as-you-go basis and the supplementary insurance is fully funded. The contribution is shared between the employer and employee in a 75/25 proportion. This proportion will be adjusted gradually until it reaches 50/50 in 2007.

Following the principle of comprehensiveness, the Code for Compulsory Social Insurance differs between the categories of insured persons according to the number and types of social risks and according to their employment status:

Compulsory insurance for all social risks. This is the largest group, which is characterised by a broad and comprehensive insurance protection having in mind the performance of labour activity in a permanent manner and the regular incomes received from it. The group includes persons working in employment relationships and other relationships similar to them in terms of durability and subordination to certain order – workers and employees; civil servants; armed forces and officers and sergeants from the Ministry of Inferior; members of co-operatives receiving labour remuneration; and executives of commercial companies.

Compulsory insurance for disability, old age, death, employment accidents and occupational disease. This insurance refers to workers and employees employed with one or more employers either short-term or episodically or not longer than 5 working days per calendar month. Until 1 January 2002, this group was insured only for employment accident and occupational disease. This insurance was financed completely by the employer. The last amendment to the Code provided them with the opportunity to accumulate also pension entitlement.

Compulsory insurance for disability due to general disease, old age and death. This insurance refers to self-employed persons, e.g. free-lance professions; craftsmen; sole entrepreneurs; owners or associates in commercial companies; farmers. The self-insured persons may enlarge the scope of social risks and by their own wish insure also general diseases and maternity.

2.2.3 Financial Administration

Pension insurance

Social insurance contributions are calculated on the basis of gross monthly earnings of the employed and declared earnings of self-employed. In 2002, the declared monthly income had to be not less than BGN 170 and BGN 850 at the maximum.

The general contribution rate for old age, invalidity and survivors pensions is **29%.** The state pays the entire contribution for civil servants and military officers. The self-employed (i.e. free lance professions, craftsmen, individual entrepreneurs, shareholders, farmers etc.) pay the full amount of contribution.

The employers pay 3% higher general contribution rate for the 2nd and 1st category of labour (harmful work conditions), as well as for the military servants. Next to this, all persons employed at the conditions of the 2nd and 1st category participate in the complementary professional pension insurance. This contribution is paid entirely by the employer.

Compulsory supplementary pension insurance (second pillar) is in the process of being implemented. The second pillar combines two types of pension funds: professional and universal, both financed on the capitalisation principle and managed by private pension companies under the supervision of the State Insurance Supervision Agency.

The professional funds have already started to accumulate resources since the beginning of 2000. They cover workers employed at the conditions of 1st and 2nd category of work. The persons covered by the professional pension funds are entitled to yearly retirement before the accomplishment of the standard retirement age. The rates of contributions in the professional funds are **12% for 1st category and 7% for 2nd category.**

The universal complementary pension insurance involves persons, born after December 31, 1959. The amount of contribution is 2% of gross earning, shared between employers and employees in the same proportion, as in the mandatory system. The implementation of the compulsory complementary pension insurance does not increase the total fiscal burden for the insured persons. In 2002 the current 29% contribution for the persons born after 1959 will be divided between the **state pension insurance with 27% rate and the universal funds with 2% rate.**

Eight private insurance companies have been licensed to run compulsory complementary pension funds. The licensed companies have concluded individual contracts with the insured persons.

Short-term insurance

Social insurance in cases of sickness and maternity is compulsory for the employed and optional for the self employed. The self-employed persons who insure themselves by their own choice pay the same **contribution rate - 3%** on the basis of the declared income for pension insurance.

The labour injury and the professional disease fund is financed by a **0.7% contribution** which is paid by the employers only. The self-employed persons are not eligible.

The unemployment insurance is funded by a 4% contribution shared between employer and employee. Self-employed people do not participate.

Health insurance

The health insurance **contribution rate is 6%.** The contribution of parents increases by 0.5% for each dependent child in the family. The income base is broader, including the income of employed and self-employed persons described above as well as rents. The state through the relevant social insurance funds insures non-employed persons, e.g. pensioners, unemployed etc. In these cases the amount of contribution is calculated on the bases of the minimum wage.

In order to minimise administrative expenditures, the contributions for the NHIF and these for the supplementary private funds are collected by the NSSI and distributed by the bank system.

2.3 Overview of Allowances

2.3.1 Health Care

The compulsory health insurance is a system for social health protection of the population, which guarantees a package of health-related services to the insured population. Health insurance is compulsory for all residents.

Health care benefits are provided in kind. The parameters and procedures related to the provision are regulated on annual basis by the National Framework Contract between the NHIF and the associations of services providers. The Contract defines the order, the contents and the payment of the health care activities and services provided to the insured population.

The duration of benefits is unlimited but could be terminated with cessation of the payment of health insurance contributions and/or with non-compliance with the prescriptions of General Practitioners (family doctors) concerning prophylactics or health promotion.

Medical doctors and dentists are approved on behalf of the Bulgarian Medical Doctors Association and the Bulgarian Dental Surgeons Association. The membership in these organisations is compulsory by law. It is a prerequisite for eligibility to sign a contract with the Regional Health Insurance Fund appointment with accredited medical establishments under labour contracts or for private medical practice. GPs paid on a capitation basis – per registered patient plus additional payments for activities connected with health priorities, health promotion and prophylactics according to targeted programs and bonuses for working in non-attractive environment (remote areas, mountain areas, etc.).Specialists are receiving fee for **visit** and for clinical procedures are paid fee for **service**. Dentists are paid per diagnosis price. Hospital doctors are salaried, but all hospitals are trade entities and the salaries there depend on the financial result. Hospital care is being paid by the NHIF on the basis of so-called ”clinical pathways” and through the global budgets of the Ministry of Health and municipalities.

Insured people posses the right for free choice of General Practitioner and outpatient care specialist, choice of hospital is still under regulation. Insured person pays to service providers co-payment amounting to 1% of the standard national minimum monthly wage for every visit to the GP and outpatient care specialist and 2% of the standard national minimum monthly wage for each day of stay in a hospital, but limited to 20 days annually. No fee required from people suffering diseases defined by a list in the National Framework Contract; unemployed, those eligible for social assistance, juveniles (including those accommodated in orphanages), military conscripts, military invalids, and prisoners.

Dental care is provided largely on purely private basis. Service package for the insured people is negotiated on an annual basis between the National Health Insurance Fund and the health care providers.

2.3.2 Sickness

Sickness benefits are paid by the state social insurance system. The incapacity for work needs to be demonstrated by a medical expertise. The insurance for general diseases entitles to benefits after a six monthly insurance period, and the insured for professional diseases and maternity are entitled to benefits after one day of insurance only.

There is a waiting period for the first 3 working days of the sickness benefits in case of general disease. These days are paid by the employer up to a maximum of 15 working days per year.

The general daily sickness benefit amounts to 80% of the average gross daily pay or the average daily insurance basis for 6 calendar months prior to commencement of sickness. The daily cash allowance is limited to the daily

net remuneration during the reference period. Sickness benefits are paid until recovery or qualification for invalidity pension.

2.3.3 Maternity

Maternity leave is 135 days including 45 prior to the delivery. The replacement rate of benefit for pregnancy and birth is 90%. The maternity benefits are 90% of the former income. The income base is calculated in the same way as the sick pay. The minimum amount of daily benefit is the minimum daily wage and the maximum is the individual's daily average pay for the 6 months period prior to commencing maternity leave. The benefits are paid by the state social insurance system

After maternity leave, the social insurance system provides benefits for **parental leave.** The amount of benefits is equal to the minimum wage. The paid leave starts after the end of maternity leave and continues until the child reaches its second birthday. The parental leave is transferable to the father and the grandparents if they are insured for all risks.

Uninsured mothers are eligible to 1 year parental leave according to the new Law for Family Benefits since April 1, 2002. The entitlement becomes income tested and the eligibility threshold will be defined by the Sate Budget Law.

2.3.4 Invalidity

Invalidity pension is bestowed for at least 50% lost capacity of work. The required period of insurance for invalidity pension for general disease is as follow:

No minimum period for those under the age of 20 or the blind:

- 1 year until the age of 25;
- 3 years until the age of 30;
- 5 years above the age of 40

Invalidity pension for labour injuries or professional diseases is not related to the insurance period.

The amount of **invalidity pension for general disease** is calculated on the basis of the reference insurance income multiplied by a coefficient equal to the number of years of insurance. In case the claimant is younger than standard retirement age, the age difference becomes the "adopted insurance record". This adopted insurance record is influenced by the following coefficients:

Incapacity co-efficient

more than 90%	0.9
71 to 90%	0.7

Invalidity pension for labour injury and professional disease is calculated on the basis of the national average monthly insurance income for the preceding year (see section 2.3.5.) multiplied by the individual coefficient (a ratio between the actual individual's income and the respective national average insurance income) calculated before the date of injury, and a coefficient reflecting the loss of work capacity:

incapacity	co-efficient
more than 90%	0.4
71-90%	0.35
50-70%	0.3

The Code for Compulsory Social Insurance provides for a number **non-contributory invalidity pensions:**

- military invalidity pension for military officers, conscripts, drafted reservists and civilians assisting the national army who were injured in action.
- pension for civil invalidity for injuries caused by fulfilling a civic or moral duty and for innocent people injured by the police;
- social invalidity pension for persons suffering from a reduction of working capacity of at least 71% before reaching 16 years of age.

According to the Law for Protection, Rehabilitation and Social Integration of the Disabled (1995), disabled people are entitled to the following **non-contributory targeted benefits**:

- Benefits for purchase and repairs of prescribed technical facilities (e.g. ortheses, protheses, wheelchairs) according to defined standards and up to a certain ceiling;
- Purchase of a personal car (duty tax exemptions);Benefits for repair of housing according to the specific needs of the disabled person;
- Accompanying persons for blind people and interpreters for deaf-mute people;
- Targeted monthly benefits for city transportation (15% of Guaranteed Minimum Income);
- Free transport by train or bus within the country (twice per year);Free balneological treatment (once per year);

- Targeted monthly benefits to cover telephone costs for disabled with more than 90% lost work capacity;
- Targeted monthly benefits for accommodation for single disabled, old age persons or single parents.

These benefits are provided by Municipal Social Assistance Centres. The number of beneficiaries and expenditures are presented on Table 2.3.

2.3.5 Old Age

The standard retirement age in 2002 is 61 and 6 months for men and 56 and 6 months for women. At the beginning of every year the standard pension age is increased by 6 months until 2009. Then, it will be 63 for men and 60 for women. The qualifying period is expressed as a sum of the age and the length of insurance. Claimant's age plus claimant's insurance record must equal to at least 100 points for men and 90 points for women. After December 31, 2004 the required sum of record and age for women shall be increased by one until it reaches 94.

The minimum period of affiliation is 15 years of insurance record (12 of them real service record) before the age of 65 for both women and men.

The amount of the old pension is calculated by multiplying the reference income by the sum of one per cent for every full year of insurance record. The **reference income** is determined in two different ways:

- For the period after January 1, 1997, the national average monthly insurance income for the previous year is multiplied by the individual coefficient of the claimant (a ratio between the actual individual's income and the respective national average insurance income).
- For the period before 1997, the individual coefficient is calculated on the basis of the individual's income on which insurance contributions have been paid for three consecutive years in the last 15 years before January 1, 1997.

Uninsured people older than 70 years are entitled to non-contributory social pension. It is income tested. The amount is determined annually by the government (at present BGN 44) and used to determine the minimum levels of pensions (e.g. the minimum old age pension should be not less than 115% of the social pension), as well as for the maximum ceiling of benefits (4 times the amount of social pension).

2.3.6 Survivors

All personal pensions are transferable into survivors pensions. Eligible persons are children up to 18 (up to 26 if they are students), spouses and parents, if they are not able to work.

The amount of survivor's benefit varies according to the number of survivors in the family: 50% of the pension of the deceased person for one survivor, 75% of the pension for two survivors and 100% for three or more survivors. The minimum amount of benefits is 90% of the social pension, which is applied for the lowest pensions only.

In 2001, the number of beneficiaries of survivors benefits is 116,889, including widows, widowers and children.

2.3.7 Employment Injuries and Occupational Diseases

The replacement rate for sickness benefits in cases of professional disease and labour injury is 90%. In case the labour injury or professional disease causes long-term incapacity of work, the invalidity pension is calculated under more favourable conditions (see reference2.3.4.)

2.3.8 Family Benefits

Until April 1, 2002, the insured persons received *Child Allowances* from the National Social Security Institute covered by a subsidy from the state budget. The uninsured persons (i.e. families with both parents unemployed and uninsured) receive child allowances from the municipal social assistance system.

The amount of benefits according to the previous legislation was approximately 4.2 EURO (BGN 8.56) for the first child; 8.57 for the second child and BGN 8.6 for the third child in the family). Insignificant differentiation according to the number of children in the family is inherited from the pre-reform legislation – Decree for Encouragement of Child Birth from 1968. Parents of children with disability are entitled to a higher amount of child allowance equal to 70% of the GMI.

On April 1, 2002 a new Law for Family Benefits came into force. It introduced an income-tested child allowance for families with a monthly income up to 75 EURO (BGN 150) per person. The amount of child allowance is 7.5 EURO (BGN 15), which is two times higher compared to the benefit before April 1, 2002.

All parents are eligible to a *Birth Grant* equal to 100 EURO (BGN 200) for the first, second and third child and 50 EURO for every additional child in the family.

According to the new law all family benefits for both insured and uninsured parents will be administrated by the Municipal Social Assistance Offices. The income test for the child allowances is expected to reduce the number of beneficiaries belonging to the high income groups by 20%.

2.3.9 Unemployment

The qualifying period for unemployment benefits is 9 months during the last 15 months before the end of payment of contributions.

The unemployment benefit equals 60% of the average monthly wage during the last 9 months of insurance. The amount should not be lower than BGN 70 and the maximum ceiling is BGN 130. Every year, these limits will be adjusted to the level of wages and the expected revenues in the insurance fund.

The period of payment of unemployment benefits depends on the length of insurance as follow:

- For less than 3 years length - 4 months period;
- 3-5 years – 6 months;
- 5-10 years – 8 months;
- 10-15 years – 9 months;
- 15-20 years – 10 months;
- 20-25 years – 11 months;
- More than 25 years – 12 months.

The eligibility conditions also include registration at the Employment Agency.

In December 2001, there were 160,595 recipients of unemployment benefits or 24.2% of all registered unemployed. The relatively low coverage is a result of two restrictive factors. First, there is the relatively high qualifying period and the limited access for seasonal workers. Secondly, there is the rising duration of unemployment. The majority of the non-eligible unemployed have expired periods of benefits. They continue their registration with the Employment Agency because it represents a qualifying condition for participation in active programs as well as a requirement for award of means-tested social assistance benefits.

2.3.10 Minimum Resources/ Social Assistance

The main schemes for guaranteed minimum resources are the monthly benefits and energy benefits. Lump-sum benefits are also previewed for specific needs (for example the purchase of school appliances, expensive drugs and so on). The unit of assistance, according to the present legal framework, is the family i.e. the parents and their children up to 18. One-member households and people cohabiting with other persons or family are also entitled to welfare benefits.

The **monthly benefits** were introduced in 1991 as a major instrument of poverty alleviation policy. They are granted to people who live below the eligibility income line. Initially, it was calculated as a percentage of the minimum wage. In 1992 the Government defined a basic minimum income, later renamed Guaranteed Minimum Income (GMI) as an official poverty threshold (for more details see section 4.1.2). Since 1993, an indexation mechanism has been implemented for anti-inflation protection and the nominal increase of the minimum income (e.g. GMI, social pension and minimum wage). Under the pressure of fiscal restriction, the indexation rates used were much lower than the consumer price indexes and the restrictive income policy has caused a sharp decline in real terms of GMI.

For the purpose of the means-test GMI is differentiated by a system of coefficients. The latter depends on family size and composition. Larger families are entitled to a higher income line. The equivalent scale is as follow:

- Single person - 1 GMI
- Old age or disabled person - 1.2 GMI
- Cohabiting person - 0.9 GMI
- Two members family - 1.8 GMI
- Family with a child - 2.7 GMI
- Family with disabled child - 2.9 GMI
- Family with two children - 3.6 GMI

All income sources of the family are taken into account in determining the eligibility i.e. income from salaries, retirement benefits, unemployment benefits, child allowances, etc. The total sum should be below the respective differentiated minimum of the family. The amount of income is declared by the individuals and verified officially. Means-test (so called Social Interview) is a regular procedure, that includes a visit to the home of the applying family. The eligibility requirements include a number of property criteria: there is a ceiling for the bank savings and deposits, the applicants should have only one house that is relatively small in size and should not own real estate (land, buildings) or other property (vehicles, cattle, etc.). The purpose of these criteria is to secure adequate targeting of people who are in real need and to avoid the errors of inclusion of recipients who have alternative income.

Eligibility criteria also contain a number of requirements like active job seeking and non involvement in the shadow economy. The unemployed, who are economically active, have to be registered at least 6 months with the labour office as active job seekers and should not have declined a job offer from the labour office or public work programs of municipalities. Recipients

who have been sanctioned for conducting speculative activities and who have hidden income lose their eligibility.

The low income line of the differentiated minimum and the tight eligibility criteria reduce the number of clients mostly to chronically unemployed and marginalised strata of the population. After 1992, the GMI amount has been maintained considerably under the level of the minimum salary, the unemployment benefits and even the social pension. That is why most of the families with one permanent source of income beyond the social assistance (wage, pension or short-term benefits), turn to be above the eligibility income line (Figure 2).

Energy Benefits were introduced in 1995 as a result of the liberalisation of the prices of electricity and fuel. These grants are also disbursed following means-test criteria. The income line, determining eligibility for energy benefits, is higher than those for the Monthly Benefits. It is valid for the heating season (1 November - 30 April) when the value of minimum energy consumption equal to 430 kWh per month is adding to the differentiated minimum income line. In 2001, the value of the norm for energy consumption was BGN 37. The eligibility income line for Energy Benefits in the families with children and disabled increase additionally by implementation of higher coefficients for differentiated GMI minimum (1.5 of the GMI per each child or disabled in the family). Despite the relatively small difference in the two eligibility thresholds, the number of beneficiaries of Energy Benefits is about five times higher than the recipients of Monthly Benefits. Below the energy line, there is a large number of families with recipients of unemployment benefits, low paid workers and pensioners (Figure 2).

The amount of monthly benefits and that of energy benefits is calculated as a difference between the threshold and the available income of the applying family. The lower the income, the higher the level of benefits. If the family has no other sources of income, the level of assistance is the highest possible – equal to the differentiated minimum income. Families, who are eligible but have other incomes and are close to the poverty threshold (for example low pension or unemployment benefits) are entitled to very small amounts and often they do not claim it at social assistance offices. The differentiation should be pointed out as an example of good design, which prevents from the so called ”poverty trap behaviour” and discrepancy between the eligible families situated closely below the threshold and those who are not eligible, but also poor and situated closely above the threshold. Such type of discrepancy was observed in 1996 when energy benefits were provided as a flat-rate. Then the income of eligible families of unemployed closely below the line became higher than the income of non-eligible individuals, including low-paid workers. This example shows the disincentives to work that were caused by the flat rate in

Bulgaria where many employed persons are situated in the low income strata.

2.4 Summary: Main Principles and Mechanisms of the Social Protection System

Social Security in Bulgaria was established more than a century ago in 1891 and the first social security law concerned the pensions of the state employees. In 1924, insurance was introduced for all hired workers and officials in private companies in cases of work injuries, illness, maternity, disability and old age, where the payments are on the account of the insured. Thus Bulgaria, in common with other European countries is placed firmly in the Bismarck tradition of occupationally based social insurance.

As in other Eastern and Central European countries, the pre-transition Bulgarian state expropriated social security funds and provided income security principally through guaranteed employment, and cash transfers for dependent groups, such as children, old age and disabled.

The transition to market economy, which started in Bulgaria in 1989, found the system unequipped to deal with the emerging economic risks. Furthermore, it has been overlaid with new social protection schemes, such as means-tested social assistance, to help households cope with the unpredicted shocks of poverty. Not only the number of social insurance programs increased since the start of the transition, but also the number of people receiving income support from these programs has increased dramatically. The need for reforms was also determined by the considerable financial problems of the system and the constant efforts to maintain its financial sustainability.

The main objectives of the reform are to increase coverage of the social security system, to re-establish the solidarity principle and to ensure sustainability.

Coverage

The dynamics in the last years indicate a decrease in the number of insured persons in the social security system due to the unemployment and worsening age structure of population. Thus, a key aim of the new insurance legislation is to enlarge the coverage of the self-employed persons and to improve compliance in contribution collection. This includes both improving the motivation of contributors and strengthening the control mechanisms of legislation.

Solidarity and redistribution effects

Bulgaria has an unfavourable ratios between pensioners and active contributors, and pensioners and active population. That is why the reform focused on the changes in qualifying conditions in order to re-establish the balance between the need of improving the beneficiaries' living standards and to avoid to increase the fiscal burden that reached an extremely high level before the reform (Table 2.4). For the same purpose, replacement rates have been changed linking more closely the insurance contribution of the persons and their benefits. Also, this provides incentives for longer participation in the insurance system as every additional year of service has a direct influence on the amount of benefits.

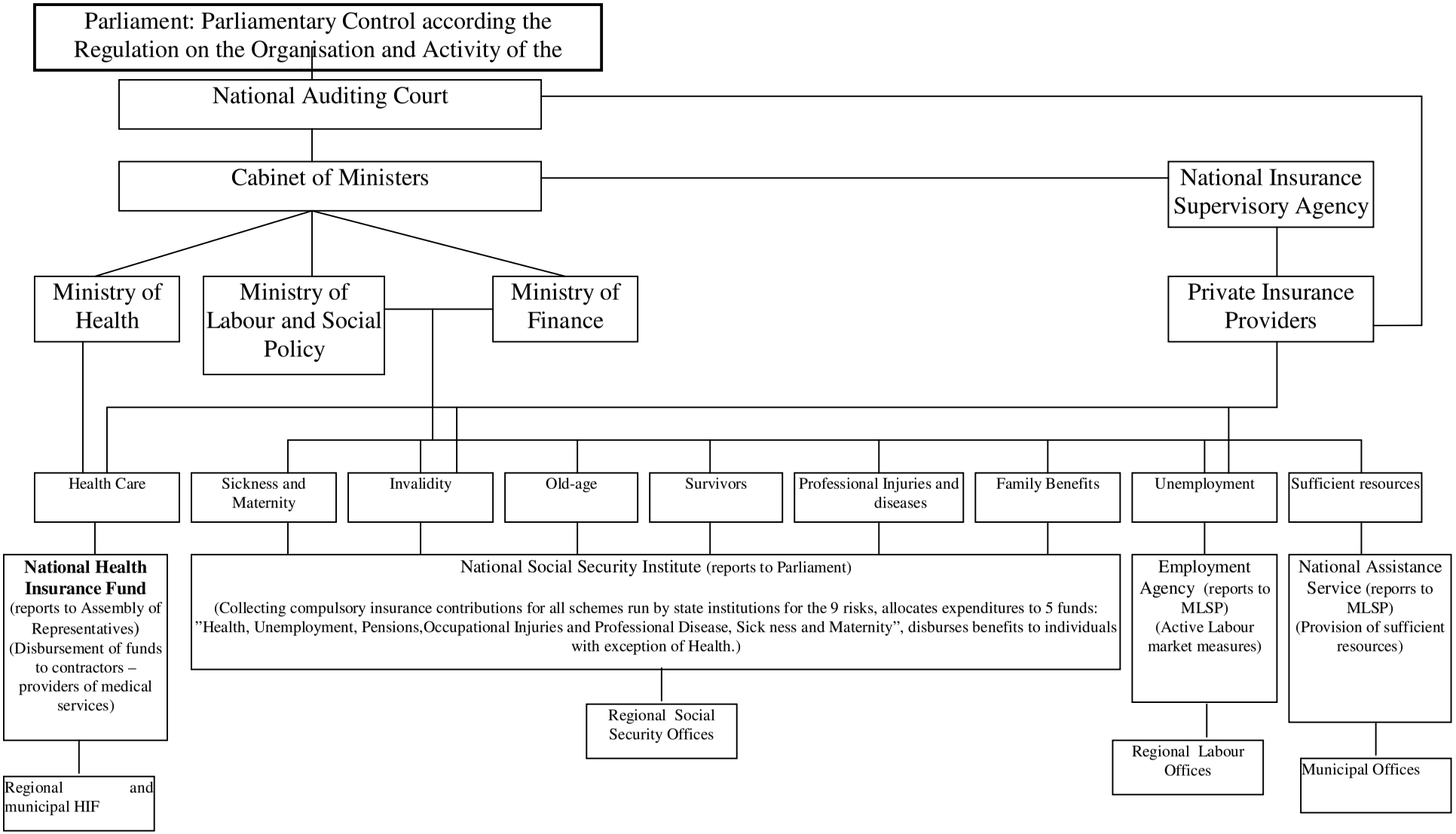
Sustainability

The actuarial projections showed an impending financial collapse of the old pension system as a result of the accumulation of non-funded eligibility rights. The social security reform was designed to avert this. Nevertheless, the Pensions Fund will still need subsidies for the next 6-7 years. The system will become financially sustainable only when the effect of restrictive qualifying conditions (e.g. increase of retirement age and length of insurance) is felt. These are previewed to enter into force step by step until 2009.

Another guarantee for the sustainable development of the system is the involvement of private social security institutions and the redistribution of risk between mandatory pay-as you-go and supplementary fully funded systems of pension insurance. At the same time, favourable legal regulation and tax exemptions for voluntary social insurance was introduced.

2.5 Annex to chapter two

Figure 2.1: Organisation of Social protection in Bulgaria



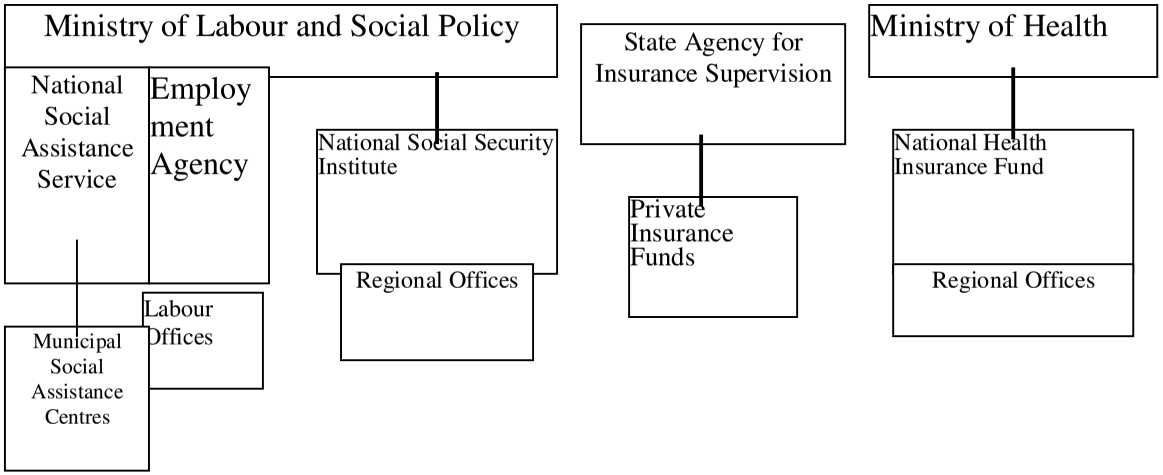

Ministry of Labour and Social Policy
National Social Assistance Service
Employment Agency
Labour Offices
Municipal Social Assistance Centres
National Social Security Institute
Regional Offices
State Agency for Insurance Supervision
Private Insurance Funds
Ministry of Health
National Health Insurance Fund
Regional Offices

Table 2.1: State Social Security Budget (1995-2001)

(BGN thousands)

	1995	1996	1997	1998	1999	2000
Revenues-total	**81,742,600**	**137,686,708**	**1,395,714,050**	**2,188,930,592**	**2,439,763.7**	**2,995,985.6**
I. Own revenues – total	73,525,690	130,481 930	1,310,492,426	2,022,923,568	2,108,063.9	2,445,593.7
1. Reserve from the previous year	231,450	952,363	1,054,010	118,219,014	74,153.3	108,802.5
2.Contri-butions	69,673,445	124,064,764	1,283,077,292	1 867,481,088	1,972,629.2	2,197,928.8
3. Other own revenues	3,620,795	5,464,803	26,361,124	37,223,466	61,281.4	138,862.5
II.Revenues from Govern-ment budget	8,216,910	7,204,777	85,221,624	166,007,024	331,699.8	550,391.9
Expendi-tures- total	**80,790,237**	**136,632,698**	**1,283,750,518**	**2,114,777,261**	**2,330,961.2**	**2,985,295.4**
1. Pensions	66,079,537	114,666,768	1,077,025,842	1,803,302,622	1,952,687.0	2,534,520.8
2. Sickness and maternity benefits	7,451,962	11,412,379	102,431,691	172,850,201	173,011.2	152,310.9
3. Parental leave and child allowance	6,766,140	9,534,095	90,043,681	113,386,863	106,473.9	106,321.7
4. Child allowance for disabled children	0	0	239,217	1,265,288	2,294.4	2,539.2
5.Adminis-trative expendi-tures	442,012	848,609	14,010,087	23,972,287	27,054.7	36,849.3
6. Other expend.	50,586	170,847	0	0	69,440.0	152,753.3

Source: NSSI, 2001

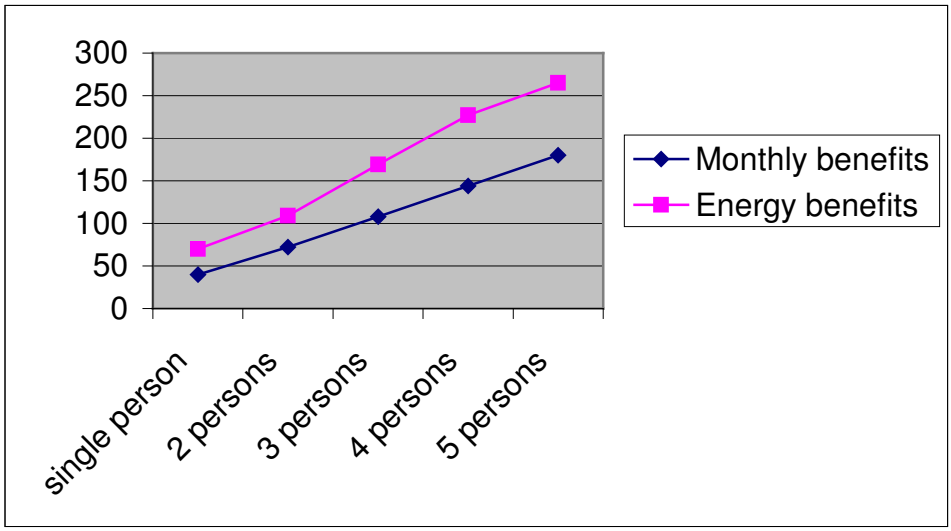
Table 2.2: Beneficiaries of Social Insurance Schemes (2001)

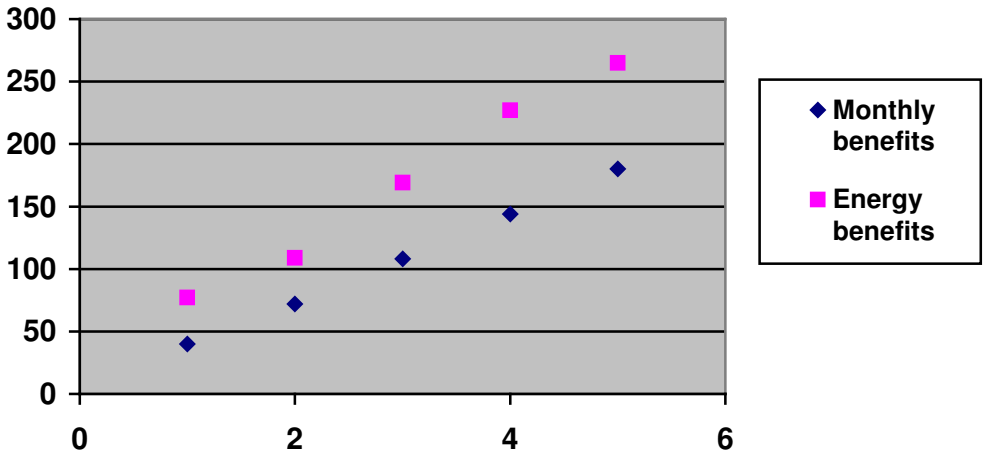
	Number of insured	Number of beneficiaries
1. Pensions	2,193,888	2,052,993
e.g. Survivors		116,889
2. Employment Injuries	1,944,505	254,816*
3. Sickness & maternity	2,081,371	3,429,557*
4. Unemployment	1,847,690	160,595

* Note: number of days

Source: NSSI, 2001

Figure 2.2: Eligibility Income for Monthly Benefits and Energy Benefits (January 2002)





Number of family members

Table 2.3: Targeted Benefits for Disabled Persons, 2001

	Beneficiaries	**Expenditures (thousands BGN)**
Benefits for city transport	185,014	9,401
Free train or bus transport	33,763	549
Balneotreatment	4,594	594
Telephone benefits	50,736	2,209
Benefits for rents	1,938	255

Source: Ministry of Labour and Social Policy, 2001

Table 2.4: Trends in the Fiscal Burden (% rates 1995-2002)

	1995	1996	1997	1998	1999	2000	2001	2002
Social Insurance	35	35	37	37	37	35.7	32.7	36.7
e.g. employee	0	0	2	2	2	7	7	9
Unemployment	7	7	5	4.5	4	4	4	0
e.g. employee	0	0	0	0.9	0.8	0.8	0.8	0
Health Insurance	0	0	0	0	6	6	6	6
e.g. employee	0	0	0	0	3	1.2	1.2	1.5
TOTAL	42	42	42	41.5	47	45.7	42.7	42.7

3. PENSIONS

3.1 Evaluation of Current Structure

3.1.1 Public-Private Mix

The new Code for Compulsory Social Insurance since 2000 has radically changed the structure and parameters of the Bulgarian social security system. A new three-pillar pension model has been introduced, including as follows:

- A compulsory public scheme financed on pay-as-you-go basis;
- A fully funded supplementary compulsory pension insurance, that covers two categories – an occupational scheme for employed at unhealthy job conditions and a universal scheme for all employed who were born after January 1, 1960;
- Supplementary voluntary pension schemes.

I. pillar – Compulsory Public Pension Insurance

The scope of the compulsory pension scheme covers all long-term insurance risks, e.g. old age pension, invalidity pension and survivors pension.

The I pillar represented state monopoly over the pension insurance until the end of the 90s. The establishment of a new public-private mix in 2000 was oriented toward a redistribution of the insurance risk between different pillars and an improvement of the financial balance of the system. Along with this structural reform, a parametrical reform has also been implemented. It aims at a better functioning of the first pillar, which remains the main scheme for guaranteeing income of the old-age population.

The new legislation implements new restrictive requirements for the entitlement to a pension, e.g. a longer insurance period and higher age, which stipulate to decrease the pensioners' burden on the active population and to favour work incentive. The new formula for pensions calculation allows a close link between benefits and contributions of the insured persons and an optimal distribution of the insurance burden between insured persons, employers and state. At the same time, the regulation of the first pillar creates economic mechanisms for raising the collection of insurance contributions while at the same time it enhances the current control over the insurance revenue.

II. pillar - Supplementary compulsory pension insurance

The supplementary compulsory pension insurance is implemented through capital funded pension schemes on the basis of defined insurance contributions accumulated and capitalized on individual pension accounts. It does not replace but only supplements the compulsory insurance of the pay-as-you-go type while creating the opportunity to get more than one pension and increasing the rate of replacement of incomes from labour without raising the insurance burden.

The rate of the supplementary pensions provided by the second pillar is a function from the personal insurance contribution and the rate of return of accumulated resources on individual accounts of the insured (decreased by the charges and taxes on administration.)

The institutional scheme envisages two independent legal entities through which the supplementary compulsory pension insurance is implemented – universal and/or professional funds, which are established and managed by licensed insurance companies.

The scope of the second pillar is narrower than that of the first pillar and covers only the risks of old age and survivors. The personal scope is also more limited and includes two categories:

- The compulsorily insured in a professional pension fund covering only the workers under the conditions of first and second labour category /the so called ”risky” labour/ with the aim of receiving entitlement to a fixed-term professional pension for early retirement. The early retirement scheme precedes the pension for insurance period and age without cumulating with it. The number of insured persons under these categories is 125,0000.
- The compulsorily insured in a universal pension fund covering all insured under the first pillar born after 31 December 1959. This scheme is targeted at 1,200,000 persons.

III. pillar - Supplementary voluntary pension insurance

The supplementary voluntary pension insurance is the third element of the Bulgarian pension system and the second element of the supplementary pension insurance based on the capital funded principle. It ensures a third pension or fixed-term personal pension for age or disability and also a survivor’s pension in case of death of the insured person, or the person who has been receiving the voluntary pension.

The primary aim is the creation of opportunities and conditions for raising the social protection of the population through participation in saving-investment schemes for voluntary pension insurance. The additional

objectives of the voluntary pension insurance are the promotion of savings, the stimulation of social initiatives of employers and the enhancement of social orientation of the privatisation.

Voluntary insurance contributions could be paid by the insured person, independently or along with the employer, as well as only by the employer without participation of the insured person. The supplementary voluntary pension insurance is implemented through cash insurance contributions at rates that have been agreed upon, which are monthly, yearly or for other periods and also through a single purchase of pension rights and investment bonds. The minimum rate of the monthly insurance contribution cannot be lower than 10% of the minimum monthly wage for the respective month and there are no maximum ceilings of contributions. All contributions for the voluntary funds are tax exempted.

The supplementary voluntary pension insurance is organized and administered by licensed insurance companies, which have the right to establish other legal persons such as the voluntary pension funds to manage their assets, to conclude insurance contracts, to collect insurance contributions and to pay the pensions of the insured persons.

The assets of the private pension funds may be invested in State securities, securities admitted for trading at regulated stock markets, municipal bonds, bank deposits and real estate and mortgages. At least half should be invested in securities issued or granted by the state. The rest of the assets are invested in other securities at the regulated stock markets. A maximum of 10% of the assets may be invested in mortgages, buildings, land or other real estate. The limitation for investment abroad is 10% of the assets of the fund.

The main controlling body is the State Agency for Insurance Supervision, which is also responsible for the licensing of private pension insurance companies. The Bulgarian National Bank is also involved, particularly in the control of depository banks keeping the cash and other securities of the private pension funds. The depositories shall not be a creditor of the pension fund and shall keep the cash under a special account separately from its own assets.

Annual forecasts for the development of the second and third pillar indicate increasing investment potential. The professional funds are expected to collect BGN 20–30 million per year (EURO 10-15 million). The universal supplementary funds will accumulate approximately BGN 100 million (EURO 50 million) The estimates of the income from investment is based on 7% expected rate of return. There is no benefits payment for the universal pension scheme in the first years, that is why the increase of the accumulated assets is quite rapid and in 2005 they reach approximately BGN 500 million (EURO 250 million) (Figure 1).

The third pillar has already started to function since 1994. Currently they have half a million insured persons and a portfolio of roughly BGN 70 million (EURO 35 million). The total amount of benefits paid in the last two years is very low – about 1% of the assets. This percentage will be kept until 2005, when the assets will reach BGN 650 million (Figure 2).

Despite the optimistic perspective for developments of the private pension insurance, there are concerns related to the weak capital market in Bulgaria. The supply of equities is relatively limited, particularly these with a lower degree of risk required by the legal regulation of the private pension funds. More than 90% of the assets of the pension funds comprises state security and municipal bonds (Figure 3). The demand exceeds significantly the supply and often the state securities are purchased above the nominal value, thus limiting the expected rate of return. The idea for targeted emissions of state securities reserved for pension funds only has been launched in 2001, but still not implemented, because these privileges would endanger the effectiveness of the capital market and the competitiveness in the banking sector.

In Bulgaria the banking system functioned very poorly until 1996, burdened by loans which were carried over from the pre-transition period. In this period the Bulgarian National Bank (BNB) provided liberal refinancing of the commercial banks. The banks then lent this money to enterprises or financed private companies under vague conditions. In many cases these loans were a form of implicit budgetary subsidy for the ineffective state owned enterprises with little chance to be repaid. The weak balance of the commercial banks helped bring on the Bulgarian financial crisis in 1996 when several banks were closed. The currency board introduced since 1997 has restored confidence in the bank system, improved economic discipline and stopped the re-financing of budgetary deficit by BNB, thus the situation in the banking sector has improved dramatically.

Once the mass privatization auctions were initiated at the mid 90s, there was increased need to develop new capital markets. Trading of shares began in 1997 and was substantial for several months, but more general trading on the new stock exchange did not really begin until March 1998. The main institution is the Bulgarian Stock Exchange – Sofia. At first, trading volume on the stock market was high as a result of the mass privatization procedures, but in the next years there was a trend toward decrease and in 2001 the trading level was about BGN 30 million. The low volume of trading raises questions about the viability of the Bulgarian Stock Exchange.

The liberalization of the banking market and entry of foreign banks has helped to diversify products and introduce new services into the banking market. Although banks are extending credits to the agricultural sector, small and medium size enterprises and consumer and housing mortgage credits, Bulgaria's credit market is still underdeveloped. In 2001 only 31.5%

of assets of the banking systems are in the form of loans. In the context of continuing high liquidity and generally cautious lending policies of Bulgarian banks, the spread between the average interest rate on credits and that paid on deposits remained overall significant. In 2001 the annual interest rate on short-term BGN loans was 13.2% and the average interest level for time BGN deposits was 3.4%. The annual rate of return for the state securities remained about 5%.

The Bulgarian National Bank is expected to encourage the banking sector by easing restrictive commercial bank regulations which were imposed with the introduction of the currency board arrangement. The persistence of this restrictive regulatory framework would deter the development of the sector in the long-term. A gradual deregulation of the banking sector is also a prerequisite for EU accession and a requirement of the European Commission and the European Central Bank.

The development of a modern and competitive bank system would enhance the evolution of the whole financial system in Bulgaria, including the stock exchange. Given the restrictive monetary and fiscal environment in the country, the financial market should become an important source of company financing. The role of the capital market should be strengthened to facilitate the access of capital to profitable projects and to attract a larger volume of foreign portfolio investments.

The total number of pensioners in 2001 is 2;370;000. The total monthly income per capita in the households of pensioners is BGN 140, which is 12% higher than the average for the country (BGN 125). The relative improvement of the income status of this category started at the end of the 90s. Before this period pensioners were among the poorest groups of the population (World Bank, 1999). The positive development is due to the policy priority put on the pension reform and the measures to compensate inflation erosion of pensions.

The composition of income of pensioners is presented in Table 3.2. Pension is the most important income source (more than 60% of the total income in the households of pensioners).

The main alternative source of income for the group of pensioners is individual farming and in-kind production of small households plots. In the households of pensioners in-kind income reaches 22.4% of the gross revenue. Inter-familiar solidarity is a traditional value for the Bulgarian society, however, the low living standard of the working population do not allow for sufficient informal transfers from active generations to the old-age people. In most of the cases these informal transfers have the opposite direction from pensioners to the younger generation and consist of in-kind products or help in the housekeeping and bringing-up of the children.

3.1.2 Benefits

Old Age Pensions

The new eligibility conditions for old age pensions have been implemented since January 1, 2000 The standard retirement age in 2002 is 61 and 6 months for men and 56 and 6 months for women. At the beginning of every year the standard pension age is increased by 6 months until 2009. Then, it will be 63 for men and 60 for women. The qualifying period is expressed as a sum of the age and the length of insurance. Claimant's age plus claimant's insurance record must equal to at least 100 points for men and 90 points for women. After December 31, 2004, the required sum of record and age for women shall be increased by one until it reaches 94. The time schedule for a gradual increase of the retirement age and the qualifying period for men and women is presented in Table 3.1.

The minimum period of affiliation is 15 years of insurance record (12 of them real service record) before the age of 65 for both women and men.

The formula for the first pillar pensions is *defined-benefit*. The pension is determined by the following three elements:

- Length of insurance period (every year of insurance amounts to 1% of the average monthly insurable income; for the workers in dangerous and detrimental conditions, this percentage is higher);
- The individual coefficient of the pensioner – a ratio between the individual income of the person and the average insurance income for the country during the length of service;
- The average insurance income for the previous year.

Example: The amount of the pension for a worker in the manufacturing industry who retired in 2002 would be calculated as follows:

Pension = AII · IC · IR%
where:
AII is the Average Insurance Income in the year preceding retirement (BGN 243 in 2001);
IC is the Individual Coefficient – a ratio of the wage and the average insurance income for the preceding years insurance record (1.14 for the respective industry)
IR - 1% for each year Insurance Record
243 · 1.14 · 39% = **BGN 108.03**

The individual coefficient is calculated on the basis of the individual's income on which insurance contributions are paid for all years of insurance after January 1, 1997, until the moment of retirement. For the period before January 1, 1997, three consecutive years in the 15 years of participation in

the insurance scheme are chosen by the person, and for the period after that date until the moment of retirement.

For the purpose of calculating the individual coefficient the following shall be determined:

- the ratio between the average monthly insured income of the person for the chosen period through to December 31, 1996, and the national average monthly wage for the same period, as announced by the National Statistical Institute. monthly insurance income for the same period.
- the ratio between the average monthly insured income of the person for the period after December 31, 1996, and the national average monthly insured income for the same period. The national average insurance income includes wages, other remunerations paid on the bases of civic contracts, management contracts etc. and the insurance income of the self-employed persons. It is monitored and announced monthly by the National Social Security Institute;

The individual coefficient is then determined in the following way: each ratio under paragraph 4 is multiplied by the number of months for which it has been established, and the sum of the results achieved in this way is divided by the total number of months included in the two periods.

If the person has not worked after January 1, 1997, the individual coefficient shall be equal to the ratio under the above item 1, and if the basic period is entirely after this date, the individual coefficient shall be equal to the ratio under the above item 2.

The replacement rate for the old age pension expressed as a ratio between the average pension and the average wage is between 30% and 40%. (Table 3.3) The analyses of this relatively low value of replacement rate should take into account that it is calculated as a ratio of the average gross income and average pension, which is not taxable in Bulgaria. The net replacement rate has a higher value compared to the gross one, because of the high share of contribution included in the gross wage. The average pension received by one pensioner is 48% of the net average monthly insurance income.

All pensions are indexed on an annual basis, using a coefficient, not lower than the consumer price index for the previous year and not larger than the index for the increase of the average monthly insurance income.

Persons who are not entitled to an old age pension acquire the right to a non-contributory Social Pension. Eligibility criteria are 70 years of age and income test. The amount of the Social Pension is defined annually by the government. In 2002 it is 44 BGN.

The amount of the Social Pension is also used for setting minimum and maximum limits for the pensions. The minimum amount of the old age pension guaranteed by the legislation is 115% of the social pension for pensioners achieved required sum of eligibility criteria (sum of age and insurance period) For pensioners who have not completed the full length of insurance the guaranteed minimum benefit is 105% of the Social Pension. At the same time, there is also a ceiling on pension amounts – the maximum pensions cannot exceed four times the Social Pensions.

The pensions from the second and third pillars are *defined-contribution*, e.g. their amount depends on the rate of return of the private pension funds and the administrative expenditures of private pension companies.

The amount of minimum pension (BGN 44) is higher than the level of the Guaranteed Minimum Income (BGN 40) which defines the right to social assistance benefits. That is why, most of the pensioners are above the official poverty threshold. At the same time, the low replacement rate leads to a significant worsening of the income status of people reaching retirement age. Their pensions are 2-3 times lower compared to the wages before retirement. The relative impoverishment is combined with other social deficits related to the retirement, such as loss of social contacts and isolation. There are no special programs for provision of part time jobs targeted at the pensioners. The employment of persons who receive pensions is allowed by law, but the stagnated labour market does not offer opportunities for the big majority of pensioners. According to the statistics of the National Social Security Institute in 2001 there were 58,000 employed pensioners, or 2.5% of the total. The rest of the group rely mostly on the income from pension, despite that many of them still have the capacity of work.

Invalidity Pension

Invalidity pension is bestowed for at least 50% lost capacity of work. The required period of insurance for invalidity pension for general disease is 1 year until the age of 25; 3 years until the age of 30 and 5 years above the age of 40.

Invalidity pension for labour injuries or professional diseases is not related to the insurance period.

The amount of **invalidity pension for general disease** is calculated on the basis of the reference insurance income multiplied by a coefficient equal to the number of years of insurance. In case the claimant is younger than standard retirement age, the age difference becomes the "adopted insurance record". This adopted insurance record is influenced by the following coefficients:

Incapacity	co-efficient
more than 90%	0.9
71 to 90%	0.7

Invalidity pension for labour injury and professional disease is calculated on the basis of the national average monthly insurance income for the preceding year (see section 2.3.5.) multiplied by the individual coefficient (a ratio between the actual individual's income and the respective national average insurance income) calculated before the date of injury, and a coefficient reflecting the loss of work capacity:

incapacity	co-efficient
more than 90%	0.4
71-90%	0.35
50-70%	0.3

The share of invalidity pensions as compared to the total number of pensions increased from 10.2% in 1998 to 16.2% in 2001. This development is due to the new legislation, which makes it possible for persons with loss of work ability over 70% to receive two disability pensions – a *personal* invalidity pension for general sickness or for work injury and a *social* pension for disability in the amount of 25% of the Social Pension for old age. The number of people who receive a second social pension for disability in 2001 is around 190,000 persons.

There is no evidence that the increase of disability pensions is caused by a low control in the field of medical expertise. The average monthly amount of an invalidity pension in 2001 is BGN 68, which is relatively low compared to the average old age pension (BGN 90). This difference explains the lack of motivation to apply for disability pension after the accomplishment of retirement age.

Although the main goal of parametrical reform in 2000 was oriented toward the abolishment of non-contributory rights and financial balance between contributions and benefits, it also takes into account social consideration, such as poverty prevention and income redistribution. The adequacy of the pension system with regard to income security is provided by the following mechanisms:

- Guaranteed minimum amount of all types of pensions;
- Easy access to invalidity pensions;

- Leading role of the mandatory defined-benefits scheme and prudent implementation of the new fully funded and defined-contribution pillars which would increase the degree of personal risk for the pensioners;
- Commitment of the state to remain a last resort guarantor and to provide budget subsidies to the Pension fund during the transitional period of gradual implementation of the new eligibility conditions.

Survivors Pensions

All personal pensions are transferable into survivors pensions. Eligible persons are children up to 18 (up to 26 if they are students), spouses and parents, if they are not able to work.

The amount of survivor's benefit varies according to the number of survivors in the family: 50% of the pension of the deceased person for one survivor, 75% of the pension for two survivors and 100% for three or more survivors. The minimum amount of benefits is 90% of the social pension, which is applied for the lowest pensions only.

3.1.3 Financing of the Pension System

The first pillar is financed by the Pension Fund, which is a separate fund within the state social insurance system. Contributions and budget subsidies are the main source of expenditures. The subsidies are provided for non-contributory pensions and for compensation of the deficit.

The rate of insurance contributions in the Pension Fund, which should be paid by insured persons, employers and self-insured are annually defined by the Act on the State Social Security Budget. The same Act defines the rates of contributions for the second pillar – professional and universal pension funds.

The general contribution rate for old age, invalidity and survivors pensions is **29%.** The state pays the entire contribution for civil servants and military officers. The self-employed (i.e. freelance professions, craftsmen, individual entrepreneurs, shareholders, farmers etc.) pay the full amount of contribution.

The employers pay 3% higher general contribution rate for the 2nd and 1st category of labour (harmful work conditions), as well as for the military servants. Next to this, all persons employed at the conditions of the 2nd and 1st category participate in the complementary professional pension insurance. This contribution is paid entirely by the employer.

The rates of contributions in the professional funds are **12% for 1stcategory and 7% for 2nd category.**

The universal complementary pension insurance involves persons, born after December 31, 1959. The amount of contribution is 2% of gross earning, shared between employers and employees in the same proportion, as in the mandatory system. The implementation of the compulsory complementary pension insurance does not increase the total fiscal burden for the insured persons. In 2002 the current 29% contribution for the persons born after 1959 will be divided between the **state pension insurance with 27% rate and the universal funds with 2% rate.**

The maximum monthly level of the insurance income is a common upper limit for all insured persons and for 2002 it is envisaged to be 850 BGN. For the self-insured persons there is also a minimum monthly level of the insurance income as follows:

- Minimum monthly rate of the insurance income for self-insured persons - 170 BGN;
- A preferential minimum monthly rate of the insurance income for agricultural producers – 85 BGN and 42.50 BGN for agricultural producers who perform only agricultural activities.

Figure 4 presents the structure of contributions in the Pension Fund. The administrative measures for contribution collection from the self-insured, such as implementation of a compulsory minimum of insurance income and unified control mechanism with tax administration, has had a positive effect from the view-point of fiscal compliance. The share of the self- insured persons in the social insurance revenues has increased from 5% to 16% over the past five years and in 2001 exceeded by 6 points the share of self-employed in the labour force. However, this high fiscal burden has a negative impact on the work incentive and is considered as a prerequisite for employment in the shadow economy.

The contributions for the second pillar (professional and universal schemes) are collected by the National Social Security Institute and then distributed among the private pension companies according to the number of their clients. The information system of NSSI allows to support a personal register for each insured person and to collect information for the contributions flows in both state and private pension schemes.

3.1.4 Incentives

The labour force participation rate was 50.4% in 2001. Because of the low real value of pensions, the economic activity of persons above the retirement age is relatively high – 35% for 55-60 age group and 11% for 60-65 age group.

The Bulgarian pension reform creates a tension on the labour market. The increase of pension age and the rising economic activity of the old-age

generation are acting in a destabilising way on the labour market, particularly in the short-term perspective. According to the experts' assessment there is no conflict between the younger and older workers as in most cases they compete in different sectors of the labour market. However, there are no special surveys conducted on the risk of unemployment related to the new parameters of the pension system.

Another negative factor for work incentives is the relatively high rate of contribution and the lack of targeted preferences for particular groups at the labour market, e.g. self-employed persons, young workers, part-time employed etc. In many European countries these groups benefit from payroll tax exemptions.

The new pension system has also a number of positive work incentives. In the first place, the direct correlation between the wages and benefits in the pension formula should be mentioned. The implementation of clear rules for financial transfers in the first and second pillar and the portability of individual accounts should also be considered as a factor for work incentive promotion. In the third place, some efforts have been made to decrease the fiscal burden in the last years. In 2001, the general rate for the Pension Fund diminished from 31% to 29%. In 2002 the minimum insurance income base for self-insured persons has been fixed as a nominal value and it will be no longer dependent on the minimum wage, which increases under the pressure of trade-unions and political considerations. Special preferences are implemented for farmers: their minimum insurance income is two times lower than that of the rest of the self-employed. Farmers can pay their contributions annually until March 31 of the following year, and not monthly.

3.1.5 Coverage of the System

The pension insurance system has a relatively broad coverage in Bulgaria. The personal scope of compulsory insured covers all employed and self-employed persons, except for the working pensioners. Since 2002 the persons employed in part-time job for less than 5 days (or 40 hours) per month have also been included in the scope of compulsory insurance.

The large informal sector of the economy explains the existence of workers, who are not covered by the compulsory pension insurance system (Table 3.4). According to the estimates of the National Statistical Institute, their number has been dropping gradually – from about 310,000 people in 1998 to about 220,000 people in 2001.

Data indicate a decrease in the number of insured persons in the state pension insurance due to the fact that the number of employed persons has decreased and the number of unemployed persons has increased during the past two years. There is also a slight decrease in the number of self-insured

persons as a result of an increase in the insurance basis income, which was related to the minimum wage in period between 1998-2001. The process of closing or freezing of activity of a significant number state owned companies at the end of the 90s was also a factor that limited coverage of the pension insurance for the persons affected by the mass lay-offs.

The increasing requirements for length of service creates risks for long-term unemployed people which will not be able to reach the required sum of points at the accomplishment of retirement age. The new formula for the pension calculation is also considered as a restrictive parameter in terms of pension amount. According to the legislation before 1999, the three most favorable years with the highest wage of the insured person, chosen among the last 15 years length of service, were considered as a basis income for the pension calculation. The new formula takes into account all income. The long periods of low-paid jobs for many categories of unskilled workers will stipulate lower benefits at the level of minimum pension. These risks will influence the accessibility of the pension system in a long-term perspective, because the reform in Bulgaria has been implemented step-by step during a transitional period. The increase of eligibility conditions, e.g. retirement age and length of insurance, is previewed for a period of 10 years starting in 2000. The new pension formula includes the ”three most favorable years” for the length of insurance before January 1, 1997, thus allowing gradual substitution of the old provision by the new one.

The main source of quantitative data for the coverage of the pension system, as well as for the potential risks of exclusion, is the sociological survey ”Social Impact Assessment of the Pension Reform on the Risk Groups of Population”. It was commissioned by the United Nation Development Program in 2000 and conducted by the Club Economica. Five groups at-risk are envisaged according to the survey, e.g. unemployed, social assistance beneficiaries, disabled, large families and ethnic minorities. The unemployed takes the most disadvantaged position (Table 3.5). About one quarter of the unemployed participate in economic activities, of which 5% are legally insured, mainly under the public work programs. The rest 23.5% are working without insurance contributions, that means they are included in the shadow economy. The percentage of non-insured persons of this category is highest for the Gypsy’s minority. The coverage of the insurance system within this group is 12%, while at average it is 36% for the whole population.

The lowest length of insurance is registered for Gypsies and the large families. For the first group this fact is due to the long periods of unemployment. The periods of bringing up of the children are also an important constraint for participation in the labour market. This factor is considered in the new legislation where the periods of maternity leave are considered as a ”granted length of service” without equivalent contributions.

There is no significant gender difference of the coverage of pension insurance. The eligibility conditions for women are more favorable (three years lower retirement age and 6 years lower sum of points), thus taking into account the periods of non-employment due to family reasons. At the same time, the periods of paid maternity and parental leave are considered as a length of service.

The average duration of old- age pensions is 16 years according to NSSI statistics. The period of receipt for women is 18 years and for men it is 15 years. The data for all types of pensions, including disability and survivors benefits confirm the relatively favorable female positions. The duration of pension is 21 years for women and 16 for men.

3.1.6 Public Acceptance of the System

As a basic element of the social protection system, the pension insurance is a specific area of representation of interests of different groups of society: active population and pensioners, employers and trade-unions, different political parties.

The postponed reform of the pension insurance (about 10 years after the beginning of the transition to market economy) was due to the lack of consensus and opposition of the radical changes from both social and economic view points. Despite that, the first two years of the implementation of the new multi-pillar system since 2000 was successful according to the estimates of the Government, the Parliament and the organizations of the employers and employees, presented in the publication of the Bulgarian Pension Project (2001) ”Bulgarian Pension Model. One Year After the Start.

The public information campaign coincided with the drafting of the Pension Reform Strategy in 1998, i.e. long before the adoption of the new legislation. The preparation of the pension Reform Strategy and the draft laws were discussed and presented by means of a large-scale public awareness campaign. The preparation of the reform was also accompanied by a series of sociological surveys.

At the same time, the United States Agency for International Development has supported the establishment of a *Hot Phone Line for Pensions* managed by an independent team of trained persons which has a double function: to provide explanation to the public of all rights and obligations under the new pension legislation and, at the same time, to receive feedback on how the system is accepted by the public. The first report shows that ”the complicated and deep pension reform is accepted without important breakdowns” (Bulgarian Pension Project, 2001).

More detailed information about the public acceptance could be obtained from the survey of Club Economica "Social Impact Assessment of the Pension Reform on the Risk Groups of Population" (2000). The positive attitudes toward the pension reform prevails (59% of the respondents), but there are negative opinions expressed on some parameters of the reform that restricts the access to the pension insurance: increase of the pension age and required length of insurance, redistribution of the insurance burden between the employer and employee etc. Particularly affected are the long-term unemployed persons and the disadvantaged groups at the labour market e.g. minorities, disabled, single mothers. Data lead to the conclusion that these groups need special protection in order to ensure their integration at the labour market, which is considered as a main prerequisite for social inclusion.

3.2 Evaluation of Current Challenges

3.2.1 Main Challenges

The pension system inherited form the planed economy and developed before the reform in 2000 had to cope with a number of challenges. The collapse of the revenue side was the most important one. Prior to the transition the contribution system relied on large state owned enterprises. With the beginning of privatisation this system became more and more incapable to guarantee compliance of the revenue.

This change was similar, though more drastic, than in other Eastern European States. That is why the contributions collection from the private sector became more and more difficult during the transition. By the end of the 90s the private sector accounted for 60% of economic activity, but only for 10% of social security revenues. Another challenge was the dramatic increase of unemployment and emigration of the active population, which exacerbated the problems of demographic burden over the active working population. The lack of financial sustainability lead to an increase in poverty amongst the old age population. The income distribution of pensioners was concentrated at the lowest strata (Figure 5), thus endangering the principle of solidarity and social justice.

In the first few years of the transition towards market economy, the reaction was piecemeal steps to improve the performance of the social security system:

- A gradual institutional and financial separation of the security system from the state structure and the state budget;
- the implementation of tripartite management of the security funds;
- An attempt to support the amount of benefits in real terms and payment of anti-inflation compensations;

- The enlargement of the personal scope of pension insurance and the inclusion of self-employed;
- The development of a voluntary pension insurance (without special regulations and tax exemptions until 1999).

Nevertheless, the early reforms did not bring substantial results because of their partial nature; they were seen as insufficient and ineffective. The particularly high contribution rate had a disincentive effect at the labour market and at the same time it was insufficient to support the real value of pensions at the existing eligibility conditions. As a result, the system as a whole was rapidly losing its credibility.

The first radical reform in 2000 introduced a close binding between the pensions and the contribution in the insurance system and eliminated the largest part of the privileges such as granted insurance rights without real participation in the insurance system.

The pension system is in a process of development. That is why, when pointing at the challenges of the pension system, we have to take into account at which stage of reform we actually are. The realized reform is simultaneously parametric and structural - i.e. along with *parameters* such as the extent of the insurance payments and their distribution between employer and employee, age and insurance practice for access to pension, the extent of the pensions and others, the *structure* of the pension system itself has changed - a second and a third pillar on a capital principle have been introduced, with individual accounts.

The structural part of the reform is almost finished. The whole pack of normative documents is in force for the three pillars of the pension system. The institutional infrastructure is built - the NSSI is an autonomous institution with a Supervisory Board, formed on the tripartite principle. The functions of the NSSI concerning the supplementary insurance are extended - collection of the insurance payments and transfer to the pension funds of the second pillar. The main forthcoming steps and challenges in the field of structural development are:

- transfer of a part of the pension insurance payments from the first pillar to the universal supplementary funds, starting since 2002;
- complete assuming of the early retirement by the professional funds as of year 2010;
- further integration of all insurance institutions and establishment of a Unified Revenue Agency that would be responsible for tax collection and collection of contributions for all social security funds.

In the parametric part of the reform, the forthcoming steps include:

- gradual decrease of the ratio employed persons - pensioners by reaching the minimum age for retirement of 63 years for the men and 60 years for the women, respectively 100 and 94 points in 2009;
- universalization of the retirement regimes after the expiry of the transitional period up to year 2004 for some spheres as defence, police, extractive branches and others in which radical reforms are carried on with a mass discharge of the labor force;
- gradual equalization of the participation of employees and employers in the insurance payments up to 2007;
- in case of a better financial condition, changes in the parameters of the pension formula are possible too - for instance one year length of insurance to have a higher share (now this share is 1 per cent);
- It is possible that other changes in the parameters should impose themselves during the negotiations with the European Union (for instance a gradual equalization of the retirement age of men and women).

3.2.2 Financial Sustainability

The expenditure for pensions came to for 8% of GDP in 1995, to 9.6% in 2000 and 9.0% in 2001. This is not a high share compared to other European countries, though there is an increase after the reform implementation in 2000. Restraints in expenditures at the end of 90s in part reflect the macroeconomic priority accorded to stabilisation in the currency board period. At the same time, the deterioration in the demographic structure and the lowering economic performance lead to a relative decrease of revenues.

One of the main goals of the building of a tree-pillars pension system in Bulgaria was the financial stabilization of the mandatory state social insurance and guaranteeing of its sustainable development.

The actuarial projections before the start of the reform showed an impending financial collapse of the old pension system as a result of the accumulation of non-contributory eligibility rights. In order to prevent this, in 1999 it was necessary to either increase the pension contributions rate from 35% to 60%, or to reduce the replacement rate from 30% to 20%. The pension reform was designed to avert these alternatives, both leading to negative social and economic consequences.

The increases in retirement ages and changes to first pillar pension entitlements are already reducing the implicit debt considerably. As the system's balance gradually shifts towards fully funded pillars, this effect should be reinforced.

Nevertheless, after the reform the Pensions Fund will still need subsidies for the next 6-7 years. The new retirement age and insurance records are

gradually implemented for a period of 10 years. The system will become financially sustainable only after then, when the effect of the restrictive measures as regards the eligibility conditions is felt. At the same time, the subsidies are needed because of the political aim to implement the second pillar without increasing the total financial burden for the active population and even to reduce it. In 2001 the decrease of the contribution rate for the Pension Fund from 31% to 29% was compensated by a transfer from the state budget equal to about BGN 391 million (Table 3.6). In 2002 the shift of 2% contribution rate from the first pillar to the universal supplementary funds was also covered by a subsidy from the state budget. The total amount of transfers for compensation of social costs of the reform increased to about BGN 476 million (EURO 240 million).

3.2.3 Pension Policy and EU Accession

The main issues in the field of pension insurance that are raised by the 2001 Regular Report of European Commission for the Progress of Bulgaria for Membership, are related to the administrative and judiciary capacity of the system. Bulgaria has to develop the administrative capacity and the financial stability of the national social security system in order to be prepared in advance to meet the requirements for the full implementation of the *acquis communataire* for coordination of social security schemes of migrant workers upon the accession (Regulations (EEC) № 1408/71 and (EEC) 574/72).

The labour migration from Bulgaria to the Western Europe has been estimated at about 300 000 persons for the last 10 years. Recognition of their insurance contributions and the export of benefits for these persons turns into a considerable social issue in the context of EU accession. This results in the necessity for concluding bilateral agreements in pension insurance with the Member States before the accession. In 1999 Bulgaria concluded a new agreement for pension insurance with Germany in compliance with the requirements of Regulation (EEC) 1408/71. Up to the present negotiations are being carried out on draft agreements with Spain and the Netherlands. Negotiations with Greece, Austria and Portugal are planned.

There are also some constraints of harmonization related to the free movement of capital, particularly of the assets of supplementary pension funds. For the time being the legislation stipulates restrictions resulting from the necessity of minimization of the financial risks during the initial stage of the establishment of private pension funds: Foreign persons are allowed to be shareholders or founders of private pension insurance companies only if they are licensed under Bulgarian legislation and if they submit bank warranties confirmed by the Bulgarian national Bank. Next to this, pension insurance companies are entitled to invest no more than 10% of its assets abroad, in state securities of other states and equities of foreign capital

markets. This limitation is considered as an obstacle for the free movement of capitals within the EU. It is also a negative factor for competitiveness of private pension funds. Thus, it should be removed upon accession.

3.3 Evaluation of Recent and Planned Reforms

3.3.1 Recent Reforms and Their Objectives

The three-pillar pension system that was set up in Bulgaria is based on the principle "security through diversity". It is developed in compliance with the framework of stabilization macroeconomic policy. The main goal of the new Code for Compulsory Social Insurance is guaranteeing long-term financial stability. The amendments envisaged for 2002 provide for the progress in the following main directions:

- Administrative measure for achievement of financial balance between the contributions and benefits and compensation of social cost of the pension reform through subsidy from the state budget;
- Consolidation of insurance revenues and combining insurance against unemployment with the overall state social security scheme;
- Establishment of a modern information system that comprises a personal register for the entire insured population and full records of contributions paid by the employers, employees and self-employed for the first and second pillar.

In the medium term perspective there are two main directions that will be a focus point of the pension reform: strengthening administrative capacity of the National Social Security Institute for providing high quality services to the pensioners and increasing efforts for collection of contributions.

Strengthening administrative capacity

The NSSI has a policy to improve the quality of service by making offices and services accessible to all customers, setting performance standards, training of the staff etc. Another way to improve the quality of services is to monitor the number, grounds and outcome of complaints and appeals in order to identify and solve the systemic problems.

Payment of pensions is undertaken by banks electronically and by post offices personally. It is done on a monthly basis. National Social Security Institute is obliged by law to provide information to the pensioners for the amount of the pension and all questions, related to their eligibility.

Contribution collection

The level of compliance in contributions collection is of key importance to the functioning of the pension system. This is attempted both by improving incentives and the enforcement of control.

Special measures are undertaken for the collection of the arrears that were an important problem at the end of 90s due to the decreasing economic performance in many of the state owned or recently privatised enterprises. The new legislation allows employers to apply for prolonged payment of the dept according to a financial plan for a maximum of 3 years. The plan has to be approved by the Governor or the Supervisory Board of NSSI. In this way the stock arrears decreased significantly and the financial discipline improved in the past two years (Table 3.6).

The new information system mentioned above, allows to analyse the compliance and to make risk profile of the enterprises according to their economic performance. Another measure for increasing compliance is the establishment of a Unified Revenue Agency planed for 2003-2004 period. This institution would be responsible for tax collection and collection of contributions for all social security funds thus enhancing the capacity to control the compliance with lower administrative costs.

3.3.2 Political Directions of Future Reforms

The reform of the pension system in Bulgaria enjoyed a broad political support and active involvement by the social partners. The consensus was based on the following essential preconditions:

- General dissatisfaction with the old pension system and the projections of its inevitable financial collapse;
- Willingness to accept the short term ”social cost” of the restrictive measures;
- Lack of alternative proposals of the political opposition, regarding the pension reform.
- The impression of a ”fresh start” created relatively good media and hence public support;
- The nature and design of the transition period allowed for different age groups to come to terms with the new arrangements.
- Willingness by external donors and international organizations to support the reform both through technical assistance (such as EU Phare Program, British Know-How Fund, United Nations Development Program) and initial deficit reimbursements loans (IMF and the World Bank).

The declared policy aim is to reduce the fiscal burden of the pension system over the active population thus aiming at economic competitiveness. This goal can be achieved by two different type of measures:

- the expenditures should be kept constant or reduced following the schedule for increase of retirement age;
- a restructuring of revenues should be undertaken, which involves a shift of a part of the functions in pension insurance toward the supplementary insurance and a substitution of the temporary deficit by tax-financed revenues (subsidies from the state budget).

At the same time there are a set of measures for rationalizing administration that would help for the realisation of both expenditure-oriented and revenue-oriented measures.

3.3.3 Conclusions

The success of the pension reform in Bulgaria will be determined in the coming years. It will depend on the success of the new funded pillars, and whether that will lead to a growth in financial markets and can enable further reductions in contribution rates. The specific evaluation refers to the following issues: demographic impact, financial and economic implications and social inclusion.

How does the new pension system cope with demographic problems?

The gradual increase of the minimal age for retirement and the balance of expenditures for those entitled to an early pension from the professional funds are the immediate measure to combat the unfavorable demographic changes. The extent of the funded pillars will in the future act as a supplementary incentive to postpone retirement.

What is new system's impact on financial sector developments?

The new pension system in Bulgaria influences directly the development of the financial sector. As principal institutional investors, the pension insurance companies are expected to influence to a large extent the development of the capital markets. At the same time, they will favor the development of new alternative instruments for investments like mortgages, depository orders and so on.

What is new system's impact on economic growth?

The pension reform in Bulgaria includes the stimulation of economic growth as an implicit aim. It will be successful if the expansion of coverage and

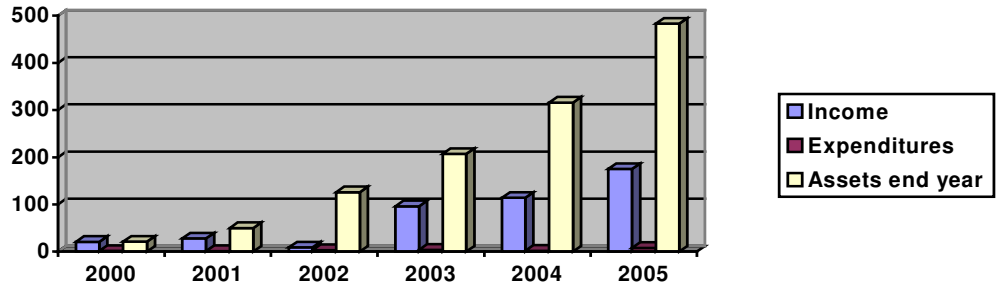
increasing compliance allow a fall of contribution rate over time, thus stimulating economic performance and competitiveness.

How does the new system improve social inclusion?

The immediate effect of reform and viability of the first pillar is to reduce political risk and increase the credibility of the pension system as a whole. An area of future concern, however, should be dealing with the position of disadvantaged groups at the labour market. The emphasis on contribution may lead to the exclusion of low qualified workers, minorities and disabled persons, and possibly to a greater reliance to social assistance.

3.4 Annex to chapter three

Figure 3.1: Forecast plans for the assets of the pension funds in the second pillar (BGN million)



Source: Social Insurance Supervision Agency, 2001

Figure 3.2: Forecast plans for the assets of the pension funds in the third pillar (BGN million)

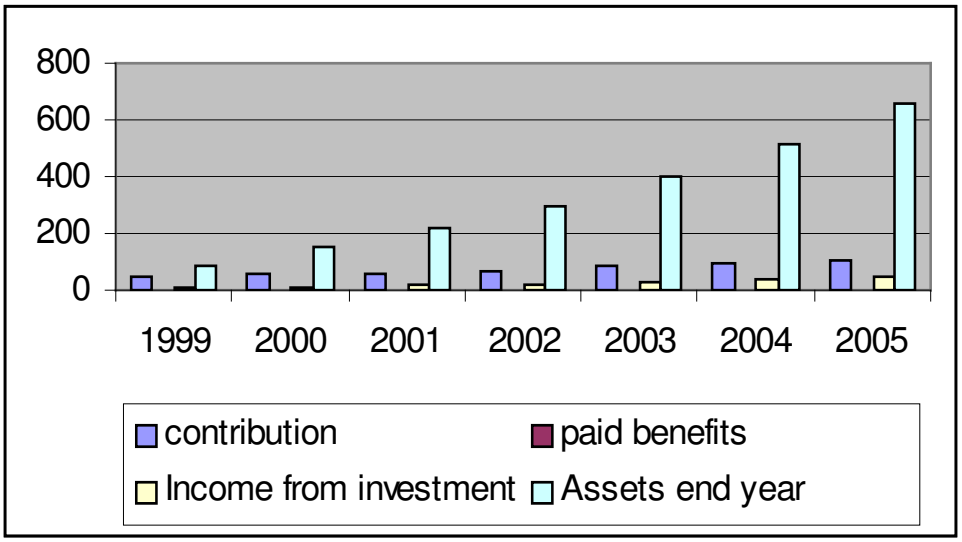
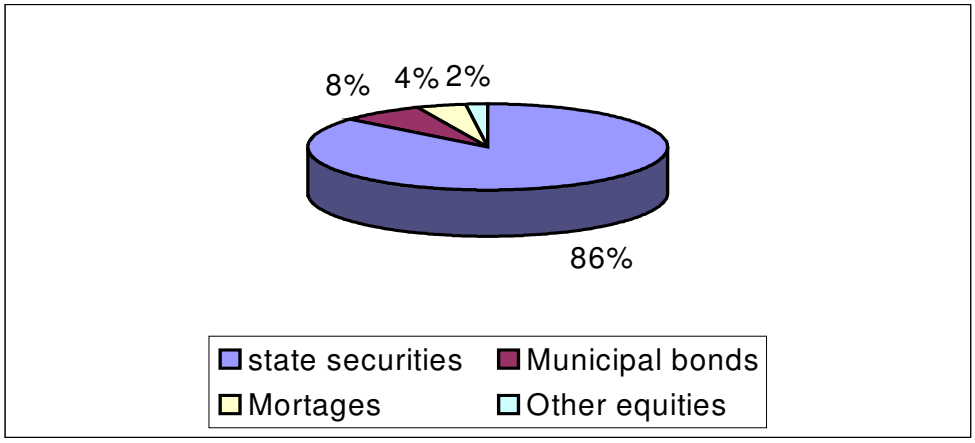
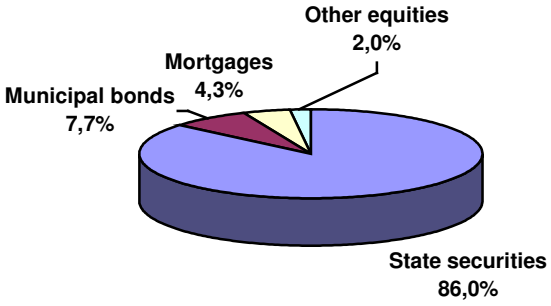


Figure 3.3: Portfolio of private pension funds (2001)





Source: Social Insurance Supervision Agency, 2001

Table 3.1: Time Schedule for Retirement Age Increases

Year	**Men**		**Women**	
	Age	Points	Age	Points
2000	60.5	98	55.5	88
2001	61	99	56	89
2002	61.5	100	56.5	90
2003	62	100	57	90
2004	62.5	100	57.5	91
2005	63	100	58	92
2006	63.5	100	58.5	93
2007	64	100	59	94
2008	64.5	100	59.5	94
2009	65	100	60	94

Table 3.2: Composition of income in households of pensioners (as % of total)

	Households of pensioners	**Average for the country**
Wages	6.7	44.8
Entrepreneurship	0.2	4.1
Property	1.1	O.7
Pension	60.5	21.7
Other social benefits	0.3	3.2
Household's plot	22.4	1.5
Sales	0.3	0.4
Other income	8.5	8.1
Total gross income	100	100

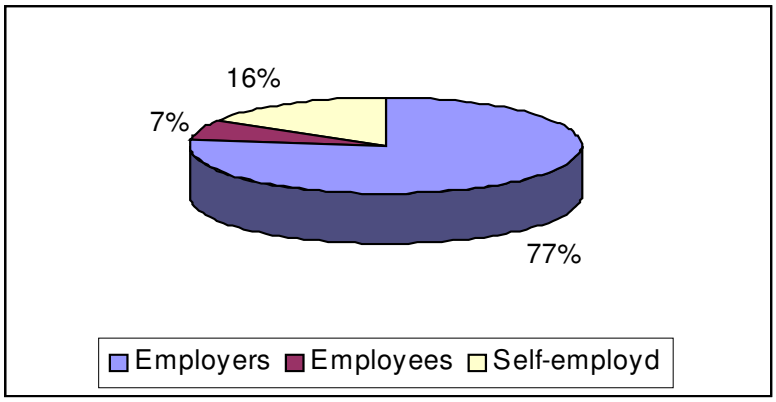
Source: Households' budget survey, National Statistical Institute, 2001

Table 3.3: Basic Indicators in Pension Insurance

	1998	**1999**	**2000**	**2001**
Minimum amount of pension /BGN/	31.68	35.83	40.00	42.00
Average amount per one pensioner /BGN/	62.10	66.93	83.42	90.72
Maximum pension amount /BGN/	95.03	107.47	160.00	168.00
Average insurance income /BGN/	164.79	180.05	217.11	241.98
Average wage /BGN/	187.44	205.05	230.00	263.00
Expenditure for pensions as a percentage of GDP	8.2	8.4	9.6	9.0
Replacement ratios:				
Min. pension amount to average insurable income	19.2%	19.9%	18.4%	17.4%
Min. pension amount to average wage	16.9%	17.5%	17.4%	16.0%
Max pension amount to average insurable income	57.7%	59.7%	73.7%	69.4%
Max. pension amount to average wage	50.7%	52.4%	69.6%	63.9%
Average amount to average insurable income	37.7%	37.2%	38.4%	37.5%
Average amount to average wage	33.1%	32.6%	36.3%	34.5%

Source: National Social Security Institute

Figure 3.4: Structure of Social Insurance Contributions - 2001



Source: National Social Security Institute

Table 3.4:. Employment and Coverage of Pension Insurance

(thousands persons)

	1998	**1999**	**2000**	**2001**
Employed	3,145	2,971	2,872	2,907
Employees	2,697	2,562	2,387	2,417
Self-employed	3,85	355	388	393
Contributors to NSSI	2,274	2,232	2,230	2,193
Employees	2,039	1,953	1,927	2,037
Self employed	234	202	189	156
Coverage rate (% contributors/employed)	72.2	75.2	77.6	75.4
Employees	75.6	76.2	80.7	84.2
Self employed	60.7	57.1	48.7	40.0

Source: National Social Security Institute, 2001

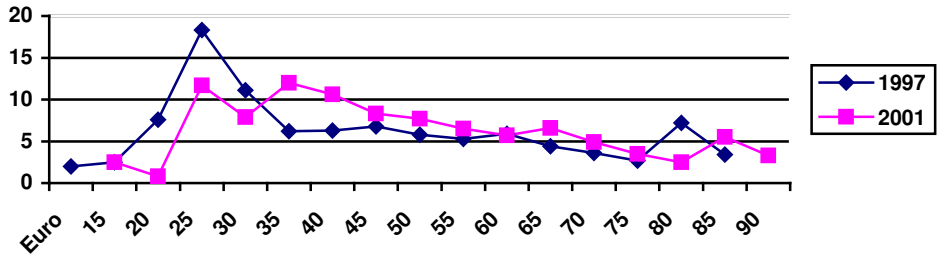
Table 3.5: Do you pay social insurance contributions?

(as % of the respective risk group)

	Yes, for all risks	Yes, for pension only	I am working, but not insured	I am not working	Total
Unemployed	2.5	2.6	23.5	71.3	100
Social Assistance beneficiaries	10.0	4.3	19.6	66.1	100
Disabled	1.9	6.5	15.7	75.9	100
Large families	34.9	0	16.5	48.6	100
Gypsies	11.1	0.9	27.2	60.8	100
Turks	21.3	4.5	16.1	58.1	100
Total	30.5	5.8	16.1	47.6	100

Source: ”Social Impact Assessment of the Pension Reform on the Risk Groups of Population”, Club Economica 2000

Figure 3.5: Changes in Income Distribution of Pensioners (1998-2001)



Source: National Statistical Institute, 2001

Table 3.6: Indicators for Financial Management of the Pension Fund

BGN million	1997	1998	1999	2000	2001
Expenditures for pensions	1,077	1,803	1,952	2,534	2,509
Deficit covered by subsidies	162	153	167	177	391
- as % GDP	0.9	0.7	0.7	0.7	1.4
Arrears of contributions:					
Stock	50	99	222	324	331
Flow	27	48	122	109	7

Source: National Social Security Institute

Table 3.7: Insured persons and pensioners (in thousands)

	1995	1996	1997	1998	1999	2000	2001
Insured persons	3,092	3,473	3,450	3,326	2,863	2,306	2.194
Pensioners	2,409	2,381	2,391	2,387	2,380	2,375	2.370
Dependency ratio	1.28	1.46	1.44	1.39	1.20	0.97	0.93

Source: NSSI, 2001

4. POVERTY AND SOCIAL EXCLUSION

4.1 Evaluation of Current Profiles of Poverty and Social Exclusion

4.1.1 Social Exclusion and Poverty Within the Overall Social Protection System

Two periods can be demarcated in the welfare changes during the transition process in Bulgaria. In the first period from 1991 to the mid 90s, the poverty had mostly quantitative aspects, such as inflation erosion of all types of income (Figure 1), increase of unemployed people and other transient factors.

After the acute economic and financial crisis in 1996, a Currency Board was introduced in Bulgaria as a new type of stabilisation policy. As a consequence, the inflation rate dropped down significantly and the real income as a whole started to get back to the level before the economic crises 1996-1997 (Figure 1). During this period stabilisation of quantitative indicators such as the poverty rate and the real income is observed. According to the draft findings of the World Bank poverty assessment in 2002 poverty dramatically decreased since 1997[3]. Despite that, the poverty rate in 2001 still remains high at the level of 11,2% , which is twice higher compared to 1995. Poverty gap indicators is decreasing significantly in 1997-2001 period, as well as the Gini coefficient measuring income inequality for the whole population.

Table 4.1: Trends in Poverty

	1995	**1997**	**2001**
Poverty rate	5.5%	36%	11.7%
Poverty gap index	0.8	5.3	1.7
Gini coefficient	27.1	31.4	29.5

Source: World Bank Poverty Assessment, 2002, draft results

At the same time, rising marginalisation and durable risk factors emerged for the lowest income groups, thus defining more qualitative than quantitative aspects of poverty. The share of long term unemployed people registered at the labour offices gradually increased from 28.6% in 1995 to 49.8% in 2001. According to the estimates of social workers more than 80% of the beneficiaries of social assistance are ”chronically” poor.

[3] Draft results presented at a workshop in Sofia, April 4-5, 2002

The research on poverty conducted by international and local organisations in the last ten years of transition confirms how problematic poverty for the overall economic and social development of Bulgaria is.[4]

The policy agenda in the last ten years focused on income poverty and deprivation, rather than on social exclusion and access to employment, education, health care, environment and the possibility to participate in the social, cultural and political life of the community. The public opinion reflects the same understanding that poverty is caused mainly by unequal remuneration and income stratification. The international comparative survey "Social Justice" conducted by the Centre for the Study of Democracy in 1991 and 1996 allows to compare peoples' self-estimation with regard to the poverty origins. Most of the interviewed in both surveys found the reasons for poverty to be the collapse of the economic system and the lack of equal starting opportunities at the beginning of transition process. (Table 4.1) The 2001 report of the Candidate Countries Eurobarometer confirms the pessimistic attitudes of Bulgarian population 12 years after the start of transition: less than one third of the 15 year old and older population were satisfied with their lives in Bulgaria, which takes the latest position amongst the candidate countries. The ratio of the not-at-all satisfied respondents reached almost one third of the population. At 55%, people in Bulgaria are most likely to say that their personal economic situation got worse during the past five years.

The Action Plan of the new government elected in 2001 gives special emphasis on the causes of poverty and preventive measures such as active labour market programs for reintegration of the risk groups, vocational training, entrepreneurship and the increase of the real income of the population as a whole. The new governmental program promotes a capability based approach of social protection instead of compensating people for being poor. Ministry of Labour and Social Policy plans to involve all economically active recipients of social assistance benefits in public work programs. This approach could be considered as a step toward broader consideration of qualitative aspects of deprivation and social exclusion, e.g. the ability of gaining access to employment, education and other public goods.

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[4] United Nations Development Program (1996-2000) National Human Development Report. Bulgaria; United Nations Development Program, International Labour Office (1998) The Poverty in Transition. Strengthening the National Policies and Strategies for Poverty Alleviation; UNICEF (1998) Women in Poverty, Regional monitoring report No5, ICDC, Florence, Italy; World Bank (1999) Bulgaria: Poverty During the Transition

4.1.2 National Definitions of Poverty and Social Exclusion

The issue of poverty was formally recognised by the government for the first time in March 1991 when the so called "second safety net" was set up. However, there is still no official poverty line to determine who, and how many are poor and there is no consensus how to combine the two main conflicting considerations: On the one hand, the poverty line should provide a minimum standard of living which includes recognition of the need for adequate consumption and a decent life. One the other hand, there is a political commitment of the government to provide social assistance to the poorest strata of population with a notion of poverty that tends to be indirectly adjusted to the affordable public expenditure.

Definition of Poverty Lines

The poverty lines that are applied for research or practical purposes in Bulgaria are described in the study "Poverty in Transition: Strengthening the National Policies and Strategies for Poverty Reduction in Bulgaria" (ILO, UNDP 1999). The study aimed to recommend an appropriate methodology for poverty line calculation and herewith to support the public debate. The main objective of the study was to recommend a methodology for setting an official poverty line. However the recommendation for regular monitoring of poverty has not been applied in the policy. The main reason was the lack of consensus between the government and the trade-unions on the positioning of poverty line.

Nine methods for poverty line calculation have been described in the report. Some of the methods, e.g. the consumer basket, are regularly applied since the beginning of the transition process. Other methods, such as relative lines of the World Bank and UNICEF are used episodically for the purpose of comparative international studies. Table 4.2 presents the amounts of the respective lines in 1997, when the comparative analysis was carried out. Table 4.8 shows the dynamic of poverty measured according to the applied poverty lines in 1997 updated by Households Budget Survey data until 2001.

The **absolute poverty line** based on a consumption basket method is the one applied most often, and boasts of the longest tradition in practice. According to the accepted definition, poor are those households (people) whose income is less than the defined minimum guaranteeing them to purchase a restricted number of basic needs (food, housing, clothing, goods and services). In the 1991-1998 period, the absolute line was calculated by the **Ministry of Labour and Social Policy** based on two consumer baskets: social minimum and subsistence minimum. The second was established in 1995 with a reduced composition and weights – here with attempting to adapt its structure and contents to the reduced standards of living of the population. The subsistence minimum contains 184 commodities of which 70 are food items and 114 are other goods. Despite the achieved reduction of

the line, the poverty level remained high and it seemed a luxury for a society to label those individuals as poor whose income approximates the average.

That is why in the last 3 years the absolute poverty line is calculated only by a research team of the **Institute for Trade Union and Social Studies** using the so called "basic needs consumer basket". The structure and weights of goods in the basic needs consumer basket reflect consumption patterns of II and III decile groups of population and take into consideration the standards of FAO and WHO (average daily intake of 2002 calories). In December 2001, the amount of this line was BGN 112 .

Of particular importance is the **Guaranteed Minimum Income** (GMI) introduced in 1992 for the purposes of social assistance. It is used as a threshold for the definition of beneficiaries and the calculation of the amount of social assistance benefits. In 1992 it was calculated on the basis of a consumer basket of 22 food items and energy expenditure. Later the government indexed GMI periodically taking into account both the inflation rate and the budget resources available for social assistance. That is why now the purchasing capacity of GMI is lower compared to the initial consumption basket. In 2000 its purchasing capacity covered 1/3 of the food basket defined in 1992. It could not guarantee the recommended daily intake of calories. Despite that, at present, the level of GMI is one of the unofficial poverty lines in Bulgaria.

The **relative line of poverty** is defined as having less than others in society. It correlates to the average living standard for a specific country. This measurement of poverty is known mainly theoretically in Bulgaria and in some cases it is used in academic studies. In 1993 UNICEF defined 50% of the average salary as poverty line, and used this to identify the number of the poor. The measure of 45% of the average salary was used to identify the number of the very poor.

A relative poverty line was also applied by the experts of the World Bank for a panel study in 1994 and 1997, when it was defined as 66% and 50% of the average expenditure per person in a household, respectively for poor and very poor individuals. The lower poverty line according to this method in September 1997 is BGN 44. The incidence of poverty, expressed as a headcount ratio, was 23% and it was significantly below the poverty incidence calculated for the absolute line of the Ministry of Labour and Social Policy and the one of the trade-unions for the same year.

One of the modern approaches to the definition and measurement of poverty is the subjective poverty line. This concept of poverty is based on the perception of the individuals, resulting from his/her previous and current economic status. According to a survey carried out by the National Statistical Institute the perception of poor existence presented by the

households is related to a monthly income about 20 USD. (ILO, UNDP 1998)

The United Nations Development Program monitors poverty through the **Human Development Index** that includes qualitative measures too, e.g. GDP per capita, level of education (measured by adult literacy and gross enrolment ratio) and life expectancy. The data presented in the National Human Development Reports for Bulgaria (UNDP 1996-2000) has also contributed to the broader understanding of poverty and deprivation. However, the need to ensure compatibility of these indicators for all over the world inevitably implies limits and reduces the content of information to the basic needs only. In 1995-2000 period the Human Development Index in Bulgaria fell from 0.797 to 0.795. The main negative factors are drop of the gross enrolment ratio from 63.6% to 63.0% and decrease of the life expectancy at birth from 70.6 years to 70.4 years.

Vulnerable Groups

Vulnerability has two sides: the first is related to the risk, coming from the social environment. The second concerns the personal deficits of the individual and the lack of capability to overcome them without external support, e.g. social assistance.

It has to be mentioned that in Bulgaria prior to the transition the notion of poverty has never been used in the social policy, but the notion ”socially-weak groups” was implemented in the pre-reform social assistance legislation as a criteria for being entitled to benefits. These were groups affected by the health of family risk which lower their capacity to work. The legal definition of ‘vulnerable groups’ was given in the Decree for Social Assistance (1951) and included the elderly, the disabled, orphans, large families, single mothers, soldiers families and so on.

The liberalisation of the economy and the labour market imposed radical reforms of the social assistance system. The main goal was to guarantee minimum resources for all citizens affected by the unemployment and poverty through means tested benefits. At the same time some of the categorical benefits have been saved in the specific legislation targeted for some groups of people.

The *Law for Family Benefits(2002)* contains provisions for means-tested family benefits and parental leave for uninsured parents.

1. The legal definition of disabled persons is given by the *Law for*
2. Integration, Rehabilitation and Social Integration of the Disabled (1995).
3. The Code for Compulsory Social Insurance (1999) defines non

4. contributory benefits for the elderly and the disabled that are not qualified for contributory pension schemes.
5. The Law for Encouraging Employment (2002) provides targeted
6. programs in favour of the youth, orphans, long-term unemployed, the disabled, single mothers and former prisoners.

Some of the studies on poverty, conducted in the last years, contain specific definitions of the vulnerable groups (”At-Risk Groups and Social Problems in the Bulgarian society” of the Center for the Study of Democracy (1995), ”Social Impact Assessment of Pension reform on the Risk Groups of Population” conducted by Club Economica (2000), Vocational education and Training Against Social Exclusion of ITF (2000). These studies used common methodology. For the purpose of identification of the vulnerable groups statistical profiles are outlined, showing how poverty correlates with the respective factors for social exclusion and characteristic features of the groups (employment, education, gender, age, health, family status, place of residence). The poverty risk is formally determined as a ratio of the number of households with incomes below the respective poverty line to the total number of households from the particular group. The poverty profile updated according to the 2001 data of the Households Budget Survey are presented in Table 4.9. Data shows that unemployment, combined with the bigger number of dependent children in the family increases the risk of extreme poverty. Economically inactive persons (e.g. pensioners and disables) are entitled to social insurance benefits and their income is above the lower poverty line (EURO 20). This fact indicates broad coverage of social insurance system. However the insured persons meet high poverty risk measured by the upper poverty line (EURO 30), because of the relatively lower level of pensions.

According to the World Bank Country Assistance Strategy Report (29327-BUL) the nature of poverty has changed, and deep poverty persists among certain vulnerable groups. Despite the improvements since 1997, poverty remains at twice the levels of 1995 when it was measured at 5.5 per cent. The nature of poverty has evolved, as recent improvements in welfare have not been equally distributed across the population. There are ”pockets of poverty” among certain groups, particularly the unemployed, ethnic minorities, most notably Roma, and families with more than four children. Roma are ten times more likely to be poor than ethnic Bulgarians. Poverty also has a significant rural dimension. Urban areas experienced a more significant drop in poverty levels since 1997, from 34% to 6%, while in rural areas poverty rates were less than halved from 41% to 24. Considerable scope remains to obtain further reduction of poverty through the development of targeted poverty intervention (e.g. for the Roma) and improving the targeting of social assistance, particularly social assistance to mitigate the impact of restructuring. Moreover, capacity in the Government

to monitor poverty and assess the impact of policies on vulnerable groups needs to be strengthened.

Interrelationship between poverty and unemployment

The economic profile of the poor could be identified following socio-economic status of the head of households living below the poverty line.[5] This profile reveals two particularly disadvantaged groups. The first one comprises households of unemployed, e.g. those of long-term unemployed with expired period of benefits, who prevail among the very poor, and unemployed who receive benefits, but they are below the level of poverty line. They are more than half of all poor households (51%). The direct correlation between poverty and unemployment allows to identify poverty in the regions with highest unemployment and restructuring industry, as well as among the groups in disadvantaged position at the labour market, e.g. unskilled workers, minorities and other groups described in section 4.2.1.

The second group with high probability to be poor comprises households of low-paid employed. It is symptomatic that below the lower poverty line fall also households of employed people, whose salary is close to the minimum wage. Their high share (21% of the poor) indicates that the minimum wage does not prevent the employed and their families from poverty. Economically inactive persons include pensioners, disabled, voluntary non-employed and other persons out of the labour force. This category is in relatively better position below the lower poverty line, compared to the unemployed (24%).

The structure of the poor households by professional status reveals the same disadvantaged position of the unemployed, whose relative share is preserved over 50% below the poverty line. The share of poor households of qualified workers is also high – 17%. This is due to the fact that they often accept low-paid jobs instead of the alternative – staying unemployed. This situation affects particularly graduates of so called Technicumes (secondary vocational schools that provide qualification in special branches of industry). Before the transition their profile was oriented towards the former structure of the state-owned real sector. That is why in the last 10 years the qualification of many of the persons with secondary vocational education become inadequate to the needs of privatised and modernised industrial enterprises. The unfavourable position of qualified workers indicates significant discrepancies at the labour market and violation of the principle that higher qualification brings higher wages. Some of the farmers are also affected by the risk of poverty and social exclusion. The most

[5] The economic profile of poor households is described on the bases of the Household Budgets Survey of NSI. The poverty line used for definition of poor is 66% of the average expenditures (applied by the World Bank poverty assessment in 1997).

vulnerable are workers employed in tobacco production. Most of them belong to the Turkish minority. More than ¾ of the plants are of oriental tobacco, which does not correspond to the EU standards for content of nicotine. Taking into account the existing structure of production the government proposed 6 years transitional period for acceptance of *acquis communautaire* referring to the tobacco products (Chapter 13 of EU talks). At the same time, the government undertakes additional supportive measures in favour of tobacco producers – the price of the rough tobacco is subsidized by a targeted extra-budgetary fund.

4.1.3 18 EU Indicators of Social Exclusion

Most of the indicators of poverty and social exclusion have been under constant statistical observation and analysis in Bulgaria. The main source of information is the Household Budget Survey conducted by the National Statistical Institute. The information is related to income, expenditure and consumption of the Bulgarian households. The survey is based on a representative sample of 6,000 households. The sample is based on a territorial principle according to a two-tied cluster method. Since 1999 the structure of household's budgets is adjusted to the EUROSTAT classification. Some breakdowns of income strata, tenure status and health status are not monitored by the regular statistic, but estimates could be obtained by population census and representative surveys.

Employment related indicators are based on the two main data sources: the Labour Force Survey of the National Statistical Institute and the unemployment register of the Labour Offices. The Labour Force Survey is conducted since 1996 in accordance with the ILO definition for unemployment. For most of the years the unemployment rate of the Labour Force Survey is about 3 points higher than the officially registered one. The difference is caused by long term unemployed persons who usually are not registered by the Labour Offices. However, the data of the Labour Offices' unemployment register are valuable to assess regional cohesion and the unemployment dynamic during the transition process because these data are collected since 1990. Data on the portfolio of the EU poverty indicators in Bulgaria are presented in Tables 4.3.

It is important to note that most of the above indicators are based on the income structure of the member states. The income stratification model in Bulgaria differs significantly. The poverty threshold set up by the European Union as a relative line (60% of the national equalised median income) shows a very low income level in Bulgaria, which does not allow to satisfy the basic needs for food and energy consumption. In 2001 the EU line is equal to 18 EURO which is about 50% lower compared to this used by the

World Bank (30 EURO). The poverty rate measured under the EU lower line is 6% and this under the World Bank line is 11.7%.

It is common practice for the developed countries with high standards of living to study poverty through defining a relative line. The economic conditions in these states allow to identify the strata of the population who live below the desirable living standards of non-poor, but nonetheless are able to meet their minimum needs. In the transitional countries, especially those in a difficult and prolonged socio-economic crisis, to define a relative line of poverty is practically unsuitable. The average or medium income is calculated from devaluated households' income resulting from both inflation erosion and unemployment. This situation leads to underestimation either of the poverty threshold, or the relative share of the poor under the relative line.

Next to this, the difference between the average and the medium income generates respective differences between poverty lines and the percentage of poor households. The use of the average income defines a line of poverty which is 18.7% higher than that based on the median income, due to the concentration of households in the lower income strata. According to ILO and UNDP study in 1998 the poverty line based on the average income shows approximately double percentage of the poor, compared to the rate under the poverty line based on median income.

4.2 Evaluation of Policy Challenges and Policy Responses

4.2.1 Inclusive Labour Markets

The economic restructuring in Bulgaria influenced both labour demand and labour supply. Among the number of reasons causing unemployment, the mismatch between the qualification of the labour force and the labour market requirements should be outlined. The most important risks at the labour market can be identified by analysing the structure of the unemployed population by age, gender and qualification (Table 4.4):

The data indicates that the **youth** account for a significant share of unemployment. They represent 27.2% of all unemployed. The unemployment rate among the young people is 29% and exceeds almost twice the average unemployment rate in 2001. Youth unemployment is higher among the male population. This is dues to the relatively shorter average period of education among the men (9.3 school years, compared to 9.9 for women). These differences should be taken into account when active labour programs are elaborated.

Women are more vulnerable to unemployment than men. The difference is not significant, but the structural characteristics and causes for unemployment are important. The reform of the labour market causes some gender differences in the aggregate indicators. 47% of the female labour

force and 38% of the male labour force are employed in the public sector. For this reason, women are more affected by privatisation and job losses in ineffective state enterprises. Next to this, the disadvantaged position of women is caused by the mismatch between their higher qualification and educational level (see section 4.2.3) and the jobs offered at the labour market.

The lack of correspondence between the qualification of the unemployed and the demands of the labour market is confirmed by the big share of **unskilled unemployed** which represents more than 50% of all registered unemployed. At the same time, the labour market does not offer vacancies for workers without qualification and these categories have very limited perspectives to re-enter the labour market and usually they are seeking employment for more than one year.

The data reveals a dramatic increase of the **long-term unemployment** in the last years, reaching nearly 50% of all registered unemployed in 2000. The development of this group combines all negative factors and risks, particularly low qualification. At the same time, it is a prerequisite for grinding poverty and social exclusion. That is why the long-term unemployed should be defined as the most risky group, which needs special measures for balancing their qualification and supplied jobs

Despite that there is no evidence for direct **discrimination of ethnic groups** at the labour market, they have highest unemployment rate, particularly Gypsies (see section 4.2.6)

The labour market policy comprises many active programs and instruments for employment promotion and inclusion of the risk groups. Until 2001, both unemployment benefits and active measures at the labour market were financed by the insurance contributions collected in the Professional Qualification and Unemployment Fund and were managed by the National Employment Agency. The increasing number of unemployed people entitled to benefits endangered the financial stability of the fund and reduced the financial capacity for active programs. The expenditures for inclusive programs decreased from BGN 62 million in 1999 to BGN 50 million in 2000. That is why in 2001 the financing of unemployment benefits were transferred to the National Social Security Institute on contribution bases. A new Law for Encouraging of Employment was adopted which provides for budget funding of the active programs and codifies the main instruments for employment promotion existing since the mid of 90s:

- Subsidies equal to the minimum wage are awarded for a 6-12 months period to employers of the young, orphans, long-term unemployed, disabled, single mothers and former prisoners;
- Lump sum grants for self-employment;

- Subsidising of municipalities and non-profit organisations for creation of temporary employment;
- Development of national programs targeted for specific groups at risk regions.[7]

The trend toward diversification of the active policy instruments that started after 1997 improved the quantitative indicators of coverage. In 2000, more than 30% of the unemployed registered at the Labour Offices where included in the active programs. Their share was higher compared to the recipients of unemployment benefits (24% of all registered unemployed). Taking into account the fact that in the 1999-2000 period, the share of active programs declined from 25% to 17% of all expenditures at the labour market under the financial constraints mentioned above, the outputs measured by job offers indicate rising economic efficiency.

However, the assessment of the active programs shows that the selective approach to the disadvantaged groups is implemented mainly by means of wage subsidies which encourage the employers to appoint respective targeted groups for a short period of time, i.e. they do not invest in workplaces. The consistent labour reintegration and exit of the disadvantage position is not clearly defined as a goal. According to the experts' opinion, the effects of the active program would rise if temporary employment is accompanied with training or retraining (Belleva and all, Employment and Labor Market in Bulgaria, ETF, 1999)

The legislation allows to implement investment programs for promotion of employment in areas that are defined by the state as priorities such as the development of certain regions or branches, construction of sites of particular importance, recovering of environment, etc. The elaboration of regional and branch programs for development is one of the main challenges in regard to the adaptation of the labour market policy to the needs of the disadvantaged groups. These programs have to include investment plans, training and retraining programs and administrative mechanism for their implementation.

As one of the first steps the *Regional Investment Fund* supported by United Nations Development Program should be mentioned. It finances several programs that are directed towards the stimulation of small and medium companies in regions with high unemployment and the development of regional initiatives for employment, etc.

The newly starting activity in the field of inclusive labour market is the establishment of *Social Investment Fund* for financing of employment

[7] The public work scheme *Temporary Employment Program* is the broadest one as far as the number of participants is a criterion. It is targeted to the long-term unemployed and covers more than 40,000 unemployed annually.

promotion actions. The first attempt to test the institutional mechanism of the Social Fund for generating temporary and long-term jobs was initiated in 1999 when the *Regional Initiative Fund* was created at the Ministry of Labour and Social Policy. It was funded by the World Bank and supported by the United Nations Development Program . The main partners in the job creation possess were municipal administrations responsible for designing and implementation of infrastructural projects at local level (reconstruction of public buildings, streets etc.). A project management unit was formed as an implementing agency at the Ministry of Labour and Social Policy. The selection of the projects approved for financing is responsibility of a Steering Committee, including representative of all stakeholders involved. This organisation allowed to build a capacity for cooperation between the central government, local governments and NGOs in providing active labour market policy. To date more than 120 public work micro-projects have been approved for financing. The project for operation of the "*Regional Initiatives Fund*" continued until 2001 as a preliminary phase of institutionalization of the Social Investment Fund in 2002, which is co-financed by the World Bank and the government. The main objective of the Social Investment Fund is to support employment promotion in regions with mixed population and highest unemployment. Expected outcome is creation of about 1,200 jobs and the planned financial resources in 2002 are 15 million BGN. Expectations are that temporary jobs will provide a step toward regular employment of the included beneficiaries. The project is also a mean to increase government's capacity to manage and supervise job creation programs[8].

The *Beautiful Bulgaria Program* was initiated in 1998 by the United Nations Development Program and supported by the PHARE Program of the EU. Due to the opportunity for the unemployed to participate on the labour market after being trained in construction, it became very popular. The program contributed for the renovation of old buildings and parks in 11 cities and showed a sustainable reintegration effect for the unemployed. Most of them kept their workplaces after the end of the program and continued to work. This program also revealed opportunities for good co-operation with the private business, the labour offices and the unemployed.

The program *From Social Care to Employment* is organised jointly by the Municipal Social Assistance Centres and the Labour Offices. It is implemented as a pilot project in collaboration with experts from the USA. At present, it covers a relatively small number of municipalities, e.g. Vidin, Lom, Sliven, Smolian etc. The program is targeted to the recipients of social assistance benefits and provides two stages of support: vocational training and then employment according to the individual work plan. The main objectives are to transfer income to the jobless poor and to promote work

[8] The World Bank Investment Program in Bulgaria, World Bank, 2001

incentive. Among the 6,101 participants in 2000, there were chronically unemployed people, ethnic minorities, disabled persons and single mothers.

Increasing the aptitude and opportunities for employment of groups with disadvantaged status on the labour market is the main concern of active labour market policy. In an environment with substantial imbalance between the demand and supply of labour force and high level of unemployment there are limited opportunities for the persons with lower education, without qualification, without labour skills etc. The active policies should take into account the economic constraints and to avoid the burden on the competitiveness, which is the main challenge for the economic development at the current stage. Another reason that makes difficult the designing and implementation of adequate active measures is the fact that identified groups with disadvantaged status on the labour market (low skilled workers, youth, disabled, minorities etc.) exceed 40% of the unemployed and vary significantly by level of education, capacity of work, motivation for training and employment (see Beleva et al., ETF, 1999).

4.2.2 Guaranteeing Adequate Incomes/Resources

As was mentioned in chapter 2, the architecture of social protection policy in Bulgaria comprises two levels: social insurance and social assistance. In the context of guaranteeing adequate resources, a third level should be added – the provision of social services.

The incidence of the public transfers for social insurance and assistance is illustrated in Table 4.9. The income from pensions represents about one third of the total households' income in the middle strata (III-VI deciles). In these groups the share of pensions exceeds the average. Social assistance and unemployment benefits are an important source of income for the first decile (where the share of these benefits is 4-5 times higher compared to the average) and for the second decile.

Social insurance

After the radical reform of the first level of the social insurance system and particularly the reduction of non-contributory benefits and the restrictive changes in the qualifying conditions, this type of policy became less efficient as an instrument for poverty alleviation. However, it still plays an important role for guaranteeing an adequate income for insured people through a set of minimum levels of benefits. The minimum amounts of pensions are defined as a percentage of the social pension, which is a threshold defined by the government. The minimum amount of unemployment benefits is also fixed by law. In addition, the social insurance system still provides a number of non-contributory benefits such as child allowances and means tested social pensions for uninsured people above the age of 70.

Social assistance

The second level of social protection is the social assistance. It combines different objectives: to make sure that the households incomes are at the guaranteed minimum level, to provide income for those who are not insured due to unemployment or other individual reasons and to compensate for the restrictive measures in other fields of social policy such as social insurance, price liberalisation and so on. The different goals of social assistance are accomplished by different types of benefits provided: means tested benefits to low-income families and universal family benefits for uninsured parents and disabled people.

As was pointed out in Chapter 2, the main schemes for targeted transfers to the poorest individuals are the means tested Monthly Benefits and Energy Benefits. The low threshold of the Guaranteed Minimum Income and the tight eligibility criteria of the means test reduce the number of clients mostly to chronically unemployed and marginalized strata of the population. After 1992, the BMI has been maintained considerably under the level of the minimum salary, the unemployment benefits and even the social pension. That is why most of the families with regular sources of income (wage, pensions, short-term benefits) turn out to be above the eligibility income.

Data for the number of recipients of means-tested benefits do not always correlate to the dynamic of poverty. The take-up coefficient measured as a relative share of beneficiaries in the total number of eligible population varies significantly (Table 4.5). The main reason for the non take-up are the tight eligibility criteria., particularly these referring to the assets and active behaviour at the labour market. Many of the long-term unemployed persons (so called ”discouraged unemployed”) prefer to start part time job in the shadow economy, instead to support their registration at the Labour Office.

In Bulgaria there is no evidence for a negative stigmatising effect of the means-tested benefits, nor for a lack of information. Data from a recent sociological survey give evidence of a positive attitude toward the social assistance system (Club ”Economica 2000”, Center for the Study of Democracy 1998). More than 70 per cent of the respondents are aware of their social rights. At the same time there are cases of violation of the rights - some of the eligible beneficiaries do not receive their benefits because of financial problems in some municipalities (see section 4.2.9).

Social services

The third level of policy comprises social services administered by the social assistance system.[9] They are targeting the elderly, the disabled and children. The main goal of these services is to help the individuals with impairments in their day to day activities and relieve the economically active population from the burden of looking after the dependent members of the household.

The currently applied forms of social services are regulated in the Social Assistance Act (1997). Among them, the network of social care institutions for the elderly, the disabled and children plays a major role. The networks substitute the care that was earlier provided by family and relatives, for example by placing clients into residential homes.. The share of children placed in institutions is particularly high[10] – 111 residents per 10,000 children below the age of 18 with a pronounced tendency of growth during the transition process. This tendency makes Bulgaria radically different from the other countries in Central and Eastern Europe. They have also inherited a high rate of institutionalisation but their levels are following a tendency of decline in the recent years.

The network of social institutions in Bulgaria was preserved at the cost of ever growing financial expenses that reached a total of 22 billion BGL for the social care institutions in 1997. Since the beginning of the transition the actual level of expenditures declined from 0.5 to 0.3 per cent of the GDP. At the same time, the prices of foodstuffs, medicines and especially that of heating and electricity , which constitute the major part of the up keep of the social institutions, went far above the average index of consumer price growth. That is why, this share of the GDP may no longer secure the normal life of the children and disabled placed in the institutions.

Furthermore, the social institutions are a precondition for a number of psychological and social problems of the people placed in them – hospitalization syndrome, social isolation, depression, etc. It is not possible to replace effectively in the institutions the normal social environment that is necessary for the development of simple skills for communication and further social inclusion of the children.

The right to a normal family environment is guaranteed by the Family Code. It provides guardianship and trusteeship in favour of children without family and mentally retarded people. In addition, a pilot program for foster families has been promoted by the Ministry of Labour and Social Policy. However, there are no economic incentives to take care for the impaired people in the normal family environment, and there are not intentions to

[9] Except some of the institutions for children at risk that are run by the Ministry of Education, Ministry of Health and Ministry of Interior.

[10] Mother and Child Homes, Homes for Children and Adolescents, Corrective Institutions, Special Schools for and Homes for Children with Physical and Mental Impairments.

implement income replacement schemes for the guardians. This is one of the factors for a higher level of institutionalisation of children and the disabled in Bulgaria.

Day care services have a relatively limited coverage. The most popular form is Social Patronage that provides food and services at home to old and disabled people who cannot take care of themselves. The total number of clients amounts to 30,000 people, which comprises 2% of the target group. The low attractiveness of this type of services could be explained with the low quality of services and the relatively high prices.

4.2.3 Combating Education Disadvantage

Education is a traditional value of the Bulgarian society. Data on the educational level of the population can be obtained from the census. For the last ten years, the educational structure of the Bulgarian population changed in the following directions:

- Significant increase of the share of population with tertiary education (from 7.9% of population in 1992 to 9.8% in 2001);
- The number of women graduated from universities (369,000) is higher than the number of men with higher education (326,000)
- Increase of the share of the population with secondary education (from 37% to 42.8%);
- Decrease of the population with basic secondary (8^{th}class) or lower education (from 24.6% to 20.1%);
- Decrease of illiterate people to 183,000 (2,3% of population), mostly from the elderly and minority groups.

Despite the positive development, there are also some alarming tendencies in recent years pertaining to the decreasing participation rate. The data show deterioration not only in secondary education, but in primary school as well.

At the beginning of transition per-primary enrolment was about 66% of the children aged 3-6 years. After the price liberalization it fell dramatically to the level of 55% in 1991-1995 period, because of the rising prices of the services. After the introduction of differentiated user fees according to the family income the utilization of kindergartens increased and in 2000 the enrolment rate reached the pre-transitional level.

The enrolment in primary education is relatively stable (99% in 1991, 99.1% in 1995, 98.8% in 2000). However the lower secondary education (up to 8^{th} class), although it is compulsory, experienced a large fall in enrolment from 90.8% in 1991 83% in 1995 and 84% in 2000).

The yearly school dropout is one of the most risky factors which endangers further integration of the affected groups. The recent study ”Bulgarian Education and Social Stratification” conducted by the Social democratic Institute in 2001 shows a dramatic increase of the number of dropouts during the last years. It is estimated at 90,000 persons or 10% of all students in primary and secondary school. In 1998 their number was estimated to 45,000 or 6% of the students (Vocational education and Training against Social Exclusion, European Training Foundation, 1998). The last study on this issue shows a dramatic increase of the number of dropouts during the last years (European Training Foundation 1998). It is estimated at 45,000 persons or 6% of all students in primary and secondary school. The most frequently quoted reason for leaving school is unwillingness to study. The female dropout in the last year of the secondary school is caused by early marriage. In some ethnic groups (e.g. Gypsies and Turks) it starts even in the first years of secondary education. Another reason for the school dropout is the unattractiveness of the teaching materials, impaired balance between academic and practical education and so on. In addition, there are economic reasons such as increasing user costs for out-of pocket expenditures, transport, school appliances etc..

The school drop-out is also related to the to illegal child labour. The official minimum age for employment is 16 in Bulgaria and 15 for some special professions, such as artists. Persons aged below 18 are under the special protection of Labour Code providing for shorter working time, healthy work environment and so on. In 2001 the Labour Inspectorate has issued only 2,831 work permissions for children aged 16-18. According to the recent survey of the Labour Inspectorate at the Ministry of Labour and Social Policy there are about 83,000 children employed in the private sector, most of which are illegally employed. Many of them are underpaid - 35,000 of the employed children receive up to 30 BGL per month which is 3 times lower compared to the official minimum monthly wage. The most worrying form of illegal work is involvement of children in prostitution and begging.

The participation rate in vocational secondary education is relatively stable and those in tertiary education increase from 18.8% in 1991 to 27% in 2000.

Three main direction of social policy should be envisaged in the field of combating education disadvantages: school drop-out prevention, vocational education and training and the programs for training of the unemployed.

School drop out prevention

Prevention of earlier school drop out is not designed as a program but rather as a separate measures and solutions, based on the experts opinion about the possible causes of this phenomenon. The majority of the dropouts are from

Gypsy origin. That is why the first solution focuses on overcoming language and cultural barriers. For this purpose, so cold pre-school groups are implemented in some municipalities (e.g. Lom, Montana etc.). The teachers from the neighbourhood work with the pupils and their parents. As a result, the yearly school drop out decreased from 20% to 2%.[11]

Another scheme that is implemented in the ”Faculteto” neighbourhood in Sofia aims to increase the attractiveness of school by offering supplementary leisure activities and school breakfast. The project is run by the Bulgarian Helsinki Committee and the municipality. The experts involved express the opinion that humanitarian aid is not an effective instrument for school attendance. It drops down after ceasing food supply and the results are not sustainable.

Vocational education and training

The adoption of the Vocational Education and Training Act in 1999 corresponds to the government's priority which is the development of human resource. This goal is underlined furthermore in the context of the economic strategy of the country and particularly as a part of the EU accession strategy and the country's preparation for the free movement of people.

The law regulates institutions, curricula and standards in vocational education and training systems. According to the new law, the main types of vocational education provided at various types of schools are as follow:

- Professional schools after VI class where students attain professional qualification and complete basic secondary education (VIII class).
- Professional schools after completed basic secondary education for acquiring professional qualification only.
- Professional schools after completed basic secondary education where students acquire professional qualification and complete higher
- secondary education (XI class). The graduates have access to tertiary education.
- Professional Gymnasiums and Technical High Schools for acquiring higher professional qualification together or after accomplishment of higher
- secondary education. The graduates can continue their education at the universities.

From the perspective of disadvantaged groups(e.g. school drop-outs, children from poor families etc.), the first two forms are important as they

[11] Monitoring of the schools implementing preventive programs is provided by Club ”Economica” in 1997-2000

provide access to vocational education for school dropouts and those young people who do not intend to finish higher secondary education.

Despite the high general participation rate in the tertiary education reaching 27% in 2000, most of the disadvantaged groups do not consider tertiary education as a realistic objective. In order to ensure the equal access to tertiary education, the government intends to improve the system of fellowships for pupils and students and to introduce a system of students loans which is not developed yet in Bulgaria.

Training of the unemployed

The training system has been designed and implemented since the beginning of the transition. It was financed from Professional Qualification and Unemployment Fund until 2001 and later from the state budget. The training for employment is targeted to the following categories: unemployed; employed in small enterprises (up to 50 persons); workers who need a new qualification due to restructuring or mass lay-off. The law knows three main forms of training: initial professional qualification; additional qualification and re-qualification.

In 2000, the number of unemployed who benefited from the training programs was 9951 persons or 1.5% of all registered unemployed. One of the reasons for low coverage is the requirement that the employers has to confirm the need of training and further hiring of the trainee. The evaluation of the net effects of the training programs indicates that most of the beneficiaries have already had a high qualification. This phenomenon is known as ”creaming” of trainees. Highly educated and skilled persons tend to be more active in training activities, and the share of low educated and unskilled on the total number of participants is lower. At the same time, there is a worrying trend towards an increase of unemployed people without secondary education.

One of the good practice examples of a targeted program for the disadvantaged groups is the *Literacy, Training and Employment Program*: It is developed as a pilot initiative of the Employment Agency in several municipalities with a compact minority population. The program comprises literacy and training modules aiming to encourage employment. In the last two years there are about 500 persons trained. In 2003 the Employment Agency intends to increase the scope of municipalities covered by the program.

The Ministry of Labour and Social Policy in co-operation with the Ministry of Education provides a program called *Transition from School to Employment.* The program targets graduates of institutions for children at-risk (Homes for Children and Adolescents, Corrective Institutions, Special Schools and Homes for Children with Physical and Mental Impairments),

school dropouts and young people without length of service. The average yearly number of the participants is still limited due to the initial stage of implementation, but increases from 1,700 graduates in 1999 to 3,100 in 2001.

4.2.4 Family Solidarity and Protection of Children

Child Poverty

Economic well being of the children is influenced by the common trend toward deterioration of the living standards of whole Bulgarian population. At the same time there is evidence that poverty affected in greater extend the families with children. The UNICEF paper "Children in Bulgaria; Growing Impoverishment and Unequal opportunities" (Gancheva, Kolev, 2001) states that while in 1992 the poverty rates for the pensioners and children were similar, in subsequent years the poverty rate for children rose faster. The World Bank poverty assessment also points that the poverty level of the large families is 24% or twice higher compared to the average.

Of major concern is the the overall decline in the quality of nutrition of the children. The average daily per capita calorie intake of the families with children varies between 2,249-1,930 depending of the number of children in the family. These levels are below the 2,500 calories FAO's threshold for under-nourishment (Gancheva, Kolev, 2001).

Family Benefits

Until April 1, 2002, the system of family benefits was regulated by the inherited pre-reform Decree for Encouragement of Child Birth (1968). Both insured and uninsured parents are entitled to the full range of benefits described in section 2.3.8. Insured parents received benefits from the National Social Security Institute and uninsured parents from the Municipal Social Assistance Offices.

The number of uninsured beneficiaries increased dramatically in the recent years. The relative share of uninsured mothers reached 40% of the total number of mothers on child care leave; the share of child birth grants reached 20% of the total number, and the share of children receiving child allowances from the social assistance system reached 12%. Entitlement to lump sums for child delivery and maternity and parental leave to uninsured parents did not depend on the employment status and did not limit the eligibility of women who are voluntary non-employed. Figures 1 and 2 show the dynamic of the non-contributory family benefits, which increase faster than family benefits paid through the Social Insurance Fund.

Taking into account the financial considerations and the cases of wrongly targeting the limited resources to all uninsured mothers, some of which are voluntary non-employed and could not be considered poor, the new Law for Family Benefits was adopted by the parliament in 2002. It will considerably restrict the benefits. The Child Birth Grant under the new law will be BGN 200 for the first, second and third child and BGN 100 for every additional child in the family. The child allowance will increase to BGL 150 and become income tested under a threshold equal to BGN 150 per family member. According to the estimates, about 20% of the families will be above the threshold and will not be entitled to child allowances. The period of parental leave for uninsured parents is shortened from 2 to 1 year and the entitlement will be income tested. All family benefits will be administered by the Social Assistance Offices for both - insured and non-insured individuals.

The new law includes school attendance as an eligibility criteria for award of child allowances. This condition is an additional measure for school dropout prevention.

Children at-risk

Protection of children's rights is a relatively new priority of the policy toward social exclusion. Bulgaria ratified the UN Convention for the Rights of Children in 1990, however the national legislation has be reformed in conformity with the Convention ten years later, when the Act for Child Protection (2000) was adopted. A State Agency for Child Protection was established under the Child Protection Act and departments for Child and Family Cares were created at each Municipal Social Assistance Centre. The main priorities of the state strategy for social inclusion of children at-risk are:

- Prevention of abandonment of children;
- De-institutionalisation of children placed in residential homes and development of alternative foster cares, day-care shelters and so on.

According to the analyses of UNICEF (R.Gancheva, Al. Kolev, 2001) there are three main risks placing Bulgarian children in disadvantaged position: teenage birth rate, unmarried mothers and high number of children placed in public institution. The birth rate among 15-19 years women is over 75 per 1,000 women in Bulgaria, compared with 45 per 1,000 in the Central European countries. While the overall number of births has declined during the transition, there was a large increase in the share of children born out of marriage. A number of studies have drawn attention to the welfare disadvantage of single-parent families. The World Bank poverty assessment found that more than 26% of single parent families are poor. There is also a higher risk for the children born out of wedlock to be placed in public

institution, which unfavourable effects on the child are described in section Social Services (4.2.2).

Another important risk that needs targeted preventive measures is related to earlier school drop-out which endanger further integration of the children at the labour market and lead to poverty (see 4.2.3)

All social risks that affect children lead to multiple negative effects in the future. That is why, there is a need to enlarge the priorities of the community child cares development. This conclusion is confirmed by the recent study of Save the Children Fund in Bulgaria (Save the Children Fund, macroeconomic Policy and Children's Rights, 1999)

4.2.5 Accommodation

The housing size and the dynamics in Bulgaria are regularly monitored by the National Statistical Institute, e.g. the number of newly built and occupied dwelling units, usable floor area, structure and type of housing, and utility access.

The Bulgarian population keeps relatively good status in terms of housing property. According to the last population census there are 421 dwellings per 1000 of population. The households living in their own dwelling is 92%. However, this is a transient situation inherited from the previous periods when the state subsidised ineffective building industry rather than pursuing a sustainable housing policy.

In 1999, the number of newly built dwelling units in the country as a whole was 9,824. Compared to previous years, this number shows a growth of almost 100%. However, for the whole period since the beginning of the 90s, the trend has changed towards a gradual but clearly marked decrease in the number of newly built dwelling units. The number of newly built dwelling units in 1990 was 62.28% higher than their number in 1999. The lowest number of newly built dwelling units was registered in 1998 – 4,942, which marked a drop by about 82% compared to 1990. These figures reflect the major macro-economic and social problems related to the transition period. Like many other goods, the number of newly-built dwelling units dropped considerably which can be explained with both the reduced purchasing power of the population and an increase of prices of construction materials.

The quality of living conditions is determined not only by the access to housing but also by the availability of basic utilities – heating, water-supply, sewer systems and hot water. These indicators can be used as an indirect indicator for the social and economic status both of individual households and of regions as a whole. According to the results from the latest census, 87.5% of the households have a water-supply system installed in their

homes, the rest of households are situated mainly in villages and urban neighbourhoods situated in isolated or mountain areas. Moreover, 40,000 households in the villages do not have any access to running water and use water-wells, water pumps or other devices for obtaining water. Most of the urban households (97.4%) live in homes that are connected to the main public sewer network or local sewerage systems (septic tank or septic pit). The corresponding percentage for the villages is 77.9%.

Another indicator of the quality of housing is the general state of the dwellings in terms of living conditions. According to the surveys, 30% of households live in buildings that need urgent repair of the sewer system, the roof, the electricity network, etc.

Homelessness is not considered as a social problem in Bulgaria. Next to the big share of persons living in their own dwellings, there is a broad coverage of residential institutions for the vulnerable groups, e.g. old-age, disabled, mentally damaged, orphans (see section 4.2.2 – social services). Despite that these institutions provide accommodation, they do not satisfy the needs for social inclusion of the groups at risk and they should be subject of special housing programs.

The high percentage of ownership among the majority of the population is a factor that contributes to underestimate the necessity of the housing policy for disadvantaged groups. Bulgaria has hardly any experience in the field of social housing programs such as granting housing benefits, providing of low-interest loans etc. A small number of dwellings in the big cities are municipal property. They are reserved and rented at low prices for people registered at the municipality as ”groups at-need”. However, the number of registered families exceeds the available municipal housing significantly.

4.2.6 Ethnicity

The main constraint in the identification of ethnic profiles of poverty is the lack of quantitative information. Official statistic collects data by ethnic origin for a long period of time (e.g. 1992, 2001). However, the information is limited and covers only a few aspects such as access of minorities to housing and partially access to the labour market. The rest of specific statistics about education, health,, household budget survey, labour force survey etc do not allow to be disaggregated on ethnic bases. That is why the sociological surveys play an important role for filling in the gaps in quantitative information (World Bank Poverty Assessment, ”Poverty and Ethnicity” of the International Centre for Minorities (1999), ”Social Consequences of Introduction of a Currency Board in Bulgaria” of the Centre for the Study of Democracy (1999).

The disparity of poverty among different ethnic groups according to the World Bank Poverty Assessment is shown in Table 4.6. The poverty rate

among Turks is 40%. Among Gypsies, it is 84.3% and exceeds more than twice the average of the country. The share of the groups in the poor population is another important poverty indicator. Gypsies and Turks represent one quarter of the poor, despite a share of 13% on the whole population. The poverty depth index for the minorities is proportionally larger, measured as the distance between the poverty line and the income of the poorest households.

The survey data shows that the most important ethnic differences are associated with education (Table 4.7). The lowest educational level is observed among the Gypsies, where 57% of the respondents do not have attended compulsory basic education. Turks are in a disadvantaged situation regarding to secondary and tertiary education. However, most of them have accomplished the 8th class. The compulsory basic degree does not provide sufficient quality of the labour force, but at least it offers a perspective for continuous education and vocational training for adults.

The fact that the low level of education predominates as a social risk among young Gypsies is particularly disturbing. The school dropout and the low attendance are typical problems for this group. Although equal access to education has been saved during the transition process and the municipalities still provide free textbooks until 8th class, public spending is not well targeted to the regions with a compact minority population.

As a result of the lower educational level, the unemployment rate of minorities is extremely high (Figure 3). According to the sociological survey, it is 80.8% among the Gypsies which is 5 times higher than the average of the country. The unemployment rate among Turks is also higher than the average. Despite the lower deviations, compared to the Gypsies' unemployment rates, the position of the Turk population at the labour market is particularly unfavourable in some regions. These are municipalities with closed state enterprises that used to provide employment in traditional branches, such as the tobacco production and the mine industry.

The data of some qualitative studies such as in-depth and focus groups interviews shows that Gypsies are deprived in terms of access to public services (International Centre for Minorities 1999, World Bank 2000). Many houses in Gypsies' neighbourhoods do not meet sanitary standards. Poverty and poor living conditions are factors for deterioration of the health status. Even though the study was carried out the year before the health insurance system was introduced and therefore, basic health services were still free in Bulgaria, many Gypsies were reported not to visit doctors or vaccinate their children.

Both quantitative and qualitative indicators corroborate the hypotheses that belonging to an ethnic minority group is a factor for social exclusion.

This evidence is observed despite the fact that the Constitution and the social legislation consider the principle of equal rights in terms of welfare, health, education and access to the labour market. The existing system of social services ensures equality in terms of general conditions for access, but not equity in terms of meeting specific needs of minorities.

The Framework Convention of the Council of Europe on Protection of National Minorities was ratified in May 1999. The ratification is a significant step to overcome social tension regarding the treatment of ethnic groups. As a consequence, a National Program for Equal Participation of Gypsies was adopted in April 1999. It was elaborated by the joint efforts of the government, Gypsies' organisations and organisations for protection of human rights within the National Council for Ethnic and Demographic Issues. The program sets out core principles and general measures to fight discrimination and unemployment, to increase levels of education and health care, to improve housing conditions, and to ensure cultural protection and access to the national media. The program envisages the establishment of a National Committee for Prevention of Discrimination. Gypsies' representatives have been appointed to 10 of the 28 districts administrations of the country. Gypsies' advisors have also been appointed to a number of ministries. These activities reflect the political commitment of the Bulgarian government to improve the situation of the Gypsy population. However, the program now needs to be followed up by specific actions of the responsible ministries. The budgetary resources for the implementation of this program also needs to be allocated.

The PHARE project "Investments in the development of labour market and vocational training" comprise a special module targeted for regions with mixed ethnic population and inclusion of minorities affected by unemployment in training for acquisition of vocational education, key knowledge and skills. The expected outcomes of the project are about 2 000 young people trained, where more than 80 per cent of them should start work within one year after enrolment in the programme. The sources of funding for the entire project are 5.0 million EURO from PHARE and 1.75 million EURO internal budget resources.

The Regional Initiatives Fund at the Ministry of Labour and Social Policy finances pilot projects for employment in several municipalities with compact Gypsy population (Russe, Vratsa, Plovdiv, Stara Zagora etc.).

The Turkish minority is relatively better integrated and represented in political life. However, some of the regions where this minority is concentrated are hit by economic problems and suffer from low investment and high unemployment. The state purchases of the tobacco production is one of the most important instruments of economic support. For the purpose of increasing the participation, the Ministry of Education has

special provisions that include the mother tongue of minorities in the curriculum.

4.2.7 Regeneration of Areas

There are significant local disparities in terms of poverty distribution, despite the small territory of the country. This fact is explained with the high level of concentration of groups affected by poverty risk (ethnic groups, settlements with deteriorated demographic structure, regions with persistent unemployment, etc.)

The poverty profiles prove that the impoverishment differs for the cities and the villages (World Bank 1999) Below the selected poverty line (66% of the average gross expenditure) live 33% of the urban population and 41% of the rural population.

Another important problem for people in small settlements is the limited access to training services and active programs, which are organised by the Labour Offices and provided in the bigger towns and cities.

The poverty status can also be envisaged by regions of the country. Municipalities and districts are the basic units of administration in Bulgaria. There are 280 municipalities and they differ significantly by territory, population and economic profile. The status of municipalities is regulated by the Law for Local Governance and Local Administration (1991) that regulates the right of self-government. The districts are bigger administrative units. Their number is 28 and they represent central government functions at local level.

Bulgarian labour market is not mobile and even high regional unemployment is not a factor in increasing labour mobility. Internal migration numbers about 160,000-200,000 people per year and the flow is mostly from the towns to the villages. A reasonable explanation for the internal mobility of the population seems to be the ageing of the population and the ownership of property. According to the estimates of the European Training Foundation the low mobility may be explained by the fact that high share of population are owners of land or houses and appear not to sell their property. The undeveloped market of lend also contributes to this attitude (Belleva et al., Employment and Labour Market in Bulgaria, ETF, 1999).

The economically disadvantaged regions (municipalities or districts) have inherited from the period of planned economy a poorly developed transport infrastructure, an almost unproductive and highly specialised agriculture and an inefficient industry that is currently being restructured. These characteristics of the regions are the major prerequisites for deterioration of the social status of population. The unfavourable social and economic situation of the region can be attributed mainly to the discrepancies at the

labour market. The high local disparities of unemployment are shown in Figure 4. The standard deviation of the unemployment rates registered by the Labour Offices is 8.65. In 13% of the municipalities, the unemployment rate exceeds twice the average for the country. The regions at higher risk are those with high unemployment rate, low welfare status of the population and often with a compact minority population (Vidin, Montana, Pazardjic, Smolian etc.). The higher unemployment rate is an additional cause for the decrease of local revenues (tax base) and the increase of expenditures for social assistance. Local social policy of the municipalities most affected by the unemployment suffers from a chronic deficit of funds.

4.2.8 Disability

The definition of disability is based on a medical expertise which defines the degree of lost work capacity. People with more than 50% lost capacity are entitled to a pension. The demographic characteristics of disability are influenced by the fact that medical expertise is required not only for the economically active population, but also for the people after official retirement. This is the reason why the elderly prevail amongst the disabled and why the relative share of the disabled increases in direct correlation with age. The number of disabled per 1,000 of population is 7.6 for the 16-24 age group and 62 for the people aged 55 and above.[12]

The economically active disabled represents only one quart of the group. Most of them are working at sheltered enterprises and co-operations, which are about 100 throughout the country. They are subsidised by the state budget and receive tax exemption. Another part or the disabled is employed at the mainstream labour market, where the employers provide appropriate job places, according to quotas the Labour Code provides for. Despite these guarantees, the unemployment rate of the disabled exceeds the average of the country, reaching more than 20% in the last years.

Despite of the relatively low percentage of invalidity among the youth, they have to be considered as one of the most disadvantaged groups in terms of access to education. Almost all children with impairment receive primary and secondary education outside of mainstream schools. They study in so called ”special schools”. Disabled children with moderate and severe mental retardation which have no access to education are placed in residential institutions. The number of institutionalised children is 2,500 or nearly half of all children with mental impairments. The high level of institutionalisation, inherited from the past, creates the precondition for a number of psychological and social problems – hospitalisation syndrome, social isolation, depression, etc. It is not possible to replace effectively in the institutions the normal family and social environment that is necessary to develop communication skills, independent life and social inclusion.

[12] Source: National Statistical Institute

There are 116 schools for children with special education needs. As there are no special schools established in all areas in the country, the students coming from far away towns have to stay at the residential shelters and to live out of their homes and families. The network of special school has been created in 1960-1970, as a consequence of the state monopoly in childcare and education. During the transition period, this network has been saved and supported, despite the fact that it enlarges social risks for disabled children and youth. From the advanced point of view, the segregated education does not contribute to the social inclusion and provides low quality of services.

The integrated education is promoted by law, but in practice, there are no real opportunities to exercise the rights due to the curriculum and due to a lack of specialised staff and school appliances, appropriate architectural facilities etc. in the mainstream schools.

The policies for social inclusion of this specific group are codified in the Law for Protection, Rehabilitation and Social Integration of the Disabled (1995). It includes the following basic rights:

- Health rehabilitation;
- Integrated education, professional orientation and training;
- Accessibility of public services;
- Sheltered employment and tax exemptions;
- Targeted benefits for technical facilities (see section 2.3.4) and social
- services;
- Participation of organisations of the disabled in the governance of
- these policies.

The funding for sheltered employment, targeted benefits and facilities of the disabled is provided by the Rehabilitation and Social Integration Fund. It also ensures co-financing of pilot projects and initiatives of the organisations of the disabled in favour of social integration.

One of the most effective forms of integration of the disabled are *the Social Vocational Education Institutions*. There are 10 institutions in the country under the auspices of the social assistance system. They provide occupational training and services to disabled individuals aged 14-35 and mentally retarded people with light and moderate impairments. In 2000 the students numbered 1,700. It is envisaged to expand the scope of the training and the range of services significantly in order to include training in new occupational skills and to introduce new curricula corresponding to the interests expressed by the students and to the advanced needs of the labour market. The students are also entitled to additional support, e.g. housing facilities during the period of education and universal benefits the Law for Protection Rehabilitation and Social Integration of Disabled provides for.

4.2.9 Other Factors in Social Exclusion

Traffic in Women

Trafficking in Women is one the most worrying dimensions of social exclusion. The recent study conducted in 2000 by "Animus" Foundation shows that 10,000 women are living abroad engaged in forced prostitution. According to their estimates Bulgaria takes one of the first places in East Europe in trafficking. Higher risk exist for two regions: North-East (Varna, Dobrich and Russe) and South-West (Blagoevgrad, Kjustendil, Petrich) that are close to the borders. The women from the small villages are considered more vulnerable because of difficult access to information and preventive education.

The main policy measures proposed at a round table on Trafficking in Women held in Sofia on March 16, 2000, were: campaign for increasing public awareness and preventive education; strengthen border control; social protection for the victims of the forced prostitution, e.g. accommodation, training and employment programs. The existing social protection measures are provided mainly by the non-governmental organisations financed from foreign donors. There are no targeted state programs for the victims of trafficking or sexual violence.

4.2.10 Administration, Access to and Delivery of Services

Municipalities are vital to the development of social cohesion. There are 280 municipalities in the country that differ significantly by territory, population and economic profile. The status of municipalities is regulated by the Law for Local Governance and Local Administration (1991) that provides for the right of self-government. According to the law local government fulfils following functions:

- Management of local property and local enterprises and finances of the municipality,
- Support of infrastructure and local development,
- Financing of education, e.g. pre-school, primary and secondary education,
- Health services co-financing,
- Culture – theatres, orchestras, libraries, museums, local customs,
- Public services- water supply, electricity, central heating, telephones, parks, transport etc.,
- Social assistance and housing for vulnerable groups,
- Environmental activities,
- Development of sport and recreation activities.

Despite the reformed legislation however, the transition and restrictive budgetary policy has endangered the capability of local management in dealing with complex problems, one of which is social integration of excluded groups. Another newly emerging challenge is the administrative reform in the public sector, related to higher requirements for qualification and efficiency of the servants and mass lay-offs in local administration.

The social assistance system is the main institution responsible for the poverty alleviation policy. It is a function of the local government. At the beginning of the transition process, 273 Social Assistance Offices were established in Bulgaria as autonomous legal persons under each municipality. The National Social Assistance Service represents the central administrative level. It is responsible for the development and supervision of the legislation. The Municipal Social Assistance Offices are in charge of the means test and entitlement. Providing means test they exchange information with other government agencies (labour offices, social security, tax administration , etc.)

The new Social Assistance Act (1998) has amended the administrative structure by an intermediary body - the Regional Social Assistance Office. Before 1998, the absence of such an intermediate structure between national and local authorities appeared to be an obstacle for comprehensive control over the large number of municipalities throughout the country. The administrative structure of the system is presented in Figure 5.

According to the new act, the directors of the Municipal Social Assistance Offices are appointed by the central government. About 3,000 social workers are employed in the municipal Social Assistance Offices . The norm is one social worker per 2,500 of population in each municipality. The administrative expenditures for the social assistance system, including wages ad maintenance of the local offices account for almost 2% of the total budget.

Financing is provided by the local budget. It includes own revenues, such as half of the income tax and some local taxes as well as block grants from the central government bargained annually according to local priorities and expected social expenditures in the municipalities. Usually, most of the municipalities are not capable to cover rising needs for social assistance, due to the growing long-term unemployment and poverty. More than 50% of the municipalities, have ”municipal debts” in the field of social assistance. It comprises benefits which are allowed by the Municipal Social Assistance Office, but their payment is delayed or a reduced amount only was paid due to the lack of resources in the local budget. This type of debts emerged in 1993 for the first time and in 1998, they reached 15% of the allowed benefits.

Recognising this problem, the Government applied new co-financing mechanisms in 1999 which aimed at matching central and local responsibilities for poverty alleviation. According to this mechanism, half of the planned local expenditures for monthly benefits and uninsured parents is reimbursed by an earmarked subsidy from central government. Next to this, the central budget provides earmarked subsidies for the Energy Benefits, because they were introduced as a compensation for energy prices liberalisation and still have a direct effect on public opinion. Facilities for the disabled are also financed by an extra-budgetary fund. In this way, the total amount of central budget subsidies accounts for more than half of all social assistance expenditures

The interaction between the state and the NGOs is an important element of the policy for social inclusion. The main characteristics of the NGOs in the social sector, e.g. number, structure and target groups, are summarized in a study conducted in 1999 by the USA Institute for Sustainable Communities (Democracy Network Program). About 1300 or 1/4 of all registered NGOs conduct activities in the field of poverty prevention and social inclusion. Only 26% of NGOs in the social sphere rend services to the vulnerable groups, the rest majority provides information and analyses or acts as a think-thank organisations.

The main types of activities related to social inclusion are training services, health services (particularly hospices and long term cares), day cares for disabled, old age people and children, shelters for homeless persons, family consultations, granting humanitarian aid. The main target groups are old age persons, disabled and children, but the prevalent part from the activities of the NGOs are directed towards responding to urgent needs, instead to targeted a particular group at risk. Described profile reveals that the majority of the NGOs have limited capacity to render services, and they cover limited territory of the country, mostly the big cities.

The data for the projects implemented by NGOs indicates prevalently foreign sources for funding, e.g. participation in projects, financed by foreign donors (over 90%). The ordinary duration of the projects is 6-12 months. As a result of this, the achieved results are not sustainable, and the financing of the respective NGOs is unstable. A limited part of the activities in the third sector are financed by budget subsidies, particularly projects for disabled persons, providers of foster cares, day cares for groups at risk etc. The services providers could apply for funding at the extra-budgetary funds of the government (*Rehabilitation and Social Integration Fund* and *Social Assistance Fund*) .

4.3 Evaluation of Future Challenges

4.3.1 Main Challenges of Social Inclusion

The new legislation in the field of social assistance allows targeting the poorest groups and insures relatively broad coverage of the groups at risk, such as children and dependent people. However, the social assistance system still cannot cope with the increasing poverty. There is a contradiction between the legal rights and the opportunity of their real exercise, which is mainly caused by the financial restrictions. The most important policy challenges are:

- Financial stabilisation, e.g. budget planning and distribution of responsibilities between the central and local level. Priority of this issue was underlined in the World Bank Country Assistance Strategy: "14. A weakness of the system of social assistance cash benefits is the financing mechanism. Responsibility for funding most social assistance programs is shared equally between the state and municipal governments. However, some local governments – and particularly the poorest which have the greatest need – are unable to finance benefits fully. In other cases, the amount of the transfer from the central government budget is not sufficient. As a result, benefits are delayed or unpaid in some areas."
- Elaboration of a system for poverty monitoring for the purposes of a balanced social policy. An officially defined poverty line should be discussed and accepted by the government and the social partners. The poverty line should be set with regard to the acceptable standards of living, rather than being related to the fiscal constrains. The government's commitment to provide assistance for the poorest families is not necessarily based on the official poverty line. The income threshold defining eligibility for means-tested benefits could be set as a percentage of the official poverty line (for example, the Guaranteed Minimum Income could be equal to 50% of the officially adopted poverty line). In this way, social assistance policy and particular benefits provision could be adjusted to the available budget resources. Another reason that justifies the distance between the official poverty line and the means-tested benefits is the widespread informal economy as a source of income, e.g. in-kind production, family plots, inter-familiar transfers and so on. The differentiated approach is recommended in the ILO and UNDP report "Poverty in Bulgaria: Straightening the National Policies and Strategies for Poverty Alleviation" (1998)
- Social assistance policy should be re-oriented from the provision of cash benefits to social services that are much more efficient in terms of reintegration of the vulnerable groups (family support, training, in-kind benefits etc.). All persons with income above the Guaranteed Minimum Income, but deemed to be poor according to the official definition, would have access to a relevant form of social support and the local governments

would be motivated to develop a network of services instead of the obligation to support only income.

- The involvement of private resources and co-operations with the NGOs is also considered as a priority of social inclusion policy. The existing legal provisions (e.g. the Social Assistance Law, Public Education Law) are related to licensing procedures, but not to measures for supporting the co-operation. The financial legislation does not envisage direct or indirect tax deductions or subsidies to the third sector, even if the subject of activity of the NGO is targeted for disadvantaged groups. Some extra-budgetary funds such as the Rehabilitation Fund and the Social Assistance Fund under the supervision of the Ministry of Labour and Social Policy covers part of the expenditures for social initiatives of NGOs, but this practice is still limited

4.3.2 Links to other Social Protection Policies

Social assistance and poverty alleviation policy can not be reformed separately from the social insurance system, which defines the ”demand” of targeted benefits. During the first years of transition, the social security system has kept the broad eligibility criteria and preserved certain large-scale universal schemes paid from the insurance funds: long-term unemployment assistance, non-contributory family benefits, low retirement age and short qualifying periods for the insurance schemes. These parallel schemes were a prerequisite for limited needs of means-tested benefits.

As a whole, the reform of social insurance in Bulgaria are oriented towards the solidarity principle and financial stabilisation that will help further increase of insurance benefits and prevention of poverty amongst the majority of population, e.g. pensioners, the disabled and recipients of short term benefits. Despite that, some disadvantaged groups of population will be negatively affected by the reforms.

The pension reform relies on strong dependency between contributions and benefits, e.g. increase of the retirement age and the required length of insurance for entering the scheme and a tight correlation between the amount of pensions and the income received during the whole length of insurance. At the same time, part of the pensions of people born after 1960 will depend on contributions in the second pillar and will be influenced by the capital market risks. As an immediate consequence of these reforms, the access of people with long-term unemployment periods to the pension system will be restricted. Next to this, the low-paid workers will receive relatively lower pensions, compared to the previous system that permitted to choose the highest insurance base from the last 15 years of service.

The unemployment insurance has also restricted the access to benefits by introducing a 9 months qualifying period that limits the access of seasonal

workers. The last amendments in the legislation have abolished the non-contributory benefits for the long-term unemployed under the consideration that this scheme enters into the general social security system and should be subordinated to the equivalence principle.

The design of the health insurance ensures equal access of disadvantaged groups to the health services, particularly children. The state and social insurance funds cover the pay-roll taxes for all uninsured people and formally no one will be excluded from the system. Some health services with important impact on overall social welfare, such as immunisations, child cares and health education and training would remain the responsibility of the state, although health insurance would cover most types of health promotion activities. However, the indirect costs for health services (such as drugs, transport expenditures in rural areas and so on) are considered as one of the major factors for limited access of low income families to the health care. Targeted in kind transfers for poor families are needed, in order to equalise the access to health care for the vulnerable groups.

The income support of the groups affected by the restrictive reforms in the social security should gradually shift to the social assistance system.

4.3.3 Political Directions of Future Reforms

Two main directions could be envisaged in the political strategy of the government: targeting of resources and guaranteeing the legal rights of social inclusion.

Targeting

As the goal of the overall social reform is to target limited public finances to those who need it at the most and who are most affected by the transition process, the social assistance system seems to be rather an effective instrument for income redistribution than the universal benefits schemes.

The draft Law for Family Benefits envisages targeting child allowances to those who actually need them, better addressing and avoiding duplication of administration.

Changes in the Social Assistance Law are previewed for 2003 that would promote participation of the unemployed recipients of social assistance benefits in public work schemes.

Under the restrictive orientation of social protection, the service provision becomes the main focus of social inclusion policy. The National Strategy on Social Services is currently elaborated at the Ministry of Labour and Social Policy. The Strategy will take into consideration the new social-economic

conditions in the country and the situation with institutions for social services. The main objectives that will be achieved are: shift from institutional to community care; improvement of life-conditions and equal access to social services; promotion of alternative social service provision, rising decentralisation and co-operation of public and private supply; financial stabilisation; promotion of professional qualification and skills of social workers, development of day care centres etc. The specific measures will be undertaken by elaborating and implementing uniform state standards for social services and revision of the existing legislation in this field.

Guaranteeing legal rights

The governmental program pays special attention to the right of the disabled to independent life and previews amendments to the Law for Protection, Rehabilitation and Social Integration of Disabled. Following the recommendation of the EU commission, the government will upgrade the legislation in conformity with the *acquis communautaire* in the fields of anti-discriminatory policy and the equal treatment of women and men. The accessibility of the labour market should also be enhanced through amendments to the existing acts. The new acts as well as the amendments to the specific legislation in the field of employment and labour relations are expected to create a stable base for social integration of the most vulnerable groups.

Parallel to the new legislation, the administrative capacity is considered as a factor to exercise social rights. Human resource development, investment in social services and renewal of equipment are considered as major elements of a social inclusion strategy.

4.3.4 Social Exclusion, Poverty and EU Accession

The need and prospects of elaborating policies for social inclusion of disadvantaged groups receives highest priority in the context of the National Program for Acceptance of the *Acquis*.

As a result of the application of the Copenhagen political criteria, Bulgaria has gained considerable success in democratisation and protection of human rights of the individual. The implementation of adequate policies has been supported by technical assistance of the EU PHARE Program, the World Bank, the United Nations Development Program and bilateral co-operations with the member states. Many of the projects have been targeted for development of administrative capacity as a prerequisite for exercise of the rights in the field of social inclusion (development of active programs at the labour market, upgrading of information systems for risk assessment and so on).

Special emphasis is given on the protection of minorities and equal treatment for women and men. The EU Regular report for the progress toward accession (European Commission, 2001) notes some weaknesses in these fields. The overall assessment shows that no progress has been made in adopting a detailed and effective anti-discrimination policy in favour of minorities. With regard to the equal treatment of women and men, the amendments to the Labour Code in 2001 prevent the indirect discrimination, but only for employed women. The self-employed women and the unpaid family workers are still exposed to a higher risk of social exclusion. The negative assessment of the EU is an important external factor for changes in the political attitudes and for addressing adequate policies.

The main perspectives of EU accession in the field of social protection and policy toward poverty are presented in the Common Position of Bulgaria and the European Commission in chapter 13 of the talks with the title ”Social Policy and Employment”. Until 2001, the government intends to prepare a draft Law for Equal Opportunities of Men and Women that will transpose Council Directives 76/207 and 75/117. For the same period, a draft Law for Prevention of Discrimination should be prepared in compliance with Directive 2000/43 EC. Next to this, as a response to the critics of the Commission, the National Employment Plan for 2002 enlarges significantly the selective program at the labour market targeted for disadvantaged groups. In this way, the opinion of the EU expressed in the framework of the pre-accession talks plays a corrective role for balancing financial and administrative resources of the national policy in favour of the vulnerable groups.

Some of the effects of accession would have a negative impact. The competitiveness of the human resources in Bulgaria would be lower compared to the needs of the EU economy, thus endangering the integration at the labour market as a main prerequisite for social inclusion. The intention of the EU to implement a transitional period referring to free movement of people between the member states and the newly accessed county should also be envisaged as a potential risk for deepening of social differentiation. The Bulgarian position envisaged activation of bilateral agreements for employment with the member states in order to guarantee the rights of migrant workers in the perspective of eventual constraints for movement of workers.

4.3.5 Conclusion

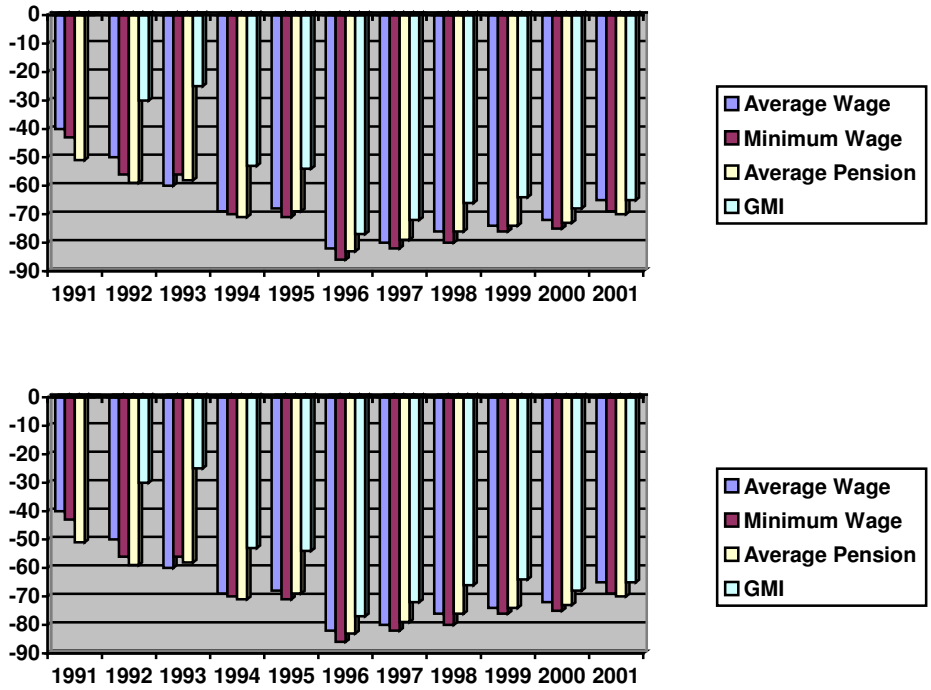
There is no social safety net that could cope alone with the extremely high social price of the transition process. The reforms in social security, conducted in extremely short terms under the pressure of fiscal restrictions, complicate additionally the social protection of population.

Most of the failures of the social policy in Bulgaria have been related, directly or indirectly, to the economic prerequisites for social development. Privatisation, investment in job creation, land reform and access to credits are all important to the success of the social development. These economic reforms have been expected to alleviate the social costs of the transition for the population.

On the other hand, however, the comparative analyses in other countries shows that there is no correlation between the economic growth and human development indicators. Macro-economic stabilisation and economic growth during the last two years did not have direct and sustainable positive impact on the welfare status of the population. The GDP growth is only a precondition for a decent standard of living in terms of overall economic provisions, but it is no sufficient guarantee for social development**.** That is why the policy focus should shift to the effectiveness and efficiency of the social protection system itself, e.g. better targeting of available resources and guaranteeing a wider range of social rights.

4.4 Annex to chapter four

Figure 4.1. Real Income Indexes (1990=100)



Source: National Statistical Institute

Table 4.1: Reasons for Poverty (as % of respondents)

	Very important	Rather important	Neither important nor unim-portant	Rather unim-portant	Completely unim-portant
Lack of capability	9.8	19.2	16.9	27.6	26.5
Lack of Luck	11.1	31.2	20.1	18.2	19.6
Poor morale	19.0	27.2	19.5	17.1	17.1
Lack of endeavour	12.2	26.1	18.9	23.1	19.7
Discrimination	8.6	18.8	19.0	23.7	29.8
Lack of equal opportunities	44.6	37.7	9.0	3.9	4.8
The failure of the economic system	72.9	22.3	3.3	0.7	0.7

Source: Center for the Study of Democracy, 1996

Table 4.2: Comparison of Poverty Lines and Poverty Rates

Definition of poverty lines	**Poverty level (BGN)**	**Poverty rate (as % of all households)**
I. Absolute poverty lines:		
1. Subsistence Minimum calculated by the Ministry of Labour	78	52.9
2. Basic Needs Basket of the trade-unions	62	34.7
3. Guaranteed Minimum Income used in social assistance	27	3.1
4. Orshanski method	89	63.9
II. Relative poverty lines:		
1.UNICEF (50% of average wage)	83	58.1
2. World Bank (66% of average expenditures)	54	24.8
3. 50% of median income	37	8.27
III. Subjective poverty line	46	73.9

Source: ILO, UNDP, 1998

Table 4.3: EU Indicators on Social Exclusion in Bulgaria

			1996	**1997**	**1998**	**1999**	**2000**	**2001**
S80/S20 quintile share ratio			:	:	3.8	3.6	3.6	3.9
Gini coefficient			:	:	25.7	25.0	24.8	26.1
Risk-of-poverty threshold	*1 person hh*	*NAT*	:	:	1,160	1,231	1,268	1,326
(illustrative values)		*EUR*	:	:	593	630	648	678
		PPS	:	:	2,406	2,555	2,631	2,750
	2 adults 2 dep. children	*NAT*	:	:	2,435	2,586	2,663	2,784
		EUR	:	:	1,245	1,322	1,361	1,423
		PPS	:	:	5053	5365	5524	5776

Table 4.3 continued: EU Indicators on Social Exclusion in Bulgaria

			1996	1997	1998	1999	2000	2001
Risk-of-poverty rate	*Total*	***Total***	:	:	15	14	14	15
by age		***M***	:	:	13	12	13	14
by gender		***F***	:	:	16	15	14	16
	0-15	***Total***	:	:	14	15	18	19
		M	:	:	13	16	18	17
		F	:	:	14	15	18	20
	16-24	***Total***	:	:	15	16	17	21
		M	:	:	15	16	18	22
		F	:	:	16	16	16	19
	25-49	***Total***	:	:	12	12	13	15
		M	:	:	12	12	14	15
		F	:	:	12	12	13	15
	50-64	***Total***	:	:	11	9	9	10
		M	:	:	9	8	9	10
		F	:	:	12	11	10	10
	65+	***Total***	:	:	23	19	14	15
		M	:	:	15	11	7	8
		F	:	:	29	25	19	20
Risk-of-poverty rate	*Employed*	***Total***	:	:	6	5	6	7
by most frequent activity		***M***	:	:	6	5	6	7
by gender		***F***	:	:	6	6	5	6
	Self-employed	***Total***	:	:	7	4	6	7
		M	:	:	9	3	6	8
		F	:	:	3	5	5	5
	Unemployed	***Total***	:	:	29	30	29	32
		M	:	:	29	30	30	35
		F	:	:	29	29	28	30
	Retired	***Total***	:	:	19	17	13	14
		M	:	:	13	10	8	9
		F	:	:	23	21	15	17
	Inactive/other	***Total***	:	:	14	15	17	18
		M	:	:	14	16	18	17
		F	:	:	15	15	17	18

Table 4.3 continued: EU Indicators on Social Exclusion in Bulgaria

			1996	1997	1998	1999	2000	2001
Risk-of-poverty rate	*Total*		:	:	15	14	14	15
by household type	*1 person hh*	***Total***	:	:	39	36	28	30
	1 person hh	***M***	:	:	24	22	20	20
	1 person hh	***F***	:	:	42	39	30	32
	1 person hh <30yrs		:	:	33	36	-	4
	1 person hh 30-64		:	:	25	22	21	24
	1 person hh 65+		:	:	46	43	33	33
	2 adults no children	*(at least one 65+)*	:	:	17	12	7	8
	2 adults no children	*(both < 65)*	:	:	9	6	6	6
	Other hh no children		:	:	4	6	6	10
	Single parent	*(at least 1 child)*	:	:	28	31	23	23
	2 adults 1 dep. child		:	:	11	9	8	11
	2 adults 2 dep. children		:	:	12	9	14	16
	2 adults 3+ dep. children		:	:	35	46	51	59
	Other hh with dep. children		:	:	12	14	16	15
Risk-of-poverty rate	*Total*		:	:	15	14	14	15
by tenure status	*Owner-occupier*		:	:	14	14	14	15
	Tenant		:	:	25	21	19	26
	Other		:	:	:	:	:	:
Dispersion around	*40% of median*		:	:	3	4	4	4
the risk-of-poverty	*50% of median*		:	:	8	8	8	9
threshold	*60% of median*		:	:	15	14	14	15
	70% of median		:	:	23	22	22	24
Risk-of-poverty rate anchored 1996 (e)			:	:	:	:	:	:

Table 4.3 continued: EU Indicators on Social Exclusion in Bulgaria

			1996	1997	1998	1999	2000	2001
Risk-of-poverty rate	*before all transfers*		:	:	34	35	39	42
	including pensions		:	:	16	17	17	19
	including all transfers		:	:	15	14	14	15
Persistent risk-of-poverty rate		***Total***	:	:	:	:	:	:
by gender		***M***	:	:	:	:	:	:
		F	:	:	:	:	:	:
Relative risk-of-poverty gap		***Total***	:	:	20	20	20	20
by gender		***M***	:	:	:	:	:	:
		F	:	:	:	:	:	:

Source: Eurostat; 2002

Table 4.4: Unemployment Dynamic and Structure (1991-2001)

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
1. Unemployment rate*	6.7	13.2	15.7	12.8	11.7	12.5	13.7	12.2	14.2	17.7	17.3
2. Youth up to 29 (% in total unemployed)	29.1	27.7	26.8	24.0	24.8	25.7	22.9	21.9	31.5	28.5	27.2
3. Women (% in total unemployed)	54.2	52.4	52.9	54.3	55.5	53.6	52.7	53.8	54.4	53.2	51.5
4. Long-term unemployed (% in total unemployed)	NA	NA	24.3	25.6	28.6	24.3	21.7	32.5	30.2	40.7	49.8
5. Unskilled unemployed (% in total unemployed)	32.4	49.8	50.2	52.9	56.7	57.2	57.8	58.6	58.2	56.7	57.4

* Unemployed registered at the Labour Offices

Source: Employment Agency, 2002

Table 4.5: Recipients of Social Assistance Benefits (thousands)

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Categorical benefits											
1. Uninsured parents	87	136	160	183	285	251	292	277	289	325	329
2. Facilities for disabled	298	271	235	225	178	135	146	146	225	235	286
Means-tested benefits											
1. Monthly benefits	89	189	253	201	69	65	76	105	197	215	243
take-up coefficient	12%	76%	58%	54%	47%	35%	41%	54%	61%	51%	57%
2. Energy benefits	-	-	-	-	137	476	516	537	564	617	630
take-up coefficient	-	-	-	-	29%	72%	84%	86%	81%	85%	87%
3. Lump-sum benefits	115	438	258	163	166	109	135	118	120	98	82

Source: Ministry of Labour and Social Policy

Figure 4.2: Parental leave for insured and uninsured parents (thousands recipients)

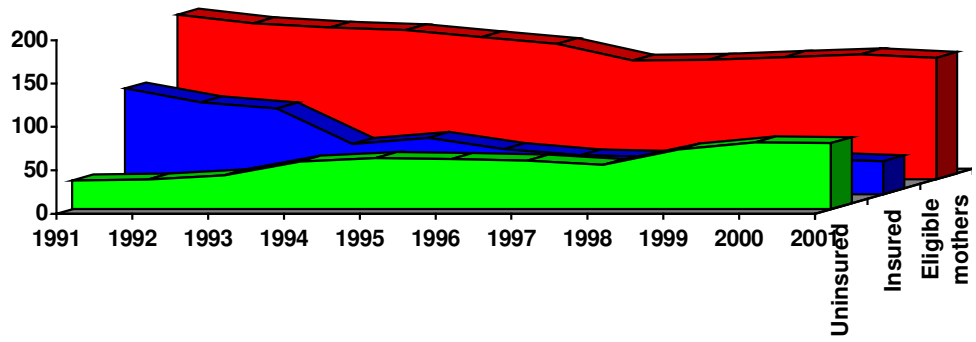
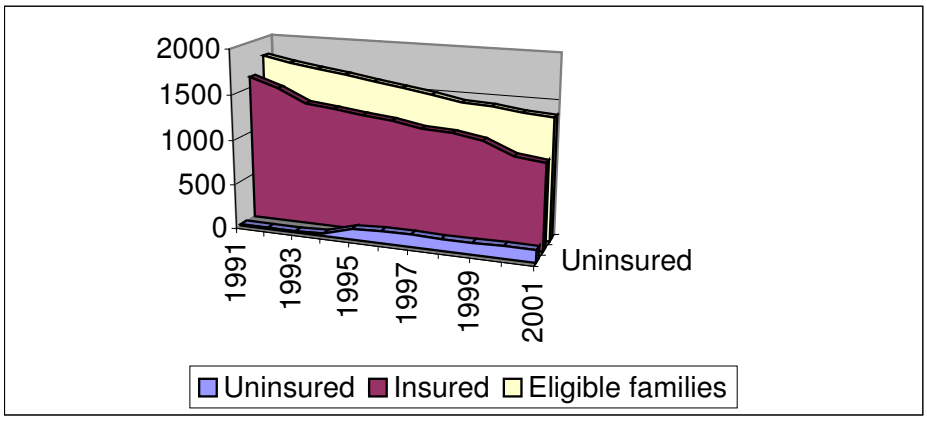


Figure 4.3: Child allowances for insured and uninsured parents (thousands recipients)



one label missing: "Insured"

Table 4.6: Poverty Measures by Ethnic Groups

	Share in Population	**Poverty rate**	**Share in the poor population**	**Poverty depth**
Bulgaria – total	100	36.0	100	11.4
Bulgarian	83.6	31.7	73.5	8.5
Turks	9.5	40.0	9.5	12.8
Gypsies	4.6	84.3	15.2	46.6
Other	2.3	46.9	1.8	15.0

Source: World Bank, 1999

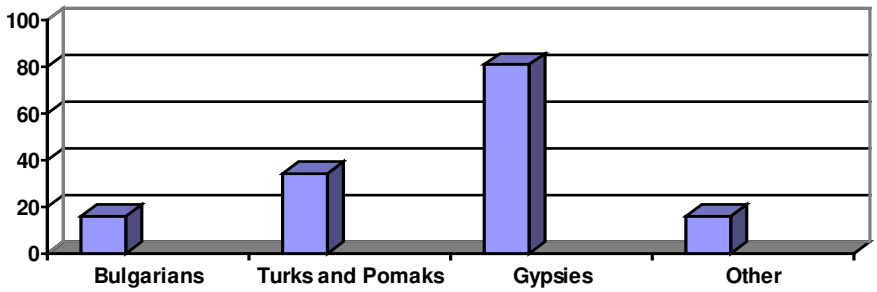
Table 4.7: Ethnic groups by completed degree of education (as % of the population aged 18 and above in the relevant ethnic group)

Completed degree of education	**Bulgarians**	**Turks and Pomaks**	**Gypsies**	**Average for the population > 18**
Lower than primary	1.2	11.8	18.7	3.1
Primary	6.4	14.0	37.8	8.8
Basic secondary *	22.2	49.2	37.9	25.2
Secondary	52.7	20.8	5.5	47.6
Tertiary	4.7	4.3	0.1	15.3
TOTAL	100	100	100	100

* 8^{th} class

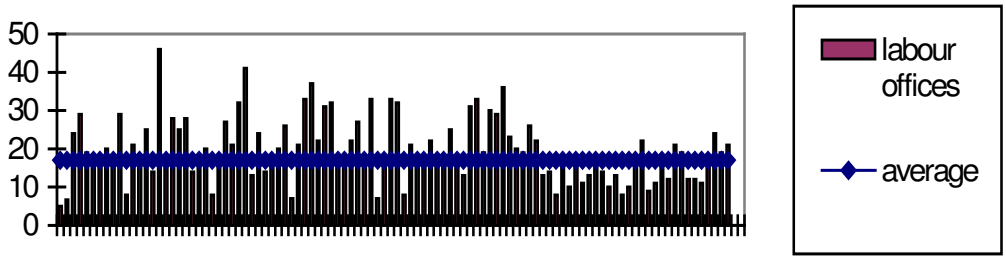
Source: Centre for the Study of Democracy, 1999

Figure 4.4: Unemployment rates by ethnic groups



Source: Centre for the Study of Democracy, 1999

Figure 4.5: Unemployment Rates by Labour Offices - 2001



Source: Ministry of Labour and Social Policy

Figure 4.6: Administration of Social Assistance: Central and Local Responsibilities

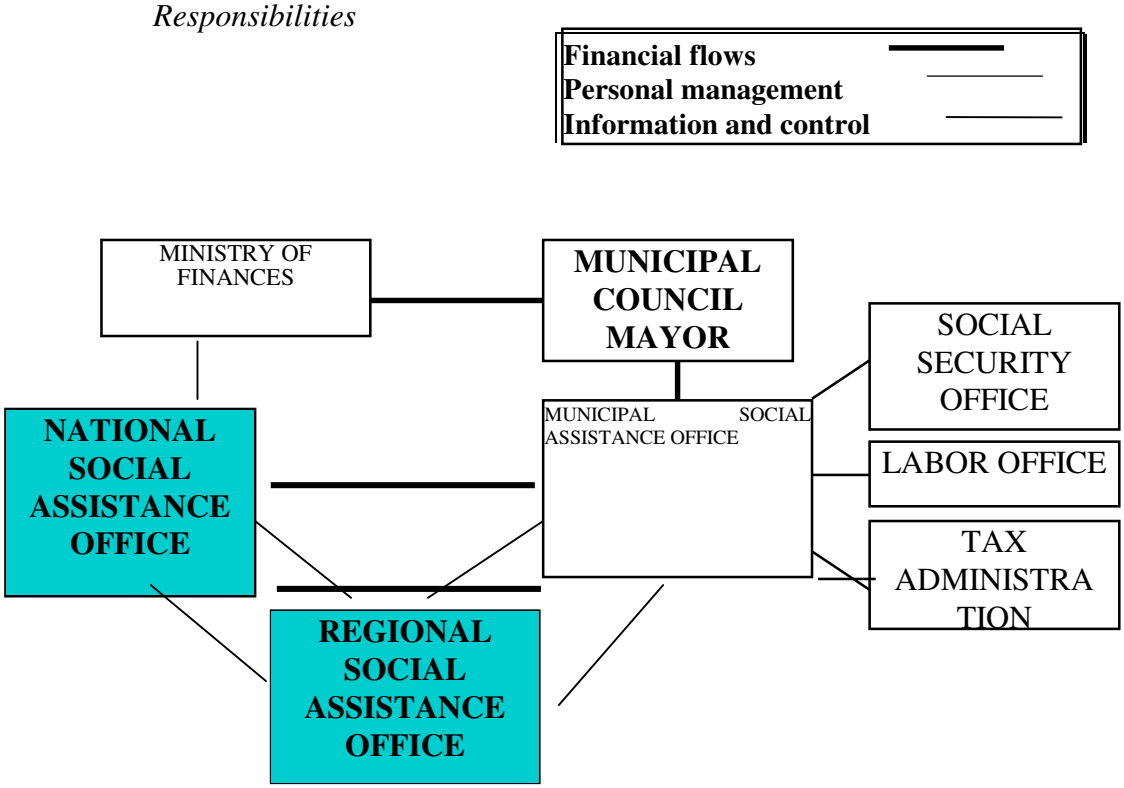


Table 4.8: Dynamic of Poverty (1995-2001)

	1995	1996	1997	1998	1999	2000	2001
Absolute poverty line (BGN)*	4.9	10.1	78	81	88	97	105
Absolute poverty rate %	66.8	79.4	52.9	38.7	36.0	38.1	39.7
Relative poverty line (BGN)**	2.5	4.4	54	56	58	60	61
Relative poverty rate %	24.7	19.6	24.8	23.0	19.9	14.6	11.7

Notes:
* Minimum consumption basket calculated by MLSP until 1997 and after by the trade-unions.

** Relative poverty line applied by the World Bank equal to 66% of households expenditures

Source: Households Budget Survey, NSSI

Table 4.9 Pensions, Unemployment Benefits and Social Assistance as % of the Total Household's Income by Deciles' Groups

	Average	I	II	III	IV	V	VI	VII	VIII	IX	X
Pensions	23.7	21.8	27.8	33.7	36.0	33.4	31.9	29.8	24.7	18.7	11.4
Unemploy-ment benefits	0.7	2.9	1.7	1.2	0.9	0.8	0.7	0.6	0.5	0.4	0.2
Social Assistance	1.3	6.6	3.2	2.3	1.5	1.2	1.0	1.0	0.9	0.7	0.6

Source: Households Budget Survey, NSI, 2001

Table 4.10: Risk Groups by Poverty Status

Lower poverty line: Basic Minimum Income (EURO 20)		**Upper Poverty Line: 66% of average households expenditures (EURO 30)**	
Social group	Percentage of risk	Social group	Percentage of risk
Socio-economic status			
1. Unemployed	21.1	Unemployed Economically inactive	76.4 55.9
Professional status			
Unemployed Low-qualified workers	4.3 3.6.	Unemployed Low-qualified workers	58.7 53.3
Educational level			
No education With primary education	8.2 4.4	No education With primary education	65.4 60.9
Number of children below 18 years			
1. With 3 and more children	35.4	With 3 and more children With two children	81.2 58.7
Number of members of the household			
1. With 6 and more members	17.8	1. With 6 and more members	76.0
Pensioners			
Households without pensioners Households with pensioners	5.9 4.4	Households with pensioners Households of pensioners	53.5 52.7
Residence			
1. In the villages	4.6	1. In the villages	51.2
Size of settlement			
Small villages Small towns	5.5 4.1	Small towns Small villages	52.1 51.0

Source: Households Budget Survey, 2001

5. HEALTH CARE

5.1 Evaluation of Current Structures

5.1.1 Bulgarian Healthcare System

The Bulgarian healthcare system consists of bodies, institutions, organizationally independent structures whose task is to strengthen, preserve and restore the health and support the treatment of diseases, based on the medical science and practice, traditions and the specific social and economic conditions in the country.

The national healthcare system is built on three levels:

- National - covering the territory and the population of the whole country;
- Regional - covering the territory and the population of an administrative district of the territorial division of the country;
- Municipal - covering the territory and the population of a municipality.

On a national level, the management and the co-ordination within the system is carried out by the Minister of Health, who is the sole body of the state authority, who is responsible for the healthcare. On the regional level, the management and the co-ordination is carried out by the Director of the Regional Health Centre (RHC), which is a territorial body of the Ministry of Health. On the municipal level the responsibility lies with–the head of the municipal health office.

Besides the mentioned administration, which represents the state and the municipal health authorities in the Bulgarian healthcare system, there are other institutions and structures which deal with healthcare financing, the rendering of medical care and with activities, related to the public healthcare. These are:

The National Health Insurance Fund with a Head Office in the city of Sofia, 28 Regional Health Insurance Funds – one in every district centre and 120 municipal offices. NHIF is established under a special law with the responsibility to carry out the mandatory health insurance in the Republic of Bulgaria, which is a system of social health protection of the population, guaranteeing a package of health services for every citizen. The obligatory health insurance contribution amounts to 6% of the income of every employee, divided between the employee and the employer in proportion 25:75 for 2002. The National Health Insurance Fund buys healthcare for the health insured persons with the funds, collected from the contributions and based on contracts with medical doctors and health establishments.

Professional organizations of doctors and dentists – these are organizations, established by law. The Bulgarian Doctors Union and The

Union of the Dentists in Bulgaria – which unite all doctors, including dentists, through mandatory membership and bear the responsibility for the signing of the National Framework Contract with the National Health Insurance Fund every year. The National Framework Contract specifies the rules for best medical practice, for compiling and implementation of a Code of Doctors' and Dentists' Professional Ethics, for disciplinary proceedings and arbitration, for the organization and implementation of training courses for doctors and dentists, for the protection of their rights, etc.

Medical care establishments, which might be:

- Individual practice for primary medical care;
- Group practice for primary medical care;
- Individual practice for outpatient specialized medical care;
- Group practice for outpatient specialized medical care;
- Medical centre; specialized centre; medical dental centre;
- Diagnostic and consultation centre;
- Medical diagnostic and medical technical laboratories;
- Hospitals:
  - for active treatment;
  - for continuous and long – term treatment;
  - for rehabilitation;
  - for continuous and long – term treatment and rehabilitation.

  The hospitals may also be:
  - specialized;
  - multiprofile;
  - regional;
  - district;
  - interregional;
  - national;
  - university.
- Emergency Medical Care Centres;
- Blood Transfusion Centres;
- Dispensaries – with or without a stationary;
- Homes for medical and social care;
- Hospices.

Healthcare establishments, carrying out activities, related to the public healthcare, namely: promotion, prevention, screening programmes for controlling socially significant diseases, anti-epidemic and epidemiological control, etc.

These are:

- Hygiene-Epidemiological Inspectorates – 28 – one in each district and their branches in the municipalities - Hygiene-Epidemiological Offices
- National centres with functions in the public healthcare

These include the National Public Health Centre, the National Hygiene, Medical Ecology and Nutrition Centre, the National Radiobiology and Radiation Protection Centre, the National Infectious and Parasites' Centre, the Pharmaceuticals' Executive Agency, the National Health Information Centre, and the Regional Health Centers, dispensaries.

The National Public Health Center is responsible for the provision of analyses of health care systems and models, development of projects for the implementation of the national health strategy and measures for health promotion and prevention.

The National Health Information Centre is developing and maintaining information data base for the health and demographic status of the population, the resources and the activities in the health sector. It also analyses the information needs in the medical practice and provides with medical and statistical information.

The Hygiene and Epidemiological Inspections are responsible for preserving and strengthening the public health through assessing the health indicators and risk from health aggressive factors of environment, prognosis, planning and implementation of efficient control, anti-epidemic and prevention activity.

The National Centre for Hygiene, Medical Ecology and Nutrition is dealing with scientific, diagnostic and expert activities in the field of hygiene, nutrition and environment recovery.

Health establishments under the Ministry of Defense, the Ministry of Interior, the Council of Ministers, the Ministry of Justice and the Ministry of Transport have also functions within the healthcare system.

The same concerns other institutions as well, which are outside the Ministry of Health, but represent Higher Medical Institutes and the colleges . These include the Medical Universities of Sofia and Varna, the Higher Medical Institutes in Pleven and Plovdiv, the Medical Faculty with the Thracian University in the city of Stara Zagora and the Higher Military Medical Institute in Sofia.

There are also healers in Bulgaria, who have no diplomas in medicine and whose number is not covered by statistics. In this respect, the informal payments to them have not been studied. There are informal payments in the health system; however they have not been studied with methods which

would guarantee the trustworthiness of the data. It is considered that the black market does not exceed 5% of the costs of healthcare.

After the start of the reform in the healthcare sector in 1999, a large-scale and quick decentralization process took place within the system. The National Health Insurance Fund, the Bulgarian Doctors' Union and the Union of Dentists in Bulgaria were established and they were delegated functions, obligations and rights through special legal acts. The same happened also with the health establishments in the outpatient and inpatient sectors, which were transformed from public health establishments with state or municipal share into financially, economically and legally independent commercial enterprises – either limited liability companies, or joint-stock companies. Their ownership has turned into a corporate private ownership – either state private or municipal private. A part of the health establishments in the outpatient sector was privatized by the doctors' teams by the end of 2001.

The concept of ownership in the Bulgarian healthcare system is related with the following terms from the general property legislation – public state property, private state or private municipal property or pure private property.
Public state properties as defined in the Law for State Ownership are all objects of exclusive belonging to the state as per Bulgarian Constitution, the estates of public and state institutions and the estates needed for permanent supplies for public needs from national importance and through public use. For the health sector these are emergency healthcare services, blood transfusion centers, psychiatry clinics, institutes and national centers the activities of which are connected with the so called indivisible effect for the population (hygiene and epidemiological inspection, state sanitarian control, etc.), approximately 15% of the hospitals.
Private state properties (or municipal) are all other estates or entities where either the state or the municipality is the majority shareholder or single proprietor. In the Bulgarian health sector these are 79% of the hospitals. They are registered as trade companies under the Trade Act and can enter into contractual relations with financing institutions and this legal status facilitates their operation in market oriented environment.
Purely private are approximately 6% of the hospitals.

Where as the out- patient care sector is concerned, the medical activity there is fully privatized. It belongs to the health care providers themselves. The assets such as buildings, equipment, etc. are owned either by the doctor or the group of doctors themselves (such as most GPs, dentists, group medical and dental practices, etc.) or they are owned by the municipality or other private owner and the medical professionals are contracted or pay rent for the use of them.

The National Health Insurance Fund is the main financing institution for the out – patient care sector and second in volume buyer (after the Ministry

of Health) of hospital services for the population. Its administrative efficiency is high. No budget overspendings were made in 2001, contracts with more than 18,500 healthcare providers (both individual and corporative) have been signed and medical and financial audits have been carried out for more than 30% of the medical care establishments within a one year period. The payments to the healthcare providers were carried out every month without any delay. The administrative efficiency of the health authorities has improved after the administrative reform, which was based on the State Administration Act and the Civil Servant Act and was carried out in 2000. Health administrations are still demonstrating some weak points due to the newly introduced requirements of the Health Establishments Act and due to the insufficient qualification and training campaign among them. The primary health care doctors are redirect patients for consultation and treatment to the hospital care sector. Monthly limits for GP referrals to specialists exist. They consist of 8% of the total number of assigned patients and are indicative. Depending on the structure of morbidity, the age of the patients and the number of chronically ill this percentage can be increased. There are no limits for hospitalization.

The health insurance contributions are obligatory and they are being gathered through the existing structures of the National Social Security Institute. They are further transferred to the National Health Insurance Fund. Unlike other CEECs and some EU countries, Bulgaria has chosen the model of single health insurance fund as a source of more financial stability and because in this way the maximum scope of solidarity has been reached. Further to that it provides best balance of the territorial disproportions, most economically effective development and enables monitoring and control systems over the implementation of individual contracts with healthcare providers.

With the Health Insurance Act the legislative ground for voluntary health insurance is being set. However, due to many reasons among which general economic environment in the country and lack of managerial and administrative capacity, this sector is still underdeveloped. Currently there are only two legitimate voluntary health insurance fund in Bulgaria – *Zakrila* and *Doverie.* The number of Bulgarians who pay voluntary health insurance contributions is estimated to be around 20,000.

The reform processes in Bulgaria focused on the issue of quality assurance as well. The main achievement was the introduction of the accreditation of health care establishments.

Accreditation in Bulgaria is mandatory for health care establishments for in-patient care (hospitals) and diagnostic and consultative centres and is voluntary for dispensaries, medical and technical laboratories and medical-diagnostic laboratories.

The Bulgarian accreditation program assesses the health care establishments against explicit, published standards (criteria and indices) for structures, processes and outcomes using teams (Temporary Evaluation Expert Commissions) who report to the Accreditation Council at the Ministry of Health.

5.1.2 Benefits

In the health system, healthcare is provided through two main ways –firstly, through the system of public healthcare, funded from the national budget, and, secondly, through the mandatory health insurance system. The latter is financed by 6% mandatory health insurance contributions and is organized on a social principle based on solidarity. A healthcare package is provided to every health insured citizen, which is regulated through an Ordinance of the Minister of Health. The access to healthcare is guaranteed by the National Health Map, enforced by a Council of Ministers Decree.

The National Health Insurance Fund pays for the following kinds of medical care rendered:

- Medical and dental activities for the prevention of diseases;
- Medical and dental activities for early discovery of diseases;
- Outpatient and inpatient medical care for diagnostics and treatment of diseases;
- Medical rehabilitation;
- Emergency medical care;
- Medical care in case of pregnancy, birth and maternity;
- Abortions due to medical reasons and in case of a pregnancy after a rape;
- Dental and dental mechanical care;
- Medical care in case of home treatment;
- Medicines and consumables for home treatment;
- Medical expertise about working capacity;
- Transport services in case of medical need.

Since 2001, the National Health Insurance Fund has paid for medical care, on the basis of a contract with the relevant hospital for rendered medical care within clinical pathways.

Since 2000, the Ministry of Health and the municipalities have paid for inpatient medical care in accordance with a contract with the relevant hospital, which provides for 80% advance monthly payment of 1/12th of the agreed global budget for the year plus quarterly balance payments of the

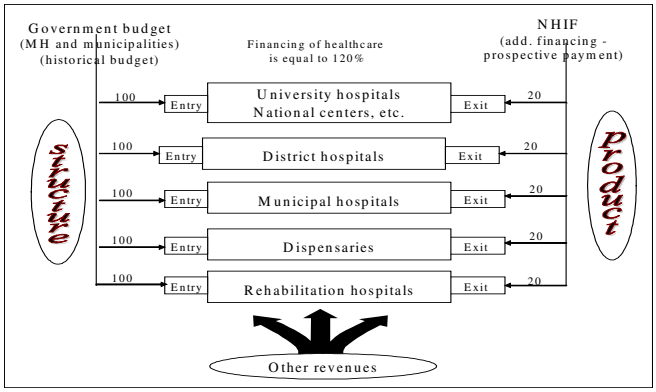
remaining 20%, based on the report for treatment activities, performed by the hospital.

Health services are being purchased also by companies for voluntary health insurance, insurance companies or cash payments by citizens, but their scale and range are not representative enough so far.

The current system which is inherited from socialist times is quite an extensive health system which is still characterised by over capacity. This could be proven with the following data:

- Doctors – 3,6 per 1,000 population or 1 doctor for 288 persons;
- Dentists – 0,6 per 1,000 population or 1 dentist for 1,581 persons;
- Middle level personnel – 9 per 1,000 population or 1 for 111 persons;
- Hospital beds for active treatment, long – term care and rehabilitation – 1 hospital bed per 123 persons.

Bulgarians are free to chose their family doctor and can change their choice once at every six months. The choice of specialist is free but the GPs act as gate – keepers. Should the patient decide to jump over the GP referral, he or she must pay a fee- for –service to the specialist. The choice of the hospital is regulated by a special Ordinance, as the state is still responsible for most of the financing in this sector. With the further introduction of the health insurance in hospitals, the choice of the patients will be released more. Currently, both the NHIF and the state through the Ministry of Health are prospectively financing the hospitals through contracts. The table below represents what were the financial flows for 2001, where 100% is the historical financing based on 2000 budgets and 20% are the prospective payments from NHIF under clinical pathways.



NHIF presentations, 2001

5.1.3 Financing the Health Care System

The healthcare system is financed through:

- Taxes, part of which are subsequently allotted for healthcare as per the Law on the State Budget of the Republic of Bulgaria;
- Mandatory health insurance contributions to the amount of 6%, an amount which is determined every year by the Parliament through the Law on the Budget of the National Health Insurance Fund. They diminish the taxable income base of the person;
- Voluntary health insurance contributions – determined on a market principle by the private health insurance companies for voluntary health insurance;
- Insurance premiums - determined on a market principle by the private insurance companies;
- Subscriptions by employers for specified health services as part of the social package provided to their employees;
- Cash payments by citizens to private practicing doctors, dentists or health establishments, which have not concluded a contract with the National Health Insurance Fund;
- The regulated patient's co -payment for use of healthcare amounting to 1% of the minimum monthly salary for the outpatient sector and 2% of the minimum monthly salary for each day of stay in a hospital, but for no more that 20 days per year. Persons, who suffer from diseases, specified in the National Framework Contract, socially disadvantaged (people who are eligible to social assistance or receive unemployment benefits), children deprived of parental care, military invalids etc. are relieved from this fee. Co- payments are not deductible from the taxes of insured people, but are subject of turnover tax for the doctor.

The overall expenditures for 2001 are in total 748.7 million EURO.

Cost sectors and proportions for 2001 are as follows:[13]

IN EURO

Primary healthcare (NHIF)	52.8m	7%
Dental care (NHIF)	18.9m	2.5 %
Specialised outpatient medical care, incl. Diagnostic services (NHIF)	59.5m.	7.9%
Inpatient care (MH, MHIF, municipalities, others)	35.8m	46.9 %
Medicines (MH, MHIF, others)	25.8m.	33.7 %

[13] The exchange rate in 2001 is 1 EURO is 1.95 BGL.

Incl. – central delivery and reimbursed (MH, MD and MHIF)	178.4m	23.8%
- free market	73.4m	9.%
Emergency medical care	-BGN 29m	

The following table illustrates the health care funding for 2001:

IN EURO

Taxes	415.3m
- incl. – MoH	242m
- Municipalities	141.5m
- Others	31.8m
Mandatory health insurance (NHIF)	207.1m
Private health insurance – about	2.6m
Private insurance	no data
Official cash payments in the medical care institutions – about	Approx. 153m
Informal payments	There is no trustworthy data, but it is considered that they represent about 5% of the total funds allocated for healthcare.

Since the year of its establishment and currently there is no deficit in the National Health Insurance Fund budget. The Fund ends the year with considerable reserve and is at present the most financially stable institution in the country. The NHIF Budget is approximately 10% of the total State Budget.

5.1.4 Incentives

The regulated incentives in the Bulgarian health system concern the following groups of people:

- Employers and employees, paying mandatory health insurance contributions – the taxable basis before taxes is decreased by the amount of the contributions;
- All contributions for voluntary health and social insurance and life insurance are recognized as expenditures for the employer as long as they do not exceed 40 BGL per employee per month and are deducted from the revenues when taxes are calculated;
- General practitioners, who work in distant settlements and in an unattractive work environment receive free of charge equipment and furniture for their cabinet by the Ministry of Health. In addition, the National Health Insurance Fund pays an amount of money for the

unattractive labour conditions. For example, in 2000, as a result of the implementation of such measures more than 600,000 persons, who live in distant regions which are difficult to access, have received a direct access to medical care for the first time. Under a World Bank loan financed project, nearly 1,800 GPs out 5,000 in total received equipment and/or grants for renovations of their practises.

- The hospitals, which are capital commercial enterprises and which gain profit, have the possibility to retain the amounts which they owe to the Ministry of Finance as tax on profit with the condition to reinvest them in medical equipment, overhauls, etc.
- The doctors and other staff who have labour contracts with hospitals are entitled to additional compensations at the discretion of the hospital management and in accordance with the kind, quantity and quality of their work. The additional compensations should not exceed 40% of the revenues from clinical pathways, financed by the National Health Insurance Fund. The clinical pathway is more a tool for quality assurance than a method of payment. It was developed with the consultation assistance of the Australian Health Insurance Commission and will be basis for the further introduction of DRGs and case- mix in the country. The clinical pathway is an obligatory package of medical activities and responsibilities of medical specialists, connected with the treatment of patients with certain diseases. Currently there approximately 40 clinical pathways developed and in use covering over 400 diseases.

The medical staff within the Republic of Bulgaria is highly qualified and this reflects positively on the quality of the medical services. In 1999, when the remuneration methods in healthcare were changed, the motivation and the attitude of the doctors towards the patients changed dramatically. The salary under a labour contract was transformed into remuneration, based on capita plus activities at the primary medical care; a fee for visit in the specialized outpatient medical care; a fee for service in the diagnostic activities and payment as per the clinical pathways in hospital care. This created a competition, which opened the health system towards the patient and improved at some places the quality of the services.

A major issue for the Bulgarian health system is how to limit the inefficient expenditures, as well as their regulation as a whole. Almost 33,851 doctors are registered in Bulgaria, from which 28,000 are considered as actually practicing. The number of medical staff of secondary education is about 70,000. In 2000 the total number of hospitals is 299, with a total of 60,552 beds. Of the existing multi- profile hospitals, 32 are regional (13%) with a total of 19,582 hospitals beds (35%) and 102 district hospitals (41%) with a total of 15,000 hospitals beds (27%). The private hospitals are 18 and they have a total of 306 beds. These high indices per capita are also immediate reasons for the inefficient expenditures in the healthcare, which, combined with an insufficient budget seriously deteriorate the health services market in Bulgaria. The introduction of the processes of the National Framework

Agreement (NFA) between the NHIF and the professional organizations is the first step towards solving the problems. The NFA contains:

- the conditions and the rules for identifying of eligible health care providers with which the RHIF is signing a contract;
- the different types of medical care provided for the insured;
- the conditions and order for providing such assistance;
- the volume, the prices and payment methodology;
- requirements for quality assurance, access, accounting, and documentation;
- the pharmaceutical lists for full or partial reimbursement;
- the rules and regulations for medical audit and financial control.

The NFA is being negotiated and signed annually.

It is important to note that the free market laws do not work in the same way in the field of healthcare and this is recognized by many analysts, including economists. One of the important constituents of the efficient free market is missing in healthcare, namely the fact that the user (the patient) is not well informed about the product (the treatment) and usually accepts the doctor's decision, i.e. the producer makes a decision on what the consumer should consume. That is why it could be considered that in some cases the demand rises in order to consume the supply. In this respect it would be useful to study the dependence between the frequency of certain diagnoses and diseases and the number of the relevant doctors – specialists.

5.1.5 Coverage of the System and Access to Care

The social health insurance of the Republic of Bulgaria, administrated by the National Health Insurance Fund, does not envisage exclusion from the obligatory insurance system. The following people are obligatorily insured:

- All Bulgarians who are not citizens of another country;
- Bulgarians that are citizens of another country, but live permanently on the territory of the Republic of Bulgaria;
- Foreign citizens or people without citizenship who have a long-term permit to reside in the Republic of Bulgaria, unless otherwise provided by an international treaty signed by the Republic of Bulgaria
- Individuals with a refugee status or those having a right of shelter.

The income base, on which the 6% obligatory health insurance contribution it is calculated, is two minimum monthly salaries as a minimum and is capped at the ceiling of ten minimum monthly salaries. Currently over 90% of the population is insured.

There are penal mechanisms for individuals who have not paid more than three due health insurance contributions – they loose their health insurance rights and have to pay for medical care by themselves at market prices. After renewing the payment of the health insurance contributions, the insurance rights are renewed as well. The non-payment of the health insurance contributions by the employer does not deprive the person of health insurance rights, and the amounts potentially paid by him/her for medical care shall be reimbursed. There is no difference in health insurance or access to medical care on the basis of gender, religion, ethnos, race or any other feature.

However, there are in practice specific groups of the population that do not know how to utilise the advantages guaranteed by the social health insurance, because of educational, cultural or other reasons.

The access to healthcare is regulated by the state and does not depend on the financial and property status of the individuals. At the moment of its rendering, the medical care is free of charge for the patient, as its cost is covered by the National Health Insurance Fund or the state budget. The National Health Map specifies the territorial coverage with health establishments and the number of necessary specialists in accordance with the healthcare needs of the population. At present, there are no regulated or actual waiting lists of patients in Bulgaria, with the very slight exceptions related to valve prosthesis, transplantations, and joint prosthesis. The route of the patient is regulated through Ordinance, issued by the Ministry of Health.

The choice of a general practitioner (GP) is completely free in the primary medical care, so that every citizen has the right to change his/her choice once in every six months. The choice of a dentist could be changed every day. The patient together with his/her general practitioner (family doctor) choose the outpatient expert or the health establishment, but within the district. Hospitals can also be chosen freely within the district, while, on a national level, the districts are attached to specific university hospitals or national centers.

The deviations from the outlined path of the patient between the regions is considered a personal choice and the healthcare received after the personal choice is paid by the patient at prices, which the specific health establishment specifies based on the market principle.

The regional distribution of health care facilities is being achieved through a National Health Map. The National Health Map specifies the territorial coverage with health establishments and the number of necessary specialists in accordance with the healthcare needs of the population. It is being prepared on the basis of 28 District Health Maps, which are health planning instruments. They are being developed after assessment of the

geographic, infrastructural, demographic, social and health characteristics of the different districts in the country. The current health care establishments and their capacity to provide medical services, the needs of the population from emergency, primary and hospital care are also taken into account. The District Health Priorities are influencing the final outlook of the map. The District Health map includes:

- The geographic borders of the health regions;
- The type, number, activities and distribution of the health care establishments in the district;
- The number of doctors and dentists in the outpatient care by specialties.

The National Health Map, apart from the above – mentioned by districts, consists of assessment of the national health priorities and the minimum number of health care establishments for both outpatient and inpatient care with which the National Health Insurance Fund obligatory signs contracts. This aims at provision of access and equality for all citizens, The National Health Map is being adopted by the Council of Ministers and is subject of actualization at every 5 years.

5.1.6 Public acceptance of the system

The healthcare legislation was almost completely renewed after 1998. Besides amendments in the already existing Public Health Act from 1973, seven new laws on the structure of healthcare were created, as follows:

a. Health Insurance Act –State Gazette No 70, 19th June 1999;

b. Healthcare Establishments Act – State Gazette No 62, 9th July 1999;

c. Professional Organizations of Medical Doctors and Dentists Act – State Gazette No 83, 21st July 1998;

d. Pharmaceuticals and Pharmacies in Human Medicine Act – State Gazette, No 36, 18th April 1995;

e. Foodstuffs Act – State Gazette No 90, 15th October 1999;

f. Control on Drugs and Precursors Act- State Gazette No30, 2nd April 1999;

g. Occupational Safety and Health Act – State Gazette No 124, 23rd December 1999.

In addition, the law on the state budget and the law on the budget of the national health insurance fund settle the annual financing of the healthcare system.

The number of sub-legislation acts is between 10 and 20 regulations per law. This creates the feeling that the system is not transparent, due to a lack of knowledge of the legal norms and a lack of practice, related to their application.

Besides this fact, it is important to mention that the health insurance was introduced in the country in an exceptionally short period- only within three years, which brought additional pressure for the quick adoption of new rules and regulations. The reforms in the health sector were accomplished in combination with other serious reforms, such as the economic sector reform (the structural reform), as well as the one of the social sector (the pension reform), which also had its impact on the public disapproval of the changes.

From the researcher's point of view, serious attention should be paid to the psychology and cultural inclinations of Bulgarians. The fact that Bulgarians do not trust the state at all and their confidence in the public institutions is exceptionally low is very interesting. At the same time, they expect that the state should solve their problems. The transition period, which has been taking place for 12 years now, gave birth to a desire to live under a non-existent social system, which could be conditionally called "a communist democracy". Similar understandings appear to be an obstacle for the perception, understanding and support of changes as a whole, but are extremely important when areas as for example healthcare are concerned. The decisions in this field affect at once all eight million Bulgarians, as well as almost 120,000 medical professionals. To reach a consensus and public acceptance on such a scale is a serious challenge.

The fact that in 1999 almost 59% of the Bulgarians did not approve of the health reform, but 94% of all Bulgarians chose a general practitioner (GP) is evidence that there is a serious difference between words and actions. The level of collecting the obligatory health insurance contributions was 98.5% by December 2001.

When speaking of public communications of the health reform in Bulgaria, it is important to mention an interesting phenomenon – creation of myths and belief in rumours. Their appearance was inevitable, but, unfortunately, additionally stimulated by the lack of professional informational campaigns from the very beginning of the changes.

Very interesting is the sociological research showing that the larger percentage of persons dissatisfied with the quality of the medical care, are those who have never used health services. The same is valid for the evaluation of the level of corruption. People who were questioned about this issue and who had never used healthcare were convinced that the level of corruption is high. At the same time, those, who were regular patients were surprised by the lack or the very small "payments under the table".

Other important factors that played a role in the process of convincing the Bulgarian society of the need of change and the benefits of the new healthcare model for the society should not be neglected. Such factors are the internal opposition of part of the medical professionals, the lack of good co-ordination between the different institutions that carry out the changes etc.

The regional discrepancies in approval and disapproval of the healthcare reform are particularly important. Doubtlessly, people living in regions of the country where the index of human development is higher, exhibit a higher percentage of approval and vice versa. The introduction of general practitioners (GPs), as well as the additional incentives provided by the National Health Insurance Fund for work in unattractive regions made doctors go back to small villages and towns, where there had been no medical care for years.

The level of knowledge in the medical circles and among the citizens is gradually improving, which leads to the fact that according to a number of sociological studies a biased approval is identified mainly in the professional areas and a higher level of disapproval is identified among the users of medical care. More efforts are needed in training and public campaigns to inform the society about the new rules of the health system, as well as about the rights, obligations and responsibilities.

5.2 Evaluation of future challenges

5.2.1 Main challenges

The reforms in the Bulgarian healthcare are provoked not only by the necessity of modernization and restructuring of the existing Semashko type system but firstly by its inefficiency and bad condition and the trends in citizens' health.

The following average numbers illustrate the above statement:

- Demographic processes – the total population decreased considerably from 8,669,300 in 1990 to 8,230,400 in 1998
- birth rate shows a firm trend of decrease
  1990 – 105,180 births
  1998 – 65,361 births
- the abortion rate is increasing in comparison with the birth rate:
  1990 – 70 per 1,000 women in fertile age
  1998 – 50 per 1,000 women in fertile age
- natural growth of population
  1990 – 0.4
  1998. – 6.4

- death rate
  1990 – 12.5 per 1,000 people
  1998 – 14.3 per 1,000 people
- Morbidity rate – excerpt for certain diseases
- tuberculosis
  1990 – 25.9 per 100,000 people
  1998 – 49.8 per 100,000 people
- syphilis
  1990 – 385 registered patients
  1998 – 7,668 registered patients
- morbidity, leading to temporary disability
  1990 – about 81 cases per 100 insured persons
  1998 – about 130 cases per 100 insured persons
- morbidity, leading to permanent disability
  1990 – 4,14 per 1,000 insured persons
  1998 – 4,64 per 1,000 insured persons

- structure of registered diseases in 1998
- Diseases of the respiratory system - 39.0%
- Diseases of the blood circulation system - 9.8%
- Traumas and toxemia - 7.4%
- Diseases of the neural system and sense organs - 12.1%
- Diseases of the skin and hypodermic tissue - 6.2%
- Diseases of the digestive system - 5.3%
- Diseases of the urino-genital system - 6.3%
- Other - 13.9%

This brief illustration of data shows that the challenges to the Bulgarian healthcare system are not small at all and do not involve only the above listed health indicators. They could be grouped in the following sequence:

- Challenges related to the health status of the population; the Bulgarian health system should overcome the negative trends in the health indicators of the population as described above.
- Challenges related to the model, structure, organization and management of the healthcare system; necessary changes are connected with decentralisation, ownership and juridical status of the health care establishments, corporisation of the management, regulation of the number of facilities without efficient administrative measures. The old Semashko model is changing into a social health insurance model based on solidarity and equity.
- Challenges related to the financing of the healthcare system; the funds for healthcare should be increased and at the same time their more effective spending should be ensured.
- Challenges related to innovations and investments in modern medical technologies and medical science;
- Challenges related to the development of the human potential in the healthcare system – medical education, specialized studies, continuous qualification, employment, quality of health service; a sound system for training and continuous education in the health sector must be developed which should be financed both by the state and the employers.
- Challenges related to the costs and efficiency of healthcare; an optimum medical effect for every unit cost should be attained in the health care sector.
- Challenges related to the introduction of new information technologies in the system. A Unified Information System should be developed in the health sector using health information standards.

5.2.2 Financial Sustainability

The dynamics of healthcare costs shows a positive trend in the last few years after the great collapse of the system in 1996.

Year	1995	1996	1997	1998	1999	2000	2001
% of GDP	3.66%	2.9%	3.3%	3.5%	4.1%	4.14%	4.33%

National Health Strategy, 2001

These figures reflect the processes of economic stabilization after the introduction of a currency board in the country and the striving of the government to improve the healthcare status and the population health indicators through legal, structural, organizational, financial and managerial reforms. The financial sustainability of healthcare is guaranteed by the legislator through the annual approval of expenditures for healthcare based on estimates for the system development, through the Law on the State Budget and the Law on the Budget of the National Health Insurance Fund. Such forecasts are an integral part of the National Health Strategy and the Operational Plan, which outline measures for the next ten years. The National Health Strategy and the Operational Plan were approved by the Government of the Republic of Bulgaria in 2001. Health authorities, municipal authorities, the National Health Insurance Fund and a number of supervising and auditing institutions monitor the expenditures for healthcare and ensure that such expenditures do not exceed the parameters set out in the relevant budgets and thus control the financial sustainability and stability of the health system.

The forecast for future expenditures is part of the National Health Strategy and looks as follows:

Year	2002	2003	2004	2005	2006
% of GDP	4.6%	5%	5.4%	5.8%	6%

National Health Strategy, 2001

The forecast is based on detailed analyses of the health and demographic indicators, the health care expenditures, the health priorities and needs of the population. It also takes into account the costs associated with the further introduction and development of the national health insurance scheme. The answer to the rising expenditures in the future is either the increase of the percentage of GDP allocated for health or increase of the health insurance contribution.

5.2.3 Health care policy and EU accession

Traditionally, healthcare is not quite the focus of the discussions regarding the pre-accession to the European Union. This is one of the underestimated

sectors with respect to its importance and the possible difficulties it could provoke. To support the last statement it is worth mentioning the notorious Kohll and Decker case in Luxembourg where it was resolved that any insured person is entitled to use medical care in any other member state and the cost of the services should be paid by the state in which the said insured person has paid his/her health insurance contributions. This case raised a number of discussions regarding the future of the healthcare systems and their budgets.

The health insurance system is major part of the social security relations in a country. Bulgaria chose the model of social health insurance that is typical for countries like Germany, Belgium, France, the Netherlands, Austria, Luxembourg, etc. Undoubtedly, the efficient introduction of a health insurance system has vital importance for the process of economic reforms because a smoothly running health insurance system would reduce the pressure on the national budget and would introduce incentives for provision of high quality and efficient medical services.

However, the direct transfer of the European laws to the legal practice in the Republic of Bulgaria would make the institutions called upon to provide social and health insurance unable to act and would lead to financial cataclysms.

Under the supervision of the Ministry of Labour and Social Policy, a number of approval procedures are organized regarding the harmonization of definitions and regulations covered by the regulations of the European Union and the resolutions with respect to such regulations. Special attention is drawn to regulation 1408/71 about the social security relations between the EU member-states.

The expected effects from the EU accession are measured within the following aspects:

- harmonization of legislation;
- deployment of capacity for practical application of such new legislation along with the relevant campaigns, training, expenses, etc.
- synchronization of insurance schemes between the member states and the candidate states;
- synchronization of educational, qualification, information and other standards;
- achievement of bilateral and multilateral agreements between the insurance institutions in the different countries and also interstate agreements with respect to social security and free movement of people, goods, capitals and services.

It is important to note that the free movement of people will affect migration differently. If current trends are maintained, the migration flows from Bulgaria to EU will be primarily doctors from the hospitals system as the reform there is slowed down and their remuneration is far from EU standards, while the quality of their work is state – of – the art. Medical staff from outpatient care will probably not be affected from the migration trend as the market there is settling and the incomes compete with European standards. However, estimating migration in health sector is difficult as one should take quite a number of factors – migration attitudes, age, family status, language barriers, education and skills verification etc. Migration from EU to Bulgaria could be primarily patients seeking for less expensive treatment of good quality. It is easily predictable that these cases will raise debates on the payment of such services and if one is sticking to the European Court Decision on Kohl and Decker case, instead of the expected brain drain, a 'health fund drain' may be witnessed. In other words, foreigners insured abroad could receive treatment in Bulgaria and the health funds where the patients were paying their contributions will be obliged to cover the cost of treatment.

5.3 Evaluation of recent and planned reforms

5.3.1 Recent reforms and their objectives

Healthcare reforms performed in the period 1999 to 2001 were radical and comprehensive. Until 1999 the health sector in Bulgaria has been developing according to the regulations and provisions of the People's Health Act adopted in 1973. In order to implement a major health reform, new legislation was adopted which regulated the introduction of health insurance, the health care establishments and infrastructure, the professional associations of doctors and dentists, pharmaceuticals and pharmacies, drugs and precursors control. (see Annex to chapter five for more detail).

As a result of the implementation of the new acts and legislation the command and administrative model Semashko was changed with a new health insurance model, which is being characterised with two main sectors – the social health insurance, based on obligatory health insurance contributions and voluntary corporative health insurance, based on the risk, the individual responsibility for the health and which offers additional health services.

The state continues to finance the public health care including the state sanitarian control, anti-epidemic measures, the health promotion and prevention programs for social significant diseases and the emergency health care services.

A private sector was developed which involves approximately one forth of the doctors and dentists in the country and which is based on the private production of services and their private payment directly from the patient.

The financing of the health sector until 1999 was done through the republican and the state budget. After the reforms the revenues generators for the system were extended through the introduction of the health insurance contributions amounting at 6% on the gross income paid in correlation of 20:80 employee: employer. New systems for private health insurance, private assurance and employers' and personal subscription for medical care. The private health sector is financed by cash payments as well. This lead to significant increase of the funds spent for health in 2000.

The payment of the doctors and dentists has been radically changed. Until 1999 every doctor received a salary defined by the state amounting to an average of 100 EURO per month and a certain percentage for experience and obtained specialty.

After the reforms and the development of the system for primary health care the payment of the medical professionals is being changed as follows:

- Primary outpatient care – capitation grant plus additional payment for work in unattractive conditions and for management of health priorities
- Specialized outpatient care – visit fee for primary and secondary examination
- For diagnosis services – service fee
- Inpatient care – salaries plus percentage for length of service, amount for specialization and amount for treatments under the clinical pathways financed by NHIF.

The healthcare infrastructure was largely restructured and reorganised through new forms of ownership and management. Older forms of outpatient care establishments such as medical auxiliary office, village health station, village health office and polyclinics were closed. The new establishments in the outpatient care that exist today are:

- Primary outpatient individual practice
- Primary outpatient group practice
- Specialized outpatient individual practice
- Specialized outpatient group practice
- Medical center
- Dental center
- Medical and dental center
- Diagnosing and consultation center

- Independent medical or medical-technical laboratories
- Hospice without stationary.

The existing hospitals were restructured into:

- Specialized or multi-profile hospitals for active treatment
- Specialized or multi-profile hospitals for further treatment and long-lasting treatment
- Specialized or multi-profile hospitals for rehabilitation
- Dispensary with a stationary
- Hospice with a stationary
- Home for medical and social care

All these can be national, regional, interregional, municipal and university establishments, having obtained the relevant accreditation.

The ownership of the above mentioned healthcare establishments was transformed from public into corporative. In the outpatient care sector all health care establishments were registered under the Trade Act as juridical entities – either personalized or capital. In the hospital sector a registration under the Trade Act made some hospitals limited liability companies or capital companies. In this way all healthcare establishments received juridical, financial and economic independence. However, the owners of the hospitals are still only the state and the municipalities, but the trade juridical status provides possibilities for attracting investments and operating in a more efficient way.

Some health care establishments such as the mental diseases hospital, Homes for Medical and Social Care, Blood Transfusion Centers, centers for emergency medical care remain public.

The medical education also has undergone some transformations. New specialties were introduced such as General Medicine and Emergency Care. The post qualification was reorganized and possibilities for private specialization under the supervision of the Bulgarian Doctors' Union and the Union of the Dentists in Bulgaria were made possible.

For the first time in Bulgaria the administrative choice of doctor was changed into a free choice of general practitioner and specialists was introduced. The choice of hospital is still regulated. Codes for professional ethics were developed as well Good Medical Practice Guidelines. The National Framework Agreement included a special chapter on patients' rights.

A quality assurance system was developed through:

- Motivation through the new system of remuneration and ownership holding
- Through free choice by the patient – horizontal competition
- Through integration – program financing and provision of vertical cooperation
- Through accreditation of health establishments
- Rules for best medical practices
- Algorithms for clinical behavior
- Contracting service packages
- Administrative and financial sanctions
- Patient's rights and user control.

The state monopoly on the health system was changed with the distribution of responsibilities between the State, the Municipalities; the taxpayers; the employers; the citizens; the medical professionals; professional organizations, the National Health Insurance Fund; the companies for voluntary health insurance; the insurance companies; consumers' organizations and international organizations and foreign partners.

5.3.2 Political Directions of Future Reforms

In order to ensure the long term viability of the system, the Government of the Republic of Bulgaria in 1997-2001 developed and started the implementation of a comprehensive reform strategy including the following: (i) streamlining the network of public health facilities; (ii) restructuring and strengthening essential services such as primary care; (iii) reforming the medical profession with regard to training, working conditions and remuneration; and (iv) introduce a national health insurance scheme which provides incentives for cost containment and quality of care.

The *structural reform* includes strengthening of the role of the primary health care system, involving general practitioners; privatization of the dentists' activities; concluding the national emergency service system, restructuring or closing down loss-generating hospitals and other health institutions; privatization of health care establishments; re-qualification and training of the medical professionals.

The *financial system reform* includes the establishment of the National Health Insurance Fund (NHIF), which finances activities with a dividable effect (having individual impact to each client of the health services) such as medical services in the primary and specialized outpatient care, hospitalization, dentist services and individual medical check-up. The state

continues caring the responsibility for the medical education system; emergency health care; state sanitary control; blood transfusion network; provision of live saving medicines; national centers and institutes; national prevention programs; scientific researches; epidemiological surveys and activities; national programs on significant diseases, inter sector and international health services co-operation.

The building of the new healthcare system includes changes in the health financing, health management and organization. The reforms in health financing resulted in the introduction of a universal compulsory health insurance scheme administered by the newly established National Health Insurance Fund (NHIF). Since its inception in 1999, the NHIF has developed into a functioning organization, including Central Office and 28 regional funds (RHIFs). Approximately 1,800 staff has been recruited, offices have been established, equipment has been procured and administrative processes developed.

The reforms to health financing, which took effect from July 2000, include wide-reaching changes in the funding of hospital services. In particular, hospitals are corporative and function as commercial trading entities overseen by a Board governed by corporate law.

While the changes in the hospital system started officially from July 2001, the primary health care services reform is progressing vastly. At present, more than 16,000 general practitioners, dental surgeons, specialists and other medical staff have gone out of the budget sector, have set their own practices and signed contracts with NHIF. Nearly 90% of the Bulgarian population has chosen its family doctor. At present the negations are held for the signing of the fourth National Framework Agreement between the NHIF and the professional associations of doctors and dental surgeons. Contracting and negations were introduced as democratic tool for interest balancing.

A considerable advantage of the new health care system will be the development of the *health insurance information system*. It started its development in 1999 and will be fully established by 2004. It will provide possibilities for accurate and timely filling of data bases that will facilitate managerial decision making; all procedures related to payment or to acquisition of administrative and medical information will be made easier; the electronic exchange of knowledge and scientific news will become possible; patients, doctors and administrators will co-exist in a system; telemedicine will make its first steps in Bulgaria.

The international support of the health reform amounts at more than 85 million USD including grants and credits provided by the World Bank, the USAID, the European Union, the Governments of Japan, Australia, Switzerland, Germany, Spain.

In 2001, a National Health Strategy 2001 – 2010 'Better Health for a Better Future of Bulgaria' and an Action plan for it was adopted by the previous Government. The main goals set up in it are the following:

- To provide conditions for infant mortality decline.
- To control NCDs morbidity, mortality and disability by developing and implementing health programs.
- To control the health hazards and provide safe working environment.
- To reduce the health risk factors of the disadvantaged people.
- To improve the mental health of the population.

The strategy was coordinated with the World Health Organization and the World Bank polices in this sector of Bulgaria.

The major political goals with respect to healthcare of the new government after the elections on July 17, 2001, are still in a process of discussion and are focused on the following topics:

- Establishment of a Chamber of Doctors and Dentists to take away the functions of the Bulgarian Doctors Union and the Union of Dentists in Bulgaria and establishment of a new body (financed also by the state budget) to be the link between physicians and the Bulgarian Doctors Union and the Union of Dentists in Bulgaria, on the one hand, and patients and health funds on the other hand. The Chamber shall act also as a licensing body of physicians and dentists to practice the profession.
- Reform of the National Health Insurance Fund through reinforcement of the state share in its management, reduction of the package of health services provided to the patients through the National Health Insurance Fund in view of stimulation of the voluntary health insurance by opening the niche, which by now has been within the scope of the National Health Insurance Fund.
- Imposing a legal obligation so that the health establishments for hospital care that are registered as corporate business companies will be re-registered as foundations. This will eliminate the possibility for privatization of health establishments in outpatient and hospital sector.
- Elaboration of act on the transplantation of tissues and organs
- Elaboration of Public Healthcare Act]
- Amendments of the Pharmaceutical and Pharmacies Act which will legalize the pharmacy chains (currently existing under hidden forms) and will introduce the rule "Roche – Bollar" which will allow to Bulgarian generic producers to prepare their documentation for medicines' registration during the period of its patent protection.

- Privatisation of health care establishments that has been blocked by the governing majority.

There is no social and political consensus with respect to the first three proposals. The right-oriented political forces, the Bulgarian Doctors Union, the Union of Dentists in Bulgaria, the physicians and dentists strongly object to the trends of nationalization of the National Health Insurance Fund, the establishment of a State Chamber and the obstructions to the privatization.

5.3.3 Conclusions

The previous Government of 1997-2001 undertook radical reform of the health care sector. The network of health facilities was streamlined with a stronger emphasis on primary care, the ownership and management of the health care establishments was corporatised although state and municipality are still major owners of facilities. The training, working conditions and remuneration of the medical profession was fundamentally reformed and a new national social health insurance scheme introduced that contains incentives for cost containment and good quality of care. The health insurance principles entered into primary health care on 1st July 2000, and hospitals started contracting with the National Health Insurance Fund using clinical pathways on July 1, 2001. Other significant focuses of change include accreditation of health care establishments, development of good medical practice guidelines, Medical Profession Ethics Code and Patients' Rights Code. The provision of medical services to the insured population is regulated through a National Framework Agreement signed annually between the NHIF and professional associations of doctors and dentists. In 2000 the first voluntary health insurance fund in Bulgaria was licensed and started its operation.

Currently there is well established capacity, organization, structures and possibilities for realization of a good and efficient health policy, modern health system with opportunity to develop and cope with the challenges of the future.

This statement, however, might significantly change in a year if the new policy, legislative amendments and managerial decisions keep the current trend.

Apparently, at this stage the Government and the governing majority of July 24, 2001 are not able to cover and assess the parameters of the implemented healthcare reform, to use the actually created possibilities and to achieve the objectives of the National Health Strategy. The reform was strongly delayed, its parameters were rashly and hastily changed and this provoked chaos and deterioration of the results.

The proposed amendments in the current legislation may lead to significant deviations from the original frames and strategy of the health reform. For e.g. one of the proposed changes is related to the possibility obligatory health insurance contributions to be handled for management and administration to voluntary health insurance funds. This would result in diminishing the scope and the quality of the social health insurance and in increase of the administrative costs.

It is noticed that often new act proposals are not coordinated between different institutions and are not related to the economic logic and current financial state of the country. An example of such kind is the amendments of the Health Insurance Act, according to which the NHIF will be obliged, equalize revenues and expenditures annually. At the same time, another amendment of the Act states that the reserve of the Fund should be increased from 5 to 10% from the total revenues.

The lack of significant managerial and strategic – thinking capacity is proven by the new decision according to which the state will be paying the health insurance contributions for children under 18 (used to be by working parent) and for the socially disadvantaged (used to be by the municipality), which will cost 80 million BGL to the republican budget. At the same time the starting discussion on State Budget for 2003 envisage decrease in the funds for health.

The slightly improved healthcare indicators of the population in reports for 2000 and 2001 are threaten to go back to their worse levels due to the deviation from the National Health Strategy and the slow down of the reform in the hospital sector, where 2002 level of debts is exceeding 100 million BGL or nearly 50 million EURO.

The drain of institutional capacity due to change of Governments in 2001 lead to practically starting from the beginning – discussing the model, the system, the structures. Investments in people such as training, qualification and professional experience have been lost due to political arguments and appointments.

In the period between 1997 – 2001 the health reform in Bulgaria gained large international support from the European Union, World Bank, World Health Organization, the Bank for Development oft the Council of Europe, the International Fund for Development, the UN Population Fund, the US Agency for International Development (USAID), the TRANSFORM Program of the German government, the Agency for International Cooperation of the Kingdom of Spain, the Ministry of Health of the Federal Republic of Germany, the governments of Switzerland, Japan, United Kingdom, the Kingdom of The Netherlands, etc. The total amount of international assistance was amounting at over 120 million USD.

Currently the a project funded under the Twining Programme of the European Union for 1.2 million EURO is stopped from implementation because of misperformance of NHIF and the implementation of the Loan Agreement with the World Bank is significantly delayed. No new international assistance activities are being envisaged or moving ahead.

In order to overcome the negative effect of all stated above, it is necessary to rebuilt political and professional consensus on the National Health Strategy and its Action Plan 2001. Health systems are rigid and difficult to change. At the same time no changes there give quick results. Today only 3 years after the start of health insurance in Bulgaria, it is dangerous ”to reform the reform”. The gaining strength model, structures and stakeholders might not be able to overcome new concussions. It is of importance to keep the main focus and contents of the reform and amendments to be made for fine tuning. It is necessary to work for the establishment of well-informed and understanding partners, followers and drivers of the reforms. Significant work is needed in the field of obtaining public support and the inclusion of non-governmental organizations in developing and implementing new initiatives.

5.4 Annex to chapter five

Legal reforms:

1996	2001
National Health Act Law on the State Budget	Health Insurance Act Health Establishments Act Professional Associations of Medical Doctors and Dentists Act Medicines and Pharmacies in the Human Medicine Act Drugs and Precursors Control Act Foodstuffs Act Safety and Healthy Labor Conditions Act Law on the Budget of the National Health Insurance Fund Law on the State Budget

Reforms of the Health System Model

1996	2001
Managerial and administrative model Semashko	Negotiation model, based on public and private mix containing: - Governmental sector - Municipal sector - Private sector - Social security sector, including: - social – represented by NHIF - corporate – represented by private health insurance companies.

Reform of the healthcare financing system

1996	2001
From taxes through the national budget and the municipal budgets	- From taxes through the national and the municipal budgets to: - hospital sector; - expensive medicines; - public healthcare. - From obligatory health insurance contributions – 6% in ratio 25 : 75 for employee:employer; - From voluntary health insurance contributions - From health insurance; - From subscription; - From cash payments – partial or full.

Reform in the remuneration of human doctors and dentists

1996	2001
Fixed salaries plus percentage for length of service and specialization	- Primary outpatient care – capitation grant plus additional payment for work in unattractive conditions and for management of health priorities - Specialized outpatient care – visit fee for primary and secondary examination For diagnosis services – service fee - Inpatient care – salaries plus percentage for length of service, amount for specialization and amount for treatments under the clinical pathways financed by NHIF

Reform of the outpatient sector structure

1996	2001
- Medical Auxiliary Office - Village Health Station - Village Health Office - Polyclinics	- Primary outpatient individual practice - Primary outpatient group practice - Specialized outpatient individual practice - Specialized outpatient group practice - Medical center - Dental center - Medical and dental center - Diagnosing and consultation centers - Independent medical or medical-technical laboratories - Hospice without stationary

Reform of the hospital sector structure

1996	2001
- National centers - University hospitals - Regional hospitals - Municipal hospitals - Sanatoria and resort centers	- Specialized or multi-profile hospitals for active treatment - Specialized or multi-profile hospitals for further treatment and long-lasting treatment - Specialized or multi-profile hospitals for rehabilitation - Dispensary with a stationary - Hospice with a stationary - Home for medical and social care - All these can be national, regional, interregional, municipal and university establishments, having obtained the relevant accreditation.

Changes in the legal status of health establishments

1996	2001
- Public health establishments - State-owned - Municipality-owned	- Outpatient sector - legal entities as per the Commercial Act: - personal companies - corporate companies - Hospital sector - legal entities as per the Commercial Act – only corporate companies; - public health establishments (mental diseases hospital, Homes for Medical and Social Care, Blood Transfusion Centers, centers for emergency medical care).

Changes in ownership and management of health establishments

1996	2001
- The ownership is state or municipal. - The management is centralized.	- The ownership is primary corporate - State-owned private establishments - Municipal private establishments - Private - The management is corporate

Reforms of medical education, specialization and continuous qualification

1996	2001
Medical education	
Medical universities designated to specialization	Medical universities designated to specialization; addition of General Practice specialization
Post-graduate studies	
Medical universities and university hospitals	Medical universities, university hospitals and other accredited health establishments
Continuous qualification	
Medical universities and university hospitals	Medical universities, university hospitals, other accredited health establishments, Bulgarian Doctors Union, Union of Dentists in Bulgaria

Reforms of the patient's rights

1996	2001
- Administrative choice - Closed system	- Free choice - General practitioner - Specialized outpatient health establishments - Regulated hospital - Competition - Regulation of the patient's rights - Regulation of the professional ethics

Quality assurance reforms

1996	2001
	- Motivation through the new system of remuneration and ownership holding - Through free choice by the patient – horizontal competition Through integration – program financing and provision of vertical co-operation - Through accreditation of health establishments - Rules for best medical practices - Algorithms for clinical behaviour - Contracting service packages - Administrative and financial sanctions - Patient's rights and user control.

Reform of the division of responsibilities

1996	2001
- The state through the Ministry of Health; - Partially by the municipalities; - Taxpayers; Hired medical professionals.	- State; - Municipalities; -Taxpayers; - Employers; - Citizens; - Medical professionals – employed and freelance; - Professional organizations – Bulgarian Doctors Union, Union of Dentists in Bulgaria; - National Health Insurance Fund; - Companies for voluntary health insurance; - Insurance companies; - Consumers' organizations; - International organizations and foreign partners

Change focuses

2001	
Disease	Health
Financing of structures	Financing of activities
Administration	Leadership and management through contracts
Centralization	Decentralization
State ownership	Privatization
Reactivity	Analysis, forecasting, strategic management
Non-transparency	Transparency, commitment
State monopoly	Shared responsibilities

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