

SHORT HISTORY OF MEDICINE IN BULGARIA

PART I: FROM 1878 TO 1903

ORGANIZATION OF MEDICAL SERVICES DURING THE PROVISIONAL RUSSIAN ADMINISTRATION

The Russo-Turkish War of Liberation /1877-78/ is a landmark in modern Bulgarian history. A provisional Russian administration is established for an year and ten months. For East Roumelia /South Bulgaria/ it ends on 31 May 1879 when ruling is transferred to general-governor Alexander Bogoridi while for the Kingdom of Bulgaria it is held on 7 July 1879 when Prince Alexander Battenberg receives power from Russian A. M. Dondukov-Korsakov.

Not regarding the short period for ruling of the newly independent Bulgarian lands, the provisional Russian administration of North and South Bulgaria makes deep social, economical and political changes which in their entity equal a real bourgeois revolution. Three are the basic signs of transformation in Bulgarian society from that time: — 1/ liquidating the Turkish feudal system; 2/ making path for development of trade and commerce; and 3/ giving wide political opportunities for the untoward population of mainly peasant masses.

Independence finds Bulgaria entirely backwards in sanitary conditions. There are diploma-registered physicians only in the big cities of the country which hardly could supply the health needs of the population. It is so far the duty of the appointed during the war Prince V. A. Cherkaski to take care of welfare questions during the advancement of the Russian army. It is to him that is due a plan for administering the medical services. With respect to limited number of physicians an institution of regional "gubernsk" and district "zemstvo" care is created. Thus district physician Dr. Stoian Radoslavov is appointed on 5 June 1877 in Svistov. On 1 July Dr. Stat Antonov takes health care of Tumovo and later the same month Dr. Alexis Christov is physician of Gabrovo. In February 1878 Dr. Dimitar Mollov is given post in Vidin sanjack. As a whole 26 district physicians are appointed in the newly liberated lands.

Meanwhile and parallel with regional medical administration a special attention to establishment of hospitals is paid. This is priority of Slav Welfare Association, Russian Red Cross etc. In the end of June 1877 a hospital with 200 beds is established in Tumovo. Later hospital facilities are made in Silistra, Tutrakan, Razgrad, Kazanluk, Plovdiv etc. With the advancement of war general-governor Prince Dondukov-Korsakov takes rapport. The sector for Internal Affairs of the created provisional Russian government deals with health care questions. General Gresser proposes that an organization of public health services is commissioned in the country with respect to physicians, hospitals and pharmacies with attracting local moral and material resources. The best answer is given by Vidin district physician Dr. Mollov. As a result on 15 August 1878 the latter is commissioned to the provisional Russian administration. His project "Temporary rules for medical administration in Bulgaria" is verified by Prince Dondukov-Korsakov on 1 February 1879. This is a primer official health document which authorizes sanitary law in Bulgaria.

Accordingly, a Supreme Medical Council is set up which includes four physicians with a minister. Structurally it is a body commissioned at the Sector of Internal Affairs, however, functionally it has approximately administrative independence. Within the country a hospital network provides treatment with a mixed scheme of repay. First class hospitals are with 100 beds and second class hospitals are with 50 beds supplied mainly from the military resource. People from both gender can be treated for 1 Fr. the first 10 days and the rest — for 2 Fr. per day. In his report to the provisional Russian administration from 14 March 1879 general Gresser remarks that hospitals network function well and it is part of the official Kingdom.

There are lists of physicians authorized to practice in the country — 78 doctors, from which 55 Bulgarians. To compensate the inadequacy of medical personal a school for assistant doctors "feldsher" is opened with two departments — medical and veterinary. This is the foundation for special courses in Sofia, Tumorovo and Plovdiv. In a program for 6 to 8 months a group of 150 feldshers graduates. These are the first steps of a national health care system.

MEDICAL SERVICES DURING COUP D'ETAT OF THE RUSSIAN GENERALS

On 27 April 1881 prince Battenberg suspended the constitution and appointed a cabinet of Russian generals. Himself he declared that credentials for seven years are wanted otherwise he refuses the crown. One way or another this political situation persisted till 7 September 1883 when the generals left for Russia and the constitution was introduced again for correction at the Great National Assembly.

The organization on the medical part of the kingdom during the period mentioned above is assigned to physician Ivan Vasilievich Grimm of Dorpat (Tartu), Estonia. His post was general-inspector on the medical part together with minister of the Supreme Medical Council. He is directly subordinate to the prince while Dr. D. Mollov, chief commissioner at the Council, gives rapport to the Sector of Internal Affairs. First thing the general-inspector issues is an increase of staff: thus, the Supreme Medical Council numbers six members — Grimm (Minister), Dr. Mollov (Senior at Internal Affairs), Dr. Mirkov (Senior at War), Tegarten (Senior at Chemical Laboratory), Neyman (Military Attaché) and Dr. Bradel (Secretary of Council).

Main points of the new medical services are improvement of legislation, organization and function of health care. In 1882 seven additional sanitary laws are issued to complement the "Temporary rules for medical administration in Bulgaria" from 1879. Here some prophylactic tasks are clarified with respect the role of rural and urban physicians, the sanitary control in manufactures and schools, the need for health education, etc. Now a foundation for scientific institutions is established with a Chemical Laboratory at the Supreme Medical Council. Head of laboratory is Albert Tegarten and activity extends on analytic, microscopic, phamacognostic, forensic and other investigations. Another scientific establishment is the Variola Institute at Razgrad district hospital with Dr. Boris

Ox as a manager. Applied research and preparation of anti-variola vaccine is done here. According special instructions "prikazi" organized psychiatry, obstetrics-gynecology and dermato-venerology help is delivered. Also dental health care is provided for first time.

Statistics in the year 1883 shows a number of one hundred and thirty physicians in the kingdom including eight pharmacists and four veterinarians. At the same time on general-inspectors initiative Bulgarian physicians are sent for specialization abroad. First in the list of those allowances is Dr. Stephan Bocharov in the field of military hygiene at Petersburg Academy. Meanwhile in the country new hospitals are opened up — six with 50 beds, four with 20 beds and also in seven towns construction of new hospital buildings is started.

A serious fault in the medical services is lack of scientific associations and a medical community. Scientific information is scarce. A necessary step is publishing of periodicals. First medical journal is "Medicinska Sbirka" (Medical Anthology) with editor Dr. Mirkov and leading article on the antiseptic method of John Lister. Subscription is made to 5 Russian, 4 German, 4 French, 1 English and 1 American journal. A library at Alexander's Hospital is administered and international book exchange started.

General-inspector Grimm succeeded for his short stay in the kingdom to embrace with a noteworthy consistency all spheres of health care. His in-depth evaluations published in "Darzhaven Vestnik" (State Paper) have scholarly character and clarify every aspect of medical services administration.

SANITARY WORK IN EASTERN RUMELIA

The Organic Statutes of Eastern Rumelia /1879-1885/ pay little attention to sanitary work. It has the same features as that during the Provisional Russian Government and is under the control of the Directorate of Internal Affairs. First leader, jurist Gavril Krastevich, is in a difficult position for he is in front of a dilemma to choose between two opposite sanitary variants. According the Russian model health care is totally state powered including ambulatory, hospital, and sanitary-epidemiological activities under Supreme Medical Council constituency. The Turkish sanitary organization on the contrary during the Tanzimat period functions in a western manner: all hospital and ambulatory care are excluded from state competency and are under charge of charitable organizations and private practitioners.

Thus from the necessity to choose in November 1879, G. Krastevich puts forward at the Regional Assembly a proposal for a Sanitary Law and Statute on the sanitary part. So from the sanitary regulations voted in June 1880 a mixed system of health care is introduced in Rumelia — the state takes care of epidemiological control and ambulatory care while hospital facilities are under private initiative. The higher institution is the Sanitary Council consisting of a minister, three physicians, pharmacist and veterinarian.

The governor of Eastern Rumelia A. Bogoridi appoints Dr. Stoian Chomakov for a minister. The Council also includes a balanced staff from professionals with only one foreigner — K. Sostrojonek.

For a six year period in Rumelia the Council resolute sixteen normative documents. Problem legislation decrees the statute of general practice physicians, vaccinations, veterinary control, dead burials, pharmaceutical statute etc. Aside from legislature the Sanitary Council elaborates certain materials like statistics for sickness, hospitalized, and diseased; instructions to regional physicians; reports to the Director of Internal Affairs; communications to the press etc. An analysis of appointed medicals in the region reveals 28 district and 6 sector regulars — all of them graduates from France, Roumania, Russia, Turkey which attests a very high standard. As a national proportion we see 25 Bulgarians, 4 Greek, 3 Russian and 2 Armenian physicians. Approximately 20% from the doctors had to change their working place from two to three times. However, unfavorable working conditions are compensated with comparatively high salaries — 1700-1800 grosh; which is half as much the compensation of the sanitary chief. Compared to the police force dismissals are seldom not so much for political reasons as for lack of professional qualifications. Accusations against state physicians are unequivocal: refuse medical help to the peasants, restrain from inspection tours, lack of authority to impose hygienic norms, do not control feldshers work, show ethnic preferences etc. On such information against the Sanitary Council acts, accordingly a procedure is initiated from Director Krastevich - an inquiry commission is created which reports lead to disciplinary sanction or denial with facts in the press. Despite considerable decentralization of sanitary work prevailing statements contain good reference for hygienic, ambulatory and small surgical activities.

Few words concerning pharmaceutical services reveal serious burden for the government: overwhelming are old habits of the population used to receive medical goods without prescription from unqualified sellers. The Pharmaceutical Statute from February 1879 regulates strict control from the state, rules for preparing, preservation and allotment of drugs, conditions for establishing a pharmacy, structure and function of pharmacy etc. The Eastern Rumelia pharmacy network consists of 28 mobile units of 1st type (remuneration from the state) and 12 mobile units of 2nd type (private owners). Greater difficulties are presented by stationary pharmacies — lack of appropriate rooms, professional standing of personal, communication with hospital base — all in all 17 such pharmacies are established. Main depot for medical goods is Pharmaceutical Store in Sofia and a branch in Plovdiv exists headed by member of Sanitary Council chemist K. Sostrojonek /from 1884 A. Naidenovich/.

Hygienic matters in Eastern Rumelia are identical to them in the Principality Bulgaria: main current of diseases are caused by terrible dwelling conditions (houses are built directly on the soil terrain, no windows or apertures, people and cattle live together); so this way of life mediates vermin, filth, superstition. Nutrition is unhealthy — uncooked, hard to digest food, rotting food, spring water. Settlements have hardly canalization and sewerage; mud, compost, marshes everywhere; no regular cemetery land etc. What can do the Sanitary Council in the case is, traditionally: health education, distribution of free

medication, regulation of whorehouses, vaccination. In case of resistance to vaccination fines are imposed and also those are not admitted to school and in the army. The picture of epidemics in Eastern Rumelia reveals more significantly some variola epidemics in Plovdiv in 1882, scarlet fever epidemics in Karlovo in 1883, epidemics from syphilis, epidemics from Egyptian cholera in 1883. Quarantine function well; disinfection of people and animals is compulsory; people are relieved from anxiety etc.

While ambulatory and epidemiological activity is a priority of the state, hospital care depends on private initiative. The provisional Russian government, namely General Skobelev and Prince Shachovsky propose to Bulgarian intelligence to take care by commissioning a semi-Red Cross association. Under the leadership of the Bulgarian Exarchate on 23 May 1879 an association "St. Pantaleimon" is created. Its statute copies a Russian style — salvation work with no regard to ethnic or religious affiliations, education of health personal, cooperation to vaccinations, establishment of hospitals with drug stores. Presiding the association is head of the Sanitary Council Dr. Chomakov. The board of trustees includes eminent figures, medical doctors Vulcovich, Stambolski, Hakanov as well as deputies and members of regional committees. Funding for the association depends on charities from private persons and on reliefs from the district authorities. Main discrepancies in hospital administration appears to be the conflict for appropriation of possessions left by the Russian army, namely the military lazarettos. However, from 1879 there are hospitals functioning in Plovdiv, Burgas, Yambol; from 1880 — in T. Pazardjik; from 1881 — in Sliven, Kazanluk; from 1882 — in N. Zagora; from 1883 — in Chirpan, St. Zagora etc.

The income of "St. Pantaleimon" association is distributed proportionally to the hospitals by size, nevertheless, funding is inadequate. The problems are the same as in the Principality Bulgaria: unsuitable buildings; lack of basic appliances i.e. beds, instruments, apparatus; insufficient personal etc. The statistics from the Sanitary Council shows that most of the hospitals have 10-15 beds with approximate rate of 135 patients per bed per year. Obviously that low attendance of hospitals is due to distrust of the system, poor hospital environment, inadequate medical qualification, high mortality rate in hospitals versus home therapy etc. Finally, there is information that as early as 1879 a measure to convert mentally ill from the monasteries is introduced — the first madhouse or insane asylum is instituted to Plovdiv's hospital. As a conclusion to the review of sanitary work in Eastern Rumelia there is evidence that despite considerable decentralization effect of state health care is stable with many achievements of modern medicine gained.

SANITARY LAW FROM 1888

The Sanitary Law is entered at the 5th Common National Assembly in the second regular session /15 October - 18 December 1888/. By that time the "Temporary Rules" commissioned by Dr D. Mollov in 1879 were valid and an annex with seven civil sanitary laws were complemented by Dr I. Grimm in 1882. This jurisprudence did not spread over Eastern Rumelia where other sanitary decrees were in order. Now there is a

controversy aroused here. A contention is made that in 1884 a sanitary law was enforced by Dr Georgi Atanasovich, the then health minister of the principality. However, stenographic protocols from the 5th CNA as well as the anniversary book by Dr M. Rusev from 1904 show that such law was non-existent. It is true that Dr Atanasovich prepared a draft but the violent developments from 1885 hampered it being considered and approved.

Principal cause for the creation of new law is the Unification of North and South Bulgaria — a tempestuous event in the first decade after the Liberation. There was a pressing need to revoke the outdated matters of the previous law and to provide an even development for the newly commissioned country. Prime-minister Stephan Stambolov who was Minister of Interior as well, remark: I would like this new Law to be a better one because it belongs to the bulgarian people and we all feel happy when he is well. Further, the particulars were elaborated by Dr Panayot Zhechev — head of the Supreme Medical Council. It was approved by the National Assembly under title "Sanitary Law" and ratified with princely edict "ukase" on 18 December 1888.

With the new law health care is included fully in the administrative apparatus of the state. Within the Ministry of Interior is created a Civil Sanitary Directorate which remains a governing body till 9 September 1944. The membership of the Supreme Medical Council is enlarged. It includes the most able and authoritative specialists with a prerequisite for them to be bulgarian subjects. The Supreme Medical Council is presided by the Minister of Interior but when he is out from the country — by the minister of the Civil Sanitary Directorate. Supreme Medical Council remains the upmost consultative organ.

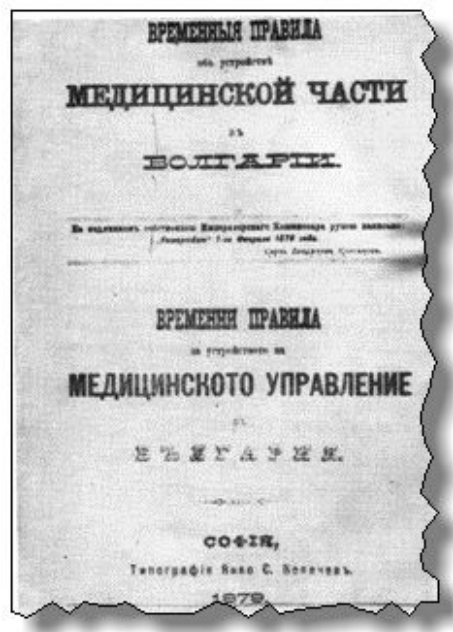
Sanitary Law defines the liabilities of county, district and municipal doctors. Also county hygienic councils are created as most important local sanitary authorities which function by 9 September 1944. They include managers of administration and health care in the county, namely: the mayor of the central county city, the county physicians, a member from the county hospital, the county veterinary, an engineer, a pharmacist and a military. First time private medical establishments are regulated under state sanitary authorities. Also first time prostitution is put under surveillance. Official Pharmacopoeia until then is unequivocal — under Russian and Austrian supervision. Afterwards, remains only Russian Pharmacopoeia. Encouragement of drug stores is promoted mainly by bulgarian subjects.

A novel act is deliverance of free health care to poor strata of population. This is forerunner of future totally free socialist health care after 9 September 1944. Meanwhile, art. 64 from the Sanitary Law, says: Municipal doctors are liable to take care of poor unwell according to a list of declaration for poverty in the community, that is, those people should be treated for free. This is not superficial state charitable act. Its a critically considered plan answer to the demands of the needy. Also, special committees are formed in the community enforced to support municipal and private physicians. As far as we know, democratic innovations of such kind are not to be found in foreign sanitary legislation. In Russia sporadic cases of free health care for rural population is encountered in some rich gubernks and zemstva. Working class movement in Germany

makes Bismarck government to create sick hospital funds but this is inconclusive reform. Free medical care for economically weak social strata is introduced fully in Western Europe after World War II.

More comments on the Sanitary Law from 1888 show that some proponents discuss whether the law was a copy of the actual one in Roumania. Dr Zolotovich points which exactly clauses are captured from it and what is not just a mechanic translation from a backward social origin from our northern neighbor. In fact, the law reflects the new democratic traditions of the Bulgarian state. As early as 1861 in Tzarigrad an organization for free medical care for poor bulgarians existed. Not without importance is the mere vigor with which the surviving heroes from the struggles of National Revival contribute. Chairman of the 5th National Assembly is famous Zachari Stoyanov. Members of parliament are Georgi Zhivkov, Dimiter Petkov, Traiko Kitanchev, etc. The architect of the Sanitary Law is Dr Panayot Zhechev /1853- 1903/ - graduated medicine in Bucharest, volunteer in the Liberation War as a battalion doctor in a Romanian regiment. All those people work for the moral and spiritual ideals for which they sacrificed.

Picture 1: Sample illustration on the text above.



(i). Title page from "Temporary Rules for Organization of Medical Care in Bulgaria" - viz., issued in year 1879 simultaneously in russian and bulgarian.

PART II: FROM 1903 TO 1945

ADVANCEMENT OF HEALTH CARE IN THE ADMINISTRATION OF PEOPLE'S LIBERAL PARTY /1903-1920/

The constitution of the People's Liberal Party unites some of the eminent political figures in the country. Among them are veterans from the National Liberation Period - Stephan Stambolov, Zachari Stoianov, Georgi Zhivkov, Dimiter Petkov, Nikola Obretenov etc; also, former members of the Conservative Party of Eastern Rumelia - Dimiter Grekov, Ivan HadjiEnev, Ivan Andonov, Ivan Salabashev etc. Thus, taking the helm of bulgarian administration /1887-1894/, the Party establishes a regime contributing to strengthen the political and economic positions of petty bourgeoisie in Bulgaria. This leads to ascension to the throne of Prince Ferdinand I (born, 26 February 1861 in Vienna - died, 10 September 1948 in Coburg), however, because of weakness of monarchic institute at that historical period, a phrase was coined — “The king reigns but does not rule over”.

Assassination of S. Stambolov creates a confusion in the Party ranks. Without its authoritative chief the perspectives of a political favorite seemed unhappy, until on 5 May 1903 the monarch summons the People's Liberal Party in the government. Again, after almost ten years of political lingering, the national destiny and long-term prestige of the country are put on high stake. This time a new political leader excels - Dr. Vasil Radoslavov. In the long run, both the king and the premier will end their life in exile. On such a historical canvass it is tempting to present the health care affairs in the country.

First session of the National Assembly on 30 December 1903 adopts the “Law on Protection of Public Health”, which revokes the Sanitary Law from 29 November 1888 and itself stays in power for the next 26 years. The Law from 1903 has its chief architect in the face of Dr. Marin Rusev /1864-1935/. The latter is eminent figure in the ranks of the Bulgarian Medical Union, one of the foremost balneologists in Bulgaria and author of many surveys on bulgarian health resorts. Now, we have a new Law which postulates an increase of health personnel and creates generally better opportunities for medical service of the population. Instead of 60 000 people per physician a new arrangement is made for 20 000 administered per physician. For this purpose district constituency is subdivided into sanitary districts "lekarski uchastuk" where physicians and feldshers are appointed according number of residents.

Next, a popular hygiene councils "obshtinski higieni soveti" are established on a municipal level with membership from the government and aiming at administrative measures if the need should arise. For instance, the hygiene councils had the power to impose a fine from 10 to 25 lv. to someone trespassing the sanitary norms of cleanness in the environment, etc. Another step is introducing for the first time compulsory vaccination for smallpox to children 1-7 years old and youths 20 years old which is administered by a Central Medical Institute for manufacturing of serum. As a whole, the health care system is ruled over by the Directorate for Protection of Public Health, a department of the Ministry of Interior, which reduces the role of the existing Supreme Medical Council and makes it an appendix to the directorate.

The advancement in the Law stimulates the business of medical drug dealers. They insist, their syndicates, on 1 June 1904 that the government should rise the costs of medications with average 60-70%. This being a fact, the opposition in the face of the agrarians says: "People have been already going to medicine-man and fortune-tellers out of poverty and You, from the ruling circles, dare drive him even further by rising the price of medications".

Meanwhile, the problem for covering the newly opened vacancies with licensed physicians persists. This compels the supplement of the "Law for Protection of Public Health" in 1906, saying that military feldshers and sanitary could work for the civil services. It is a dangerous step back, in case that quality of medical care should failure but education at that time was affordable only from abroad and thus for a long period of time. While there is a shortage of medical personal, the inadequacy for hospital establishment is even greater. In the autumn of 1903 the first orthopedic clinic (with a workshop for prosthesis) is opened. In 1905 a modern pediatric detachment is attributed to Alexander's hospital in Sofia. About that time a complex project to enhance the existing hospital base is launched. On average the logistics is increased by 30-40 beds, while in some big hospitals with 100 beds. Further, the crude number of hospitals rises from 51 in 1903 to 58 in 1908, mainly new establishments in the countryside and financed by the local gentry.

In consideration with the historical period being examined full appreciation by the governing classes was paid to the development of balneologic centers. Most important advance in this direction was the allotted special credit for building of mineral baths at the spas of Knyazhevo, Gorna Banya, Bankia, Merichleri, Varshetz, Hissar etc. On 18 December 1907 the municipality of Balchik is allotted a grant and a terrain for building a healing center at the vicinities of the town. Altogether, competent circles from the country and abroad discuss the opinion that Bulgarian Spas have good future.

If separate attention is paid to the absolute parameters of budget allocations distributed by regions, a constitution will be made that from 177 500 lv. in 1902 the budget jumped 3-4 fold in the next year. Most money are detached for Varna, Sofia, Burgas, Ruse, Shumen districts. Still, on a relative scale the health budget is alarmingly low - on average 2.5 % from the gross domestic product. The process enters into chaos after the country takes part into the tumultuous years of two Balkan Wars and the First World War.

Finally, words should be said about the opening of Medical Faculty in Sofia. The need for separate medical school is debated by the end of the past century. Thence Alexander's hospital served as a hearth of bulgarian medicine. By 1904 a medical library is bound on the territory of the hospital and by 1906 - a medical museum. The material basis is continuously updated, the wards are enlarged and adapted to host the clinics of the future faculty. In 1907, Alexander's hospital in association with the Maternity House, the other big health care establishment on the territory of Sofia-city, organize three months qualifying courses in surgery, obstetrics & gynecology and ophthalmology. The results are that 17 physicians are sent for specialization abroad, among them several future professors in the faculty: Dr. Stoian Kirkovich /Vienna, internal medicine/, Dr. Atanas

Teodorov /Vienna, forensic medicine/, Dr. Toshko Petrov /Tulusa, hygiene/, Dr. Ivan Kiproff /Berlin, eye & ear diseases/, etc.

The fourth faculty of Sofia University have its birthday on a regular session of the National Assembly at 20 January 1917. First lectures are given on 10 April 1918. The right hand for the opening of the faculty is most vigorously supported by Dr. Stephan Vatev /1866-1946/, member of the Democratic Party. Thus, a new chapter is open for homeland medicine in Bulgaria.

HEALTH 1921-1945

The world after World War I in which Bulgaria has to participate was of quite a difference. The treaty with the “Entente States” was signed in the Paris suburb of Neuilly on 27 November 1919; the country slid into a grave economic and political crisis. The puppet agrarian government of Alexander Stamboliisky with BAU /Bulgarian Agrarian Union/ was an obsolete landmark for the state of affairs. About year 1923 the political parties began a process of consolidation. On 9 June 1923 a Popular Alliance /organizing representatives of all bourgeois parties with the Military League and the Great Masonic Lodge/ coup d'etat ousted the government. On 4 January 1926 a second Popular Alliance cabinet was formed at head of which was Andrey Lyapchev /1866-1933/. From 29 June 1931 the Popular Block won the majority of the votes headed by Alexander Malinov /1867-1938/ and Nicola Mushanov /1872-1951/. Finally, from 19 May 1934 a Zveno party overthrew the government and initiated a chain of sinister persecutions of state officials until the end of World War II.

Aiming to be short, we should not like to omit the political role of other occasional formations like: 1. IMRO /Internal Macedonian Revolutionary Organization/ headed by Vanche Michailov and Menche Kurnicheva; 2. UFC /United Fascist Center/ headed by Alexander Tzankov; 3. Agrarian Union splitting to numerous divisions but most important are “Vrabcha” and “Pladne”; and 4. Royal Chancellery ebbing the tide of political forces. So far, the next page of history is outlined by an organization of Socialist State in Bulgaria.

HEALTH 1921-1945, PART 2

During the period 1921-1945, medicine and health care in Bulgaria develop on a background of complicated national and international political relations, which determine both the tendency and structure of specific socio-medical institutes. As a whole, there is somewhat of a decline from the side of medical and health policy in the country. Progressive bulgarian scholars, like Prof. Assen Zlatarov and Iliya Yanulov, make observations in their works that the very question of deteriorated health indicators of the general population is a reflection of poor labor conditions, i.e. that works as a scissors on

life style of the people. Thus, a bread which have a mean price in year 1923 - 5.63 lv /index 100/, costs respectively in year 1924 - 7.04 lv /index 125/ and in year 1927 - 8.30 lv /index 147/. One kilo of butter, respectively, in year 1923 - 34.93 lv /index 100/ and in year 1927 - 37.79 lv /index 105/. Meanwhile, the mean daily wage of a worker is 63.08 lv /index 100/ in year 1923 and 61.62 lv /index 97/ in year 1927, given that the laborer has, on monthly average, been gainfully employed.

On the mainstream, the sharp turn in politics after 9 June 1923 does not reflect on organizations and levels of health care maintenance in the country. It is true, that head of Directorate of Public Health - Dr. Veliko Georgiev /1872-1924/ quits his position, on grounds that "he would not cooperate with authority usurpation on the government". This is not surprising, while he was one of the leaders in premier's Alexandre Stamboliisky "equipe medicalle" to reform the country and the health care, arbitrarily, on a commune principles. Dr. Georgiev, together with other communist-agrarian reformers like Dr. Yotov, Dr. Popsavov, Dr. Daskalov, Dr. Kaishev, etc. perished in the political turmoil after June 1923 - some died and other emigrated abroad. The post Head of Directorate Public Health is succeeded by progressive Dr. Petar Tzonchev 11867-1947/ from Gabrovo.

The bourgeois political development in Bulgaria, which is in a nutshell radical and democratic, confounds a series of occasional formations playing role in the governing of the country. One such organization is the Bulgarian Medical Union /BMU/, founded in 1903. As a matter of fact, more information on BMU activities can be find in the journal of the organization "Annales de l'Union des Medecins Bulgares, issued volumes I - XXXVIII. In it's nearly 45 years of existence, the BMU had 26 assemblies but on the XXVI Assembly, held on 23, 24, 25 December 1945, the union came abruptly to an end. It took another 45 years that BMU had its revival under new auspices. However, it is not our aim to dwell on the history of BMU but to show its role on the political community in the country and in particular, what scientific and technologic support it gave to medicine in Bulgaria. Our main thesis is that BMU played an important role in the historical development and was always on the right hand side to support the decisions of the main ruling medical bodies - the Supreme Medical Council and the Directorate of Public Health at Ministry of Interior.

Thus, BMU hailed the constitutional "Law of State Defense" or LSD received on 4 January 1924. It approved the sanctions taken against those members of the medical community which boycott the change of policy after June 1923, according Art.15 of the LSD. Dr. Ivanov of BMU says: "That means LSD has an inverse power in relationship with the discharges of union members, having in mind that those people have ever had communist convictions". However, the union took in mind the arguments of Dr. Racho Angelov, a social-democrat and presiding council of BMU. The latter resigned from his post but the assembly of BMU, obviously realizing that this is an act of rapprochement from an independent member towards the sway of terror and violence in the country, gave him a tribute. Ahead of events Dr. Angelov turned to be right - LSD was abolished on 16 October 1944.

To assume multilinearity of views it is worth rendering the fact that medico-sanitary insurance represent the “Achilles heel” of health care during that period. Here comes the “Public Health Law” or PHL from 9 March 1929. The PHL aims at centralization of top medical leadership and further specialization and systematization of medical organs. The law transfers all expenditures of local health services to burden the budget of communities and municipalities. The PHL is acknowledged in a moment when the country economy is in a business recession and tax paying from the masses is scarce. Art.18 from PHL says: "Taxes can not be lower than the actual expenditures for the diseased" and accordingly, "Expenses for the poor are untowardly met by the communities". This gives some good opportunities for flourishing of private stationary and ambulatory cabinets. Art.192 from PHL says: "Every registered physician has the authority to open a hospital or sanatorium having in mind that he is not under conviction, disciplinary or criminal, connected with his medical service or is pending". The ethical issues connected with this file are not under consideration. The PHL gives access for profitable investment of capitals coming from shareholders and stockholders. This requirements are liberal but still they are looking for compromise between a public and a private mix.

Next moment in health issues of the period is combat with social evils, namely with tuberculosis, alcoholism, prostitution, etc. The social hygienic elements are based on wade hygienic councils under the operational leadership of the Directorate of Public Health and with strategic goal of liquidating and eradicating the so called “social pathology”. This approach was not a new one, while before the WW I there were agitated debates between the two fractions of BMU: Dr. Orahovatz’s and Dr. Rusev’s supporters. On a new scale those fractions were classified by some modern social hygiene narrators from the 1970s and 1980s as “bolshevik” and “reactionary” but we do not wish to devaluate what was written some 30-40 years ago.

Whatever, on the continuously deteriorating status of the masses we can judge from the reports of the head of the Directorate of Public Health, mimeograph from year 1931: "We would propose to decrease the taxes for delivering health care ... while prices of goods from first necessity mark a decline those in health establishments are still high. At that time the prices are — for ambulatory exam is 20 lv; for one day stationary treatment is 40-80 lv; for one day sanatoria treatment is 75-120 lv, etc. In the field of infectious disease prevention — for disinfection of one kilogram discharge is 5 lv; for hygienic douche is 5 lv, etc".

HEALTH 1921-1945, PART 3

On 19 May 1934 the political power is taken by the military league "Zveno". Head of Directorate of Public Health is appointed Dr. Georgi Ivanov. However, the burden of loose operational leadership has a timely effect on institutional settings. The government is under pressure and legislation, given that all political parties are abolished and National Assembly is disrupted, have to deal with co-ops which, in fact, represent the outrageous

ordinary masses from the street. Even IMRO had to put an end to its activity and leader Ivan Michailov /1896-1990/ fled away from the country in exile. The picture comes to be resettled at the eve of WW II when in December 1939 an election campaign for the 25th Ordinary National Assembly is held.

Meanwhile, on 22 March 1935 is issued provisional draft for "Law for Compulsory Medical Practice in the Village" or LCMPV. Despite the fact that number of physicians from that time is increased and there is an evidence for "physicians plethora", otherwise in the countryside health is far away detached from the general population. The hard mode of life and work in the bulgarian village, their backwardness and timidity, repulses the young practitioners to stay in the ambulatory. An editorial from 1940 in the "Annales" writes down: "Most of the jobs offered in the village will remain chronically vacant, because the super-pretentious doctor can not get hold there and due to lack of elementary conditions for subsistence - board and lodging".

That is quite different in the city. A greater number from the young medical practitioners are still graduates from abroad, while Medical Faculty in Sofia takes slowly a promotion of medical cadres. Those medical bachelors, naturally, apply the forms and methods of treatment which they have learned in the institutes of their education. For the first time this create a "tower of Babel", a confounding of terminology, classifications, etc. Further, specialization and post-graduate education is necessary with respect to private clientele and that is organized in two manners. Firstly, the medical doctor is sent abroad, with a stipend, to a western establishment which issues a document that the specialist has served for "such and such" period and received a title. Secondly, there is a practical training available in a bulgarian clinic, without reimbursement, which leads to a certificate for a specialty.

Both lines of specialization were a matter of debate from the Bulgarian Medical Union. Dr. Robev from the council of BMU remarks: "It is a high time that the Directorate of Public Health stop sending protégés and other partisans ... which is a violation of deontological norms and downright laws". Finally, the raising in medico-sanitary hierarchy is organized on the basis of a competition with a maturity exam, commissioned by the Supreme Medical Council. The candidates for a managing post are rated and graded on a percentile scale and the most successful ones are reported to the Council. Usually, the administration of the procedure is supported by high taxes but the benefactor, while every effort was made to prevent the corruption, still remained unredeemed.

A demographic situation in the country is evaluated through various means and population indicators. Concentration of main demographic indices is presented with crude birth rates, crude death rates and natural increase for the period 1921-1944 /per 1000 population/.

We see from the data that total mortality show a tendency for decline, while this is associated with parallel slow down of the numbers for natality and their resultive product, natural increase. Here are some data on a comparative scale for natural increase /per 1000

population/. Information is for the period before WW II: — Bulgaria /1910-12/ is 19.7; Russia /1912-13/ is 18.4; Serbia /1909-12/ is 14.5; Spain /1908-13/ is 9.3; Belgium /1908-12/ is 7.7; and France /1908-13/ is 6.9. Evidently, demographic transition in Western Europe is some 20-30 years ahead. Or maybe, some experts lament, the existing bureaucratic system in Bulgaria prevent regular registration and/or intensive-extensive mix give misclassification of rates. However, this is a misnomer which we couldn't state for sure.

Now let us dwell on some international issues concerning health policy of the “League of Nations” /LN/ and “Rockefeller’s Foundation” /RF/. The small scope of our study does not allow to give a more detailed picture on those organizations. Suffice to say, from a special committee report presided by Prof. Hecht and entitled: “Raport sur son voyage d’etude dans certin pays d’Europeen. Geneva: Health Section of the Secretariat of the League of Nations, 1924” we see that a project is undertaken for Bulgaria. With the management of Rockefeller’s Foundation in the period 1931-34, an imposing building for public health activities is constructed in Sofia, Bulgaria. Architect is Dr. K. Koev and the design is the biggest on the Balkan Peninsula, a huge six store building which stays on “Regentska Street” some 100 meters away from the Mausoleum of Vasil Levski. It is there that the Directorate of Public Health with Supreme Medical Council transfer its quarters under the name "Institutes for Public Health". It is pity that the archives of the "Institutes ..." were ravaged after the World War. We have got some information from a notebook belonging to two members from the “Teetotaler’s Association in Bulgaria”, namely Dr. Haralambi Neykov and Dr. Dimo Burilkov. Suggestions for further research on the topic are welcomed.

HEALTH 1921-1945, PART 4

We continue our narrative by the beginning of WW II in September 1939. I have read somewhere a statement about Adolf Hitler: “Einem Trompeter gebe die Macht nicht”. Whoever said it proved to be politically shortsighted. Hitler’s war shook up the world to an immeasurable scale. What happened then is a matter of fact in numerous textbooks and public files. We concentrate our attention on Bulgaria’s destiny by the period and that is done, purposefully, via a presentation of renegade man Aleksander Tsankov /1879-1959/. Here is an article about him from Encyclopedia Britannica Inc., 1968:

“Bulgarian statesman, born in 1879 in the town of Oriakhovo and studied law at Sofia University, where he became professor of economics. In 1922 he became leader of a small group called the National Concord /Naroden Zgovor/, drawn from the intelligentsia of various political parties and the mass of former officers, which aimed at combining the dispersed national forces for a struggle against the semi-dictatorship of Aleksander Stamboliski. To him fell the premiership of the coalition government, representing all the political parties except the Communists, that took power on 9 June 1923, after military coup d’etat, in the preparation of which Tsankov’s National Concord had its share. Tsankov remained prime minister until 1926, when he was replaced by Andrei Liapchev.

His tenure of office coincided with one of the most tragic periods in modern Bulgaria's history. The disturbance that broke out after Stamboliski's overthrow took thousands of lives. On 9 September 1944, after Soviet troops had occupied Bulgaria, Tsankov formed a National Bulgarian Government in Austria under German auspices and tried to recruit a volunteer corps. The advance of the Russians put an end to these efforts; Tsankov surrendered to the U.S. forces and was interned at Kitzbuhel in Austria. Later, he was released and emigrated to South America. From 1948 he lived in a suburb of Buenos Aires, Argentina. He died on 17 July 1959."

Prof. Aleksander Tsankov is important for medico-sanitary historiography because he is, presumably, the architect of modern social security reform in Bulgaria. On 1 July 1924 is enforced the "Law for Social Security" /LSS/, which cancelled all active decrees by that time. The law makes a reorganization for social security concerning the main biosocial risks by introducing insurance with "Fund for Social Security" /FSS/ which is functioning at the "Ministry of Trade, Industry and Labor. Specific for the new system is the profile administration matrix, i.e. all organizations on state, public and private level are cooperative to a certain degree, given it is not prohibited by a specific other formulation. It is an old system of "leveling" coming from XVII century England, stirred in the Cromwell army. But we are not going to dwell on the evolution of the concept right now.

The professional medical associations, subject to social security venture, are the Bulgarian Medical Association /BMA/ and the Bulgarian Dental Association /BDA/; they coordinate the operational activity for collecting the prestations and subsequently defend the interest of the insured. Thus, for the period until 1944, the mean number of workers and employees covered with ambulatory, domiciliary and some other services by the "Fund for Social Security" is — 1.24 % versus 0.65 % for the general population /N. B. these are numbers for services done, not for services paid/. However, towards the end of the period the costs for rendering such services are unrealistic, because: 1. An increasing devaluation of the Bulgarian currency; and 2. Bureaucratization of the organization towards expenditures for administrative purposes.

On the left hand of the system is the object, situated at the "Institute for Working-Medical Expertise", decreed with the same law from April 1924. We see here the principle that, whoever treats is the one who determines the length of treatment or "piggy-backing". For the first time the "Institute ..." administers: short-term, long-term and whole-term (or invalidity) expertise on disability and done with the help of trained para-medical personal. For instance, the measurement for working incapacity based on organ-topographic signs is appreciated via percentage estimation and not by reimbursement of unrealized working income. More data is available from tables of operational activity for the "Fund ...". For instance, for the period 1930-1944 /index year is 1939/, medical examinations per 1000 insured people varied from 22.2 % (1930), raised to 106.0 % (1938), and then had fallen again by 42.9 % (1944). Thus we have a binomial curve for medical examinations of insured people for the period 1930-1944.

HEALTH 1921-1945, PART 5

Let us briefly make a synopsis of the period 1921-1945 before continuing the subject with reforms following the end of WW II. The fundamentals of legislation and administration in Bulgaria during the before mentioned period was elaborated at the League of Nations - an international organization set up in 1919 to preserve peace and settle disputes by arbitration. The constitution of the League (or Covenant) was adopted by the Paris Peace Conference in April 1919 and written into each of the peace parties languages. The League's headquarters were in Geneva but its first secretary-general during the period 1919-1932 was British diplomat, Sir Eric Drummond /1876-1951/. During the Second World War the League maintained its non-political functions. Its remaining responsibilities were rendered over to the United Nations in April 1946.

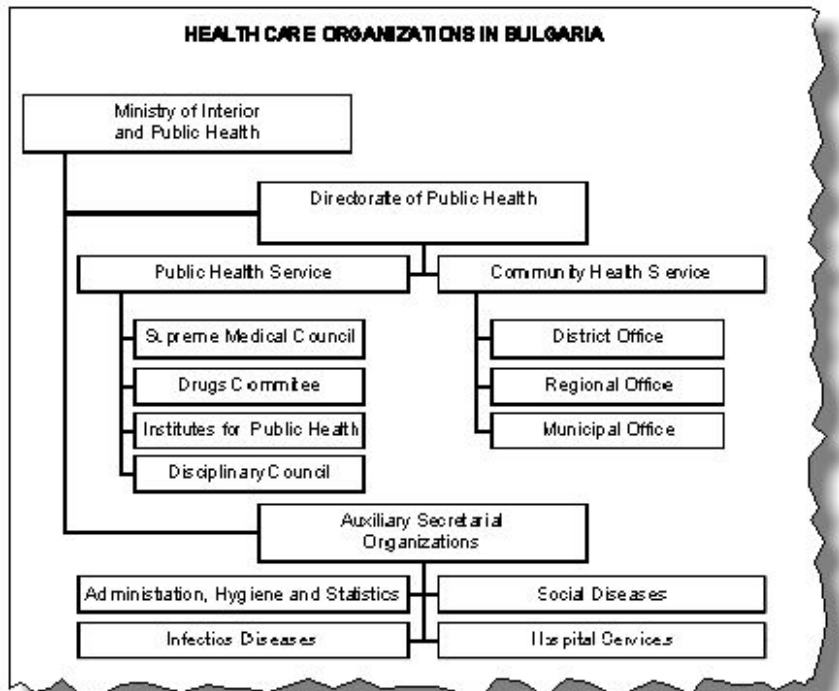
Making a survey on the General Administration in Bulgaria reveals the following — the government consists of Head of the State, the representatives of the People's Chamber and the Cabinet. The Head of the State is the King /Tsar/. The representatives of the People's, where each deputy representing 20 000 inhabitants is elected every four years, constitute the National Assembly /Sobranie/. The government Cabinet is composed of ten ministers. Bulgaria is divided into 16 provinces, 82 districts and 2391 communes, of which 82 are urban and 2299 rural, the total number of the settlements being 5652. Each province is administered by a prefect, appointed by the Minister of the Interior and assisted by a provincial council and provincial committee. The districts are administered by sub-prefects. At the head of each commune is a major, who is assisted by one or more deputies elected by the municipal council; the council is elected by the inhabitants. Questions of interest to the municipality may be submitted to a referendum at the demand of at least one-sixth of the electors. Sofia possesses a special communal organization.

The Legislative power is in the hands of the Crown and the National Assembly. The Government generally draws up laws and takes the initiative in matter of reform. Bills are laid before the National Assembly by the minister or the department responsible for their promulgation. Private members may also introduce bills, which must, however, have been signed by a quarter of the representatives in the National Assembly. The legislative bodies of the communes are the communal boards. These boards must not, however, issue regulations which are at variance with the national laws. The executive power is in the hands of the Crown, the Ministers and the Cabinet. Ministers issue executive regulations under the laws passed by the National Assembly; these regulations must be sanctioned by royal decree. Ministers cannot promulgate new laws or amend, add to, or replace existing ones. In exceptional circumstances, and subject to a decision by the Cabinet, the Crown may publish decrees having the force of law. The prefects, assisted by the provincial councils, are the highest representatives of the executive power in the provinces. They may issue orders, which must not, however, exceed the scope of the national laws. The powers of sub-prefects are purely administrative. In the communes, the executive power is represented by the mayors, whose orders have the force of law.

Finally, the Health Care organization in Bulgaria was established with a decree ? 2 from 7 February 1929 and published in the supplement of the "State Paper", vol. 277 from 9

March 1929; revised with additions according the law, published in the “State Paper”, vols. 68/1933 and 76, 178, 223/1935 and 129/1940. Below is an example of the structure for health care organization in Bulgaria.

Picture 1: Sample illustration on the text above.



(i). Organizational chart of Health Care institutes in Bulgaria (1921-1945).

PART III: FROM 1945 TO 1989

HEALTH SINCE 1945: TRANSITION PERIOD

It is our privilege to begin a review for a long period of socialist health care in Bulgaria. Our plan comprise of the following materials, divided according time periods in economic-political aspect:

- First, transition period from 1945 to 1960;
- Second, institutionalization period from 1960 to 1990;
- Third, reconstitution period from 1990 to present time.

We begin with the transition period to a socialist economy on the Soviet pattern which took longer than the immediate post-war period. Simply nationalization of private industrial enterprises in the period was not enough. A system of long-term central planning to coordinate outputs with inputs also had to be set in place. And for such planning to include all production, the collectivization of small-scale, private agriculture seemed necessary. Bulgarian economists typically identify the date of its completion (1960), as the end of transition to the Soviet political system.

Each of the first three national plans followed a strategy of extensive growth. Huge amounts of capital and labour were funneled into a few branches of industrial production. These plans honour the Soviet ideology which can be briefly retold.

First, the basic Soviet system for central planning is well known. So is Soviet development strategy: rapid growth of heavy industry to be achieved through concentrated investment from the state budget and a labour force augmented by peasant influx. A smaller rural labour force is left on the mechanized collective farms to produce the surplus needed to feed a growing urban population. Bulgaria's post-1948 transition to this planning system and strategy followed the Soviet pattern perhaps more closely than did any of the other Communist governments in Eastern Europe.

Second, although its general pattern is familiar, the period of the first three Five-Year Plans is the most neglected in modern Bulgarian economic history. Western and Bulgarian economists have concentrated their efforts on the period since 1960, where reliable statistical evidence is more available and connections to the international economy more important /N.B., Bulgaria published no Statistical Yearbooks in the 1950s/.

Bulgarian political history from 1949 to 1960 also makes a detailed appraisal of these years more difficult. Accompanying several changes in Bulgarian party leadership was the Soviet transition from Stalin to Khrushchev eras. The singular line of authority from party leadership to economic policy that is a hallmark of Soviet-style economies was doubtless present, but harder for outside observers to discern. Subsequent Bulgarian scholarship has trodden too lightly on these political matters to make clear the inner dynamics of economic policy.

The period began with the illness and death of the party's respected leader, Georgi Dimitrov. A sick man at least from 1947 onward, he died in April 1949 after several months of treatment in the Soviet Union. Dimitrov enjoyed international prestige on the left as the eloquent defendant in the Reichstag fire trial, staged unsuccessfully by the Nazis in 1934, and as head of the Comintern thereafter. He kept his position as Bulgarian Prime Minister during the Tito-Stalin split, despite his advocacy with Tito of a Balkan customs union and a Federation just a few months before the dispute erupted. Traicho Kostov, one of his logical successors and the party leader most responsible for economic policy since 1944, did not survive the purge following the Tito-Stalin split.

The actual successor, Vulko Chervenkov, had been trained in the Soviet Union for party work since his exile there in 1925. He coordinated propaganda for the Comintern from the late 1930s, and for the Bulgarian party's Central Committee after his return to the country in 1946. His background did not prepare him well, in other words, for overseeing the first Five-Year Plan. His two decades of Soviet exile did, however, prepare him to follow Stalin's lead after the split with Yugoslavia in 1948, and to reject any further delay in proceeding with rapid industrialization and forced collectivization according to the Soviet experience of the 1930s. In addition, Chervenkov came to power during Stalin's last years, when the Soviet Union's own reliance on propaganda slogans and the threat of arbitrary punishment reached its post-war peak. These were distinguishing features of economic policy in both countries from 1950 until Stalin died in 1953. Chervenkov had begun his regime by expelling one-fifth of the party membership that had grown to half a million. Many of those expelled, like half of the party membership, were peasants. So were many of the unknown numbers of suspected "enemies of the people", who were sent to concentration camps in the early 1950s. All this made the atmosphere surrounding further collectivization ominous, rather than encouraging.

First challenges to Chervenkov's leadership none the less appeared surprisingly early in the Second Five-Year Plan /1953-1957/. The plan was itself a retreat from the harsh, sometimes counter-productive measures of the first. Criticism of Chervenkov for these excesses appeared in the Bulgarian Politburo as early as 1953, and reappeared in 1955 because of continuing agricultural problems. Khrushchev's 1956 speech exposing Stalin's "mistakes" and his "cult of personality" was perhaps the most important, but not the first step in Chervenkov's demotion. Todor Zhivkov emerged from the new generation of post-war party leaders to become First Secretary in 1954, at the age of 43, and Deputy Prime Minister in 1956. But Chervenkov was to remain the other Deputy Prime Minister until 1961. Anton Yugov, the Interior Minister during the mass arrests of 1949-1950 and one of the older generation of "home communists" had re-emerged in 1956 as Prime Minister. Zhivkov strengthened his position in this triumvirate as the 1950s drew to a close. The influence of the other two still remained to be reckoned with until the shortcomings of the Third Five-Year Plan had become clear. Bulgarian economic policy did not therefore pass fully into the hands of Zhivkov and his post-war generation until the 1960s.

HEALTH SINCE 1945: TRANSITION PERIOD, PART 2

The first act, which came to reflect the new attitude of the state towards health care, is establishment of the “Ministry of Public Health” /decree ? 284 from 9 September 1944/ as a central state institution for coordinating health issues. This is a realization, de facto, for one of the main formulary from the health policy of the Party and the progressive medical community — which is the program documents of the expert group “Social Medic”, working for long years under the auspice of the Bulgarian Medical Union. Dr. Racho Angelov /1873-1956/ is appointed first Minister of Health and Dr. Konstantin Kusitasev /1900-1955/ to the chair of staff Secretary: both well known as consistent public health activists and having a long dossier as professional revolutionaries. The new Ministry is a split off organization, meaning it came out as a corollary from the “Ministry of Interior & Public Health” and by right of succession taking its actives and passives.

The main tasks of health care in the transition period are formulated in the “Program of the Fatherland Front” from 17 September 1944. They are elaborated in the form of a State Plan, containing eleven points:

1. Cultural and vital elevation of the living standard of the people;
2. Fight against infant mortality and provision of effective measures for combating infant diseases;
3. System prevention of tuberculosis and all other infectious and social diseases;
4. Sanitary development of dwelling settlements and all other populates;
5. Qualification and re-qualification of medical care at all levels;
6. Special health care of villages, factories, workshops, schools, etc;
7. Sports and physical activity recreation;
8. Social care for adults, adolescents and other outcasts;
9. Infiltration of the community with new health education;
10. Making a universal medico-social insurance;
11. Social care for motherhood.

This health platform is a demarcation for new social approach of decision making in medicine. Altogether, it show some realization of the principles of socialized medicine. The full project consisted a booklet of some 40 pages and was printed in the early 1940s, but remained concealed by the group “Social Medic” — viz., "Kusitasev, K and Mateev D. Project for State Health Care Plan. Sofia, 1940".

Meanwhile, efforts are strained from the new government to overcome the ruins from World War II. Activities, interest and participation from the side of the general population is shown towards the problems of health care. With voting on 11 July 1946 of the “Law for Cooperative Suffrage of Health Establishments” /LCSHE/, a foundation is laid for intensive development of health care. This is emphasized by minister Angelov on a briefing at the National Assembly: “Evidently, the present state of affairs need a corrective amendment”. The LCSHE arranges the following subjects of cooperation: 1. As compulsory participants are the State and the Municipalities; 2. As facultative participants are the Coops, and other Public associations, societies, companies, etc.

Accordingly, the government emitted obligation funds which were later revoked unconditionally by the State Exchequer at a limited interest rate. This is, de facto, privatization on a small scale and socialization of health care on a large scale. Further socialization on a small scale is attributed via district physicians principle. Prerequisite for this act is the adoption of new “Constitution of People’s Republic of Bulgaria” (5 December 1947) - in Art. 81 is written, that: “Liability of the state is to take care of the health of the citizen”. Furthermore, with decree ? 43 from 21 December 1949, a new health maintenance organization is arranged — namely, “Polyclinics” and functioning on the basis of the former municipal health-services, workers health check-points, district ambulatories, etc. What is important here is that, towards the end of 1949 some 69.2 % of the total population were covered with “free” medical services. This, in caveat, make us remark that much speculation has been held on the meaning of the term “free” health care. What is important here is that coverage was eligible for everyone, who was employed in the public sector at any kind of a state job. Consequently, the 69.2 % health coverage is quite a good indicator for state employment rate. The bad point is that health reimbursement often proved wrong and that is what “Marxian” economists could not foresight.

Speaking about “failure” is an issue from quality control. Our job is to give a chronology of events in the years after WW II and in the period of the Cold War. Thus, we should try to enumerate briefly what happened in the first five years, something which for the field of health care could encompass a lot of thick volume documents. First, on 12 June 1947 was voted the “Law for Sanitary Pharmaceutics Enterprises” /LSPE/ - enacting a process of nationalization for drug industry and marketing. Second, with decree ? 2 from 12 May 1948, all private hospitals and clinics were expropriated and put under the umbrella of Ministry of Public Health. Third, with decree ? I-20-874 from 19 August 1949, all establishments from the “Fund for Social Security” /FSS/ were expropriated and a new institution, under state umbrella, was created - “State Institute for Social Security” /SISS/.

HEALTH SINCE 1945: TRANSITION PERIOD, PART 3

In the 1950s, already, socialist transformation of health care was marching on a dynamic and rational scale. Within the frames of the “Second Five-Year Plan” this led to a total socialization of state apparatus: — cf., "Kolarov, P. On socialist transformation of public

health care. Sofia, 1952". The author, Dr. Petar Kolarov /1906-1966/, was architect of socialist reform in health care. Himself an inter-brigadier from Spain and U.S.S.R., he was appointed Minister of Health on 20 January 1950. Same year, with decree ? 2658 from 20 November 1950, was given state jurisdiction to a new nomenclature of health care organization in PR Bulgaria. The basis of the new decision making process included:

1. Categorization of health care establishments and health care appointments;
2. Unification of ambulatory and stationary health care units in academic structures;
3. Reestablishment of Sanitary Epidemiologic Stations /SES/ with prophylactic purpose.

The "Ministry of Public Health", renamed "Ministry of Public Health & Social Care" /MPHSC/ from 29 November 1951, functioned as a coordinating body which organize and regulate at the head of a large network of branch structures. These in itself is a replica of the scheme for the "Directorate of Public Health" before World War II. The "Scientific Medical Council", accredited with ordinance ? 911 from 14 April 1950, is the supreme consultative organ of the ministry for planning, research and development. It consist 25 members, all republican specialists in their corresponding working fields, appointed from the Minister of Health and treating different social medical problems with the help of standing committees and commissions.

In the periphery, health care is administered by the local organs of state authority - the Public Councils. Consequently, with decree ? 2822 from 29 November 1951, are established the "Sectors for Public Health" within the district, community and city public councils. The Sectors are responsible for organizing hospital and ambulatory care on the territory of the corresponding council, while some institutions of national importance are still under umbrella jurisdiction of the MPHSC. As a supplement and on middle level of administration are constituent, also, a network of corollary consultative organs with duplicate functions.

Medical planning has become particularly important characteristic for socialist health care. Planning is inseparable from budget and expenditure extrapolations of any state economy. It consist from parallel lines of development and truncates to the left. Insofar as medicine is concerned of expenditures for Ministry and Sector health establishments, planning is concentrated within the total republican budget and allocated with the help of corollary consultative organs. This seldom leads to discrepancies, but once a deficit is settled and it can be reimbursed from the state reserve. In a historical perspective, some 50 years later the federation of socialist states collapsed under the burden of state deficit. The question is, without making predictions, what could a wholesome world do if a trend on planning continue globally and this time in an inverse order for the capitalist system itself?

Next step, nevertheless, comes as the reformation of political cadres in this ountry. As an issue of utmost importance, one should have in mind that Bulgaria did not boast a plethora of medical workers in year 1950. There were, accordingly, available some 5164

physicians, 1550 dentists, and 2034 nurses in practice. This implies that health personnel administration is not concerned so much with matter of numbers as to their distribution and category level. Thence come an ordinance ? 1124 from 6 March 1951 that establish the “Institute for Specialization and Unification of Lectors” /ISUL/ as a double fold organization: — once, for methodical upbringing of cadres; and twice, to sustain peripheral structures with personnel on a mapping principle (understand here as “geographical”). Socialist reorganization seemed incomplete without ISUL and the socialist international cooperation. In the long run, socialist countries joined the World Health Organization /WHO/ and adopted the International Classification Diseases /ICD/ from about year 1960.

HEALTH SINCE 1945: TRANSITION PERIOD, PART 4

When Stalin died in March 1953, the days of his satellite followers seem to be doomed. Thus it happened for Vulko Chervenkov /1900-1980/, a miner’s son who passed through “Lenin’s Institute for International Politics”, via Party work in the “Committee for Culture”, and swaying as Secretary of the BCP “central” commanding apparatus. Chervenkov slavishly copied Stalin until April 1956, when he was replaced by Anton Yugov - a Macedonian. However, the real power in Bulgarian political life from 1956 to 1989 was vested with the Secretary of the Bulgarian Communist Party, Todor Zhivkov /1911-1998/, and under his directive the country remained as the most loyal supporter of Soviet policy in the Warsaw Pact.

In the mainstream, an intensive social-economic development of the country within the Third Five-Year Plan led to significant system processes with a reflection on health care, as well. Together with a changing canvas of lifestyle and working, parallel to a heavy state industrialization and conglomerate cooperative restructuring of agriculture, Bulgaria gained momentum as semi-developed state. Population structure of Bulgaria from that period (1944-1967) reveal a straightforward migration potential from villages to towns — from 24.1 % vs. 75.9 % ratio, the composition of human resources become 48.5 % vs. 51.5 % or we have here a net internal migration of 2.4 million people changing their residency from village to town populace.

Obviously, these urbanization patterns were rapidly on the increase, since migration of peasant population into the towns occurred at the expense, mainly, of the younger population groups which rendered imperative for industrialization process on a nationwide scale, but certainly developed disproportions on a demographic level. Those are reflected by the population statistics of PR Bulgaria for years 1944-1967, — infant mortality rate sharply declined from 120.6 per 1000 born alive in 1944, to 33.1 per 1000 in year 1967. Ever since 1944, the birth rate on a nationwide scale has been high and reaching 24.6 per 1000 population in year 1948. Thereafter, it showed a tendency for decrease.

On an organizational level, further were elaborated some aspects of health care network within the context of town-village controversy. The leading principle was - "bridging over differences between workers and peasants". How to achieve this task? In a long term perspective, this was matter of folk psychology and we are not in a position to discuss the question. There is multitude of literature written in the bulgarian parlance, but we should stick with our theme. In order to provide a qualified and ready service for the workers in the manufacture - a decree appeared from "Ministry of Health" on 24 February 1953. The aim was to promote preliminary and periodical medical examinations for the workers, with expertise for incapacity. These are rudiments of "screening" and "monitoring" procedures, as early as the 1950s and envisaged by health authorities in Bulgaria. Within a caveat mentioning, even earlier before WW II were functioning the "factories for health" in this country, but they had ultimately their precursors in the utopian literature. In Bulgaria, workers health care grew on a local basis and culminated in the 1970s with WHO's project - "Dispensarization model in Gabrovo district. Copenhagen, 1983".

In our opinion, socialist transformation of health care in the village is more interesting and deserves a special attention. This was done on a piecemeal basis, when collectivization of agriculture accorded such mega-complexes - i.e., TKZS, DZS, MTS, etc /N.B., transliteration is in bulgarian/. The bulgarian village gave good opportunities to sustain and nourish the labor of the peasants. At first hand, when urbanization of the country was not advanced and infrastructure roadways, building construction, etc. were developed on a smaller scale - booming was extensive and presupposed integration of village "district" health structures with larger facilities in the town. The number of such village establishments was - 92 sanatoriums with 1500 beds in year 1951; 266 sanatoriums with 4028 beds in year 1957, etc. Later in the 1960s an involution process began and subsequently new structures emerged in lieu of the "rural policlinics. These numbered about 300 in the end of year 1969 and were integrated to the "district" and "regional" level of administration, with limited specialized cabinets.

Another establishments, founded with decree from "Ministry of Health" on 17 July 1953, were called "Maternity and Infant Homes" with operation schedule apart. What is given bellow is some statistics for the period 1944-1967. Whereas during year 1944 there were only 7 "Maternity and Infant Homes" with 280 beds and not a single public nursery "Crèches", subsequently in year 1967 those grew to 31 with 2218 beds. In addition, 674 seasonal "Crèches" with 17 466 beds were established throughout the country. Thus, favorable conditions were provided for adequate care and education of the children, enabling the mothers to put their efforts in the production and research. The main points in this type of health care include:

- Ccomplete desensitization carried out for all pregnant woman, as well as systematic observation ever since the very first week of pregnancy;
- Dyspensarization by inclusion in special observation lists of all children, as early as in the first month of life;

— Requirement that each delivery takes place in a hospital unit or maternity home is of paramount importance for the state and organization of obstetrical aid.

Finally, few words should be said for the geriatric care in the country. Many efforts were made for securing normal life conditions for solitary old people and invalids with severe physical or mental defects. Here is some statistics for period 1944-1967:

— 126 social service units have been established with 9774 beds, against 26 asylums for old people in year 1944;

— 174 sanatorium units with 15 659 beds have been established for providing rehabilitation care, against 20 units with 2134 beds in year 1944.

Thus, sanatorium beds available per 10 000 population has increased from 3 to 19.

HEALTH SINCE 1945: INSTITUTIONALIZATION PERIOD

Bulgarian transition to economic priorities and institutions, based on the Soviet pattern, was essentially complete by the end of the 1950s. It was on this basis that economic development /i.e., modern growth supported by structural change/ was under way for the first time in Bulgarian history. The concentration of investment capital, and the arrival of factory labour from a newly collectivized agricultural sector were the key structural changes that sustained rapid growth of heavy industry and modern technology. Bulgarian economic development derived in part from a larger commitment to foreign trade, than that of the Soviet Union or of any other Eastern European country. Since 1960, moreover, the making of Bulgarian economic policy has been marked by virtually unbroken discussion - about, how to improve the productivity of labour and capital. The discussion has prompted recurring reforms in the initial Soviet system of central planning and ministerial control. More attention was paid to statistical turning-points. Increasingly less attention was paid to discrepancies between planned and actual growth; they became less glaring after 1960 and virtually disappear after 1980.

Comparisons across the entire post-war period suggest another important change under way in the Bulgarian economy from about 1960 onward. This has been the transition from extensive to intensive growth, more precisely, from growth based on increased inputs to growth based on greater productivity per input. For labour, the transition was fuelled by massive injections of new fixed capital, and proceeded more rapidly than anywhere else in Eastern Europe. For capital and other inputs, the growth of productivity has been sporadic and remains illusive. Management and technology have not improved consistently enough to increase the efficiency with which capital, in particular, is used. The concentration of more and more inputs into modern industrial production, however, has continued to be the principal source of structural change in the economy.

Characteristically, the overall rate of Bulgarian economic growth has itself declined. The productivity of capital has failed to keep up with that of labour. Raw materials have become more expensive, as they have everywhere in the world. Yet the record of growth remains a remarkable one, particularly when compared to economies of similar size in Western and Eastern Europe. If there was no economic miracle for Bulgaria in the 1960s, neither, was there a serious setback during the 1970s.

Political continuity provides part of the explanation for this relatively stable performance. By the early 1960s, as spelled out earlier, Todor Zhivkov had consolidated his position as party "First Secretary" and had become Prime Minister. In 1971, he exchanged the latter position for the Presidency of the new State Council. Under this reorganization, Zhivkov has retained authority over the Council of Ministers, although he was no longer its Chairman. He was therefore head of state, as well as, head of the party. The collective leadership of Politburo of the party's Central Committee, and 27 members of the slightly larger Council of Ministers have none the less come to play the wider role in making decisions - whatever, equivalent bodies do in the Soviet Union. Enough younger members have entered the Politburo to lower the average age to below 60, which was significantly younger than a Soviet figure.

No independently powerful figure, or, likely successor to Zhivkov emerged. His daughter Liudmila, though a member of Politburo, was never considered his probable successor nor equal; she was none the less widely mourned at her early death in 1981. Zhivkov's leadership, until November 1989, constitutes the longest period of unbroken political stability under a single authority in modern Bulgarian history. Among a population whose historical memory of the 20th century was dominated by uncertainty and impermanence, by brief triumphs and enduring defeats, this recent continuity must be of significance. In the rest of Eastern Europe, only Hungary has had a comparable experience.

HEALTH SINCE 1945: INSTITUTIONALIZATION PERIOD, PART 2

An important factor, which determines the pace of medical science in Bulgaria from that period is a drop out from the international isolation of the country - that, has been concomitant since the end of WW II. This is a welcome association with a number of international structures — UN, WHO, UNESCO, etc. — and an important step forward to following the tendencies and programs of world community, as well. Cardinal problems of men-environment-disease in the 20th century were made part of the country's policy also. This cooperation aside, Bulgaria continued to support intensive contacts with the countries of the CMEA /Council for Mutual Economic Assistance/. This international community of socialist countries, based on economic relations and fraternal cooperation, was created in 1949. It hosted international socialism, and some non-aligned countries like Finland, Iraq, Mexico on the basis of relevant agreements until dissolved in year 1989 by political liquidation. Whatever the form of cooperation, the Bulgarian medics participated actively in the field of health progress. For example, an

extremely important project of WHO and a group of Bulgarian clinicians with leader Prof. Alexi Puchlev was implemented on the research of Balkan Endemic Nephropathy in the early 1960s.

Another important feature of medical science was the augmentation of medical cadres. It was evident that post-war Bulgaria lacks the plethora of specialists, necessary to reform a health care system. Thus a massive trend was established towards production of medics. On 4 August 1945, with decree ? 180, was established second medical faculty in Plovdiv. Consecutively, medical faculties were opened in Varna /1960/, Pleven /1964/, Stara Zagora /1982/ and after the conglomeration of the National Medical Academy in 1972, filial faculties were instituted in the towns of Tolbuhin and Pazardjik. Explicitly, this gave an increase of physicians from 3500 in year 1944 to 28 500 in year 1989. The tradition to specialization of cadres abroad continued, as hundreds of young specialists became

Candidates and Doctors of medicine in the frame of WHO programs and exchange fellowships with CMEA countries, — viz., Soviet Union, GDR, Poland, Czechoslovakia, and Hungary.

Meanwhile, internal aspects of coordination were not neglected. The Bulgarian Medical Union /BMU/, which functioned shortly after the war, stepped away to be replaced by an alternative organization - Union of Scientific Medical Associations in Bulgaria /USMAB/, based on a topic principle. Specifically, the new organization was responsible for a network of internal relations in the form of congresses and seminars, as well as, for providing an atmosphere of educational and ethical problem solving. These, however, not always gave a positive result - sometime, the principles of so called “democratic centralism” were broken and there appeared ugly phenomenon, like “loss of job” or “transfer to another place” or “financial penalties, etc. Simultaneously, capitalism was presented with a monster face and the era of senators McCarthy and Fulbright sentenced to condemnation. But those were the realities of the 1960s and we are not in position to debate on the questions of Cold War, per se.

Health care from the beginning of the institutionalization period is characterized by the following features, namely:

1. Increased adaptability to the new lines of social-economic progress;
2. More regulation towards the utility of resources, and mobilization of self-control specifically in the field of prophylaxis;
3. Enhanced cooperation of health care with other spheres of the social system, with regard to complex determination of health and social problems;
4. Further democratization of the health care system, in accord with state and party directives /i.e., understand here development of relations of production, productive forces and surplus product/.

Minister of Health from that period is Dr. Kiril Ignatov /1962-1971/. Most important lines for development of the State and the Party within frames of the Fourth and Fifth Five-Year Plans are the decisions of the IX Congress of BCP /1966/ and July Plenum of CC of BCP /1968/. While trying to be parsimonious with the interpretation of data from that period, we encountered some difficulties in the transfiguration of the material. In a future presentation we shall aim to give a fuller account of the state of health care system for the period. For the moment we have at hand some documents presented by the Minister of Health in 1968, and entitled "Cardinal lines of health development in the People's Republic of Bulgaria". Here are some excerpts from the concluding sections of the document:

"In full accordance with the Thesis of the IX Congress of the BCP, the main task of the social policy of the BCP is "to assure high vitality of the nation, to affirm a healthy way of life, to build up more favorable conditions for the multilateral manifestation of the human personality. The complex approach to health comprises the accelerated development and realization of all specific activities, that affect the solution of the health problems.

The Party pays a special attention to the establishment of a healthy way of living, and the nation-wide movement for high health culture. With regard to this, additional efforts will be made for the further development of mass physical culture, sports and tourism, for increasing the sports and tourists base and its using, especially by children and youth.

Medical science has risen to a new higher level, respectfully, of its function and importance as such on account of the higher criteria and more important role of health care. The leading force of the scientific and technical revolution in our socialist health care is the powerful scientific, educational, production and organizational-methodological potential. The coordination of the research work programs is being improved, as well as, its complex character. The information possibilities are of much better use now. New forms of immediate transfer of the latest domestic and foreign scientific results to the consumers are organized, thus the health workers becoming closer to the practical health network.

In the political report of the CC of the CPSU, delivered by comrade L. Brezhnev, and in the new edition of the Program of the CPSU enormous attention was paid to the development of health care in the Soviet Union. The political report of the CC of the CPSU states, that "For both man and society there is nothing more valuable than health". The preservation and consolidation of people's health is of primary importance. The problems of health care must be considered and worked out from wide scope social positions, by involving the Councils, the Comsomol, and with the public initiative and activity of the population. This identity in the Party's outlines for the development of our socialist health care is determined by the decades old links and harmony between the BCP and the CPSU, between our countries and nations, and their health care systems. Our socialist health care was created and developed on the Soviet health care model, using all the time its enormous experience and achievements. That is the base on which the identical goals, means and ways of development are formed".

HEALTH SINCE 1945: INSTITUTIONALIZATION PERIOD, PART 3

The beginning of the 1970s were marked by several important events. On an international plan this was a series of conversations aimed at disarmament and held between Soviet and U.S. representatives - the Strategic Arms Limitation Talks /S. A. L. T./ First treaty was signed on May 1972 /S. A. L. T. - 1/, limiting defensive anti-ballistic missile systems and agreement was reached over certain other measures. A second agreement /S. A. L. T. - 2/ was concluded in June 1979, but it fell short of American hopes when president Carter's administration found it impossible to persuade the Senate to ratify the agreement. At Geneva on 1 July 1982, Soviet and American talks were renewed under the acronym S. T. A. R. T. /Strategic Arms Reduction Talks/, as an optimistic substitute for discredited S. A. L. T. negotiations. These S. T. A. R. T. talks paved the way for international agreement in the 1990s and continue until now.

As viewed on a national scale, the 1970s brought important changes in the structure of socialist society and health care sector in particular. Let us enumerate the items on the agenda, which will serve as a guide in the following narratives:

1. The X congress of BCP /1971/ gives in details the quantitative and qualitative changes in Bulgarian society. Programme is outlined for building an advanced socialist model in the country;
2. A new "Public Health Law" is voted by the 6th National Assembly /31 October 1973/. Important aspects of this Law are — viz., prohibition of private medical practice, adoption of new Moral Codex of the physician, etc;
3. Process of consolidation of medical science finds its height with the institutionalization of Medical Academy as a solid, unified, scientific, therapeutic and organization-methodical complex (Art. ? 921 from 30 April 1972). The new medical complex is accredited with statutes and regulations by article ? 0-9 from 7 February 1976.

During the period of institutionalization, Ministers of Health are Dr. Angel Todorov /1971-1977/, Dr. Radoi Popivanov /1977-1987/ and Dr. Mincho Peychev /1987-1989/. At the end of year 1989, the country falls into sharp political and economical recession. A long time regime of socialist transformation comes to an end.

Addendum: So long we have been dealing numerous times with problems of health care organization, on the pages of this booklist. An unswerving impression has accumulated, whatsoever, that during the so-called "socialist period" of development for Bulgaria there prevails the bi-partisan approach in social science disciplines and humanities, per se. This doesn't mean that socialist planning environment during those years was fake; however, a solid line of cooperation was evident from the side of state institutions in this country with wide range of international (health care) organizations — UNESCO, WHO, FAO, etc.

Below are presented some normative documents from Ministry of Health given in their original typeset. Access is from here,

<http://www.archive.org/details/PublicHealthInPeoplesRepublicOfBulgaria1944-1968>

<http://www.archive.org/details/PrimaryHealthCare>

<http://www.archive.org/details/BulgariasRoadToHealthForAll>

PART IV: FROM 1989 TO 2001

PROBLEMS OF ORGANIZATION, MANAGEMENT AND FINANCING OF HEALTH CARE

People's health is a national wealth and prerequisite for the advancement of any nation. It is, as well, a measure of the social, economic and political development of society.

The network of healthcare centers which render medical aid (diagnostics, treatment, rehabilitation, some types of prophylactic activity) in Bulgaria is well distributed, disposes of the necessary basis and a considerable number of academic, college and high-school graduates and other personnel. The macro-scheme of medical aid includes three levels — national, regional and municipal.

The public sector comprises 5 higher medical institutes (in Sofia, Plovdiv, Varna, Pleven, Stara Zagora) with a number of faculty clinics, 4 national centers with clinical bases, 287 hospitals and 3,723 ambulatory-clinical units, 917 crèches, 163 sanatorium-recreational establishments, 5 stations for fast and urgent medical aid, and 6 centers of transfusing hematology. The private sector comprises 7,445 medical consulting rooms and 3,692 dental surgeries. Besides, until the end of 1995, 64 private health utilities have also been established, including hospitals, out-door patients clinics (polyclinics), dispensaries, laboratories. The in-patient wards of the hospitals dispose of 90,991 beds (107 beds per 10,000 of the population), in sanatoriums — 19,278 beds (23 per 10,000 of the population). In crèches and nurseries there are 38,340 beds. Children up to 3 years of age are procured with 132,4 beds in crèches per 1,000 children.

Dental aid at national level is procured by a Faculty of Stomatology with a clinic. At regional level operate stomatological polyclinics, at municipal level — dental surgeries in polyclinics and health services in the villages. Here we must mark the fact that in the field of dental aid considerable portion of the necessities are already being covered by privately practicing dentists.

The medical aid network disposes of considerable in number personnel — one physician per 314 persons of the population, and one dentist per 1,487 of the population.

In Bulgaria about 60 per cent of the physicians have recognized specialties. Among therapists the relative share of the specialists is 50.8 per cent, among pediatricians — 55.3 per cent, among obstetricians — 77.5 per cent, among surgeons — 70.8 per cent, among orthopedist-traumatologists — 71.5 per cent. The number of specialists with college and high-school education is increasing.

This highly developed in quantitative respect system operates with funds of state financing. During the last years these funds sharply shrunk. The absolute increase of funds for healthcare in 1995 cannot cover the enormous relative fall-behind on the background of the general increase in the cost of living — medications, consumables, foodstuffs, heating, light, etc. This results in closing hospitals, patients procuring themselves medicines, blood for transfusion, consumables.

The problems in healthcare and inadequate nutrition brought back some forgotten diseases like tuberculosis, hepatitis, abdominal typhoid, rabies, syphilis, etc. Unemployment and stress over the uncertain future led to mass neuroses, psychoses, endocrine disorders. The efforts to overcome this heavy situation are in several directions. But, before all, serious efforts were made to render legislation in conformity with the new conditions.

The actual priority in the Government's program in the field of healthcare is the drug policy. The Law of Drugs in Human Medicine and of Pharmacies regulates drug supply for some diseases, the treatment of which is life-saving and life-supporting. These diseases are 11 and a hundred-per cent availability of respective drugs, which the patients receive in ambulatory conditions, is guaranteed throughout the whole year. This treatment is carried out under out-patient conditions and is financed directly from the budget of the Ministry of Health. Another 114 diseases are financed from the municipalities' budgets. Rendering legislative ground of the drug policy in compliance with the contemporary, generally accepted norms of the European Union member countries is considered an achievement of the National Health Strategy.

In 1996 the National Assembly is going to adopt important amendments in the Law of Public Health which will guarantee the right of a free choice of a healer and free medical aid to every Bulgarian citizen. Changes are also envisaged to reflect the transitional period towards health insurance system by virtue of which the health establishments will receive legal independence.

Discussion is being held on the Law of Professional Organizations which will stipulate obligatory membership like it is practiced in almost all European countries. Thus, professional organizations will receive the right, on behalf of all who offer medical aid, to be a party to the conclusion of a national accord. At a final stage is, as well, the preparation for adoption of the Law of Health Insurance, adapted to the already adopted Law of Creation of a National Insurance Fund and Separation of the Social Insurance Fund from the State Budget.

The amendments in the Law of Public Health go parallel with the preparation and adoption of regulations for new organization of pre-hospital medical aid which is correctly distributed by territory in order to guarantee access of all Bulgarian citizens to medical specialists in polyclinic units.

Healthcare is closely linked to prophylaxis, therefore in the National Health Strategy, adopted by the Government and approved by Parliament, a large section is dedicated to work to prevent disease. Such is the approach of the rich countries — to allocate money for prophylaxis of the healthy person because afterwards much more means will be needed for his healing.

The new organization of pre-hospital medical aid envisages the right of every citizen to choose his personal physician on the territory where he lives. It could be a therapist, a pediatrician (for children), a gynecologist (for women).

The start of the health reform in Bulgaria, which is already a fact, was preceded by a long social and professional discussion. The position of the Ministry of Health is that the valuables of the already achieved must be preserved, all factors to be precisely taken into consideration, including negative ones, so that the country would not lose whatever is already national possession in healthcare.

CRISIS IN BULGARIAN PUBLIC HEALTH SERVICES

From the point of view of public health, the demographic problems in the Republic of Bulgaria continue to go deeper. The trend towards demographic collapse has been deepening since the late 80s and at present. The negative growth of the population is -3.9 (9.3 births and 13.2 deaths per one thousand people). There is a strong tendency to a slight rise in the death rate including the younger ages, and especially among the male part of the population. This increase is most significant among the rural population. Life expectancy begins, although slowly, to go down.

To be explained, these facts should be viewed by considering a great number of factors, such as: the change in the living conditions, the sharp reduction of the nation's wealth in the last few years, the decrease of the purchasing capacity of the individual — with more than a hundred times for the people of the third age, the chronic stress, the increasing alcohol and smoking abuse, the permanent rise of drug habits, the worsened conditions in the environment, etc.

Bulgaria is a typical representative of a centralized hierarchical system with the hospital sub-system as its dominant part, with surplus of low-paid and discouraged personnel and relatively poorly developed primary health attendance service. It is a system financed only at the entrance without any effective feed-back, that is, certain structures are financed without any actual measurement of the product at the outlet. This kind of systems lack any financial incentives for the working professionals. They lack all the elements of the market and the competition. The signals coming from the system are not considered from the point of view of the general economic theory, that is, there is no search for measures of effectiveness and efficiency, and there is no search, too, for economic instruments that would improve the system. Such a system is financed with low percentage by the GNP, and in Bulgaria in the beginning of 1996 it was 4.2 % with galloping inflation and lack of flexibility in the budgetary response making it drop to 2.5 %. In addition to this evident deficit of funds, the structure of the system is such that some quite inefficient health care structures are financed. In the country, there are 29 269 working doctors or 34.9 per 10 000 people, which is one of the highest indexes in Europe. The bed space is 10.6 per 1000 people, which is almost twice as much as the average in Europe (5.5 per 1000 people). Ninety-nine per cent of the structures and the activity is state property and less than 1 % is private property.

These are widely known figures and it is clear that there is necessity for serious change in the structure and the functions of the health care system. What is being claimed and done

in 1996 in this direction? The implementation of the National Strategy “Health for Bulgaria” began and was developed as a strategy for primary health attendance directed to the establishment of General Practitioners and of every citizen's right to choose his/her own physician. Meanwhile, by way of a proposal on behalf of the government, the Parliament passed extremely unpopular measures amending the National Health Act and actually prohibiting the doctors to practice privately if they work for a public health institution. The Ministry of Health introduced attestation of the directors of hospitals, practice used 20 years ago by the Communist Party. There is a discussion of health policy in that field running in the country in an informal order, as well as, by creation of projects supported by the PHARE program and the EU.

Good teams of specialists give their views and suggestions and this will act as the basis for specific documents, which will outline the aims and the means for their accomplishment. However, the experts' opinions are used and altered to the advantage of the political doctrine and not as a response to public interests. An Instruction on Pre-hospitalization Aid was passed, which provided for free choice of a General Practitioner. The campaign was done very hastily without elucidating the people to what this might mean to them and above all, by cosmetic changes in the payment of doctors from whom it is expected to act as GPs and “gatekeepers”. The result is that only about 37 % of the people have been enlisted and have chosen such a doctor. Applied were standards for national health structure long developed by the present team of specialists of the Ministry of Health. These standards do not add any changes to the structure of big hospitals, in which hundreds of beds are not used effectively, and the personnel in the system will not be considerably re-structured.

A new regulation on doctors' salaries in hospitals and polyclinics was applied, according to which the salary contains a shifting part up to a certain limit, based on the number of treatments and the seriousness in the conditions of the patients treated by them. The regulation is in a process of adoption, but the high rate of inflation “has eaten Out” some of its positive elements.

The application of the Law on Medications and the regulation mechanisms of the prices of medicaments, which it introduced, did not achieve their aim to stop the growth of these prices, which continues to outstrip the rate of general inflation in the country. Surprisingly the Government submitted in Parliament a Draught Health Insurance Law and remarkably quickly, breaching all legal procedures, passed it on first reading. All medical professionals were shocked by the fact that that was not the long discussed project from 1993, but one that could turn health insurance into an appended warehouse to a huge National Insurance Institute, without any structures to stand for the interests of the insured, without any transparency of costs, and without a real process of negotiation between producers and consumers of health services.

In conclusion, the analysis of the activities of the majority in Parliament and the Government leads to the judgment that in progress are activities called reform, which reproduce the structure of the old system and do not change it. The achievements of the transition period as municipal self-government are being replaced by new

recentralization, the working rights of the medical professionals and the right to choose are being restricted, there is a lack of financial incentives and there is no talk of shift of property and consensus-based public agreement.

PAID MEDICAL CARE WITH PREFERENCE AND AT ONE'S CHOICE AND WILL

The crisis in Bulgarian health service was provoked by the critical economic situation in the country, as well as, by the inadequate structure of the health system itself. The delayed reform and the established legislative and ailing vacuum deepened seriously the problems facing Bulgarian physicians, health institutions and, ultimately, the patients.

During the years of socialism Bulgarian people grew unused to thinking about the price of healthcare. Everything was just "free". Therefore the confusion arising when the question of compulsory medical insurance is put forward is natural although the insurance does not cover the multitudinous possibilities in the process of medical treatment. But the government has decided to bring its intentions of rudimentary reform in the health service, to an end.

The system had been surveyed for several months and then began the process of hospital accreditation. The first to be accredited were 80 municipal hospitals, and the number of beds and wants in them were set in compliance with the actual demands of the municipalities. The over 90,000 beds (105 beds per 10,000 people) were reduced by 30,000 which are not used for treatment of those who need to be hospitalized. There is a running reorganization in public health resorts, where practically do not come patients who need treatment. Part of the departmental pre-hospital and hospital network, which only doubled the national one and had been ineffective, was shut down. The accreditation of big district hospitals, university hospitals and national centers is continuing. With regard of the aggravated economic situation, financing priorities have been established — which health institutions and which types of medical care should take priority in finding

The rules of use of that care by people were broadly notified. There was created a possibility for alternative use of the system (without observing the established order and without waiting, in return for immediate payment) by patients who would like to choose a doctor and a hospital by themselves. This temporary measure has been taken until the introduction of health insurance takes place in order to restrain the black market of health services. There are training courses where hospital managers are being educated. The programs for these courses have been developed in collaboration with EU experts and they include modern methods of management in the circumstances of market economy, public healthcare and health policy. All directors of hospitals, diagnostic centers, emergency aid centers and municipal health administration do such courses. A National Case-mix Office will be established, where information about treatment of patients from all hospitals in the country will be collected, and it will indicate tariffs and effectiveness of hospital production. The creation of a case-mix index for all hospitals in the country will allow for planning and fair distribution of the necessary resources in

accordance with the work done, and for equality of use of health services throughout the whole country as well as a guarantee for good quality. The hospital product evaluation system (Bulgarian variant of Diagnostic Related Groups) will be utilized by the health insurance system for payment of the medical service done to the insured.

The institution of “General Practitioners” was adopted for pre-hospital aid. They will look after the health of patients and whole families who have chosen them. It is intended to stimulate those doctors so that they could be able to serve as “gatekeepers” and restrict the cases of unnecessary hospitalization. The former system of socialist healthcare was mainly hospital-oriented and very often patients were needlessly hospitalized for minor reasons and had to stay in hospital for a long time. There was no organization of medical treatment at home. This resulted in the creation of many narrow specialists in the hospitals and the term “family doctor” was deprived of any meaning, thus increasing the share of costly hospital aid within the overall framework of health care. Family doctors will also take prophylactic measures in protecting and recovering people’s health.

The legislative program permitting the transition to a self-governing system of health care is being implemented, too. In Parliament was discussed and adopted the Law on Health Insurance. A plan for the introduction of a health insurance system was designed, which envisages a preparatory period of a year and a half necessary to build administration, an information system, to establish the controlling mechanisms, the methods of bargaining and payment of health services. It is essential to find redirecting and retraining solutions for that medical manpower whose jobs will be made redundant. The big problem is to accomplish the reform in a way that the social price in the transition period should be as low as possible.

Reform in the educational system also began. Medical universities in the country will be consolidated, and the state commission for admission of medical students has been reduced. There are new specialties at university for nurses and health managers. The role of the Ministry of Health will gradually shift from governing to directing, coordinating, controlling and planning.

The role of the municipalities in setting the regional schemes of health care will increase in the process of decentralization. The health institutes will function in a competing environment in respect with public funds, and with strictly established rules of the game.

The aim of all undertaken activities is to reform the health care system so that it should function in the circumstances of regulated market and competition, and turn into a dynamically developing industry, which will introduce new technologies quickly, where patients will be able on an equal and free basis to choose their own doctor, and, ultimately, increase the quality of health services. That means matched access of all in need to medical services of good quality and effect. The system will receive revenue from more than one source, it will allow the opportunity of choice of different schemes according to the variety of individual and group necessities. Simultaneously, the regulated market will permit planning of needs and resources and their correct

distribution, and it will hold the increase of expenditure through mechanisms similar to the so called managed care.

Health care intensification is intended as a result of economic intensification, but it has an immediate effect on the economy itself, which is often forgotten. In the developed countries approximately 17-18 % of the economy works for health care providing raw materials and resources, and this means more jobs and higher incomes. According to governmental forecasts, 1998 will lay the foundations of a real economized financing system for health care, which in 2 years' time will spend nearly 7 % of GDP, it will engage about 10 % of industry and will fit the health care system in the normal proportions of public revenue distribution.

NATIONAL HEALTH INSURANCE FUND - 1

The Health Insurance Act was adopted in July 1998 and so the compulsory and the voluntary health insurance was introduced in Bulgaria. The compulsory health insurance is a system for health protection of the population, guaranteeing a package of health-related services, and is administered by a National Health Insurance Fund. The Act regulates the signing of a National Framework contract between the NHIF and the professional associations of the healthcare providers.

At present we are facing the challenge to build a brand new organization with more than 280 territorial structures and 4500 employees throughout the whole country. The Bulgarian health insurance system has a three level structure - national (NHIF), regional (RHIF) and local (local health insurance services). The authorities of the NHIF are the Assembly of Representatives, the Governing Board and the Supervisory Board and Director.

The Assembly of Representatives includes representatives of employers elected for a period of 4 years on quota principle, insured persons and the state. The Assembly adopts and amends the Regulations on the structure and activities of the NHIF and the RHIF. In addition to that it appoints and releases members of the Governing Board and the Supervisory Board, approves the draft annual budget of the NHIF and its annual report.

The Governing Board together with the Director of the NHIF represents the Fund at the negotiations on the preparation of the National Framework contract and signs it. The Board prepares the annual budget and the annual report of the Fund and takes decisions on the signing of contracts. The Supervisory Board executes general control over the activities of the Governing Board, the NHIF Director and the RHIF Directors.

The Director of the NHIF represents the Fund within the powers vested in him by the Governing board and organizes and directs the activities of the Fund in accordance with the law. The organizational structure of the NHIF includes five main streams of activities — finance, medical and information activities, human resources, public relations and

international cooperation, and general administration. The main task of the NHIF and its structures is ensuring equal use of medical services and their payment to the provider.

The functions of the central management of NHIF include overall management of the system and redistribution of revenues in accordance with the regional characteristics; evaluation of the health insurance costs; analysis and proposals for the prices of medical services; preparation of the National Framework Contract; development of models for the influence of the price policy on the health and health insurance systems; preparation of the essential pharmaceuticals list; training of staff, legal and public relations activities; international activities and cooperation, and development of policy, strategy and methodology of NHIF.

The functions of the RHIF include the preparation of the regional health insurance scheme, including the regional health structures of the outpatient and hospital care; the number and the structure of the covered population; the distribution of the revenues and costs; the evaluation of the financial result of the health insurance, etc. In addition to that, the RHIF defines the specific duties and obligations of the local health insurance services, controls the implementation of the individual contracts with the health service providers on the territory of the region, make evaluation of the health status of the population and of the volume of activities in the health institutions, as well as, analysis of the health necessities of their region.

The functions of the local health insurance services are connected with the preparation of registers of the insured persons and the health service providers, the preparation of the individual contracts with the outpatient and hospital care providers within the municipality, and control on the availability of medical care and its quality.

NATIONAL HEALTH INSURANCE FUND - 2

In 1998 the Bulgarian Parliament adopted the Health Insurance Act, which set the basis for restructuring of the outdated and inefficient in present conditions public health care system in Bulgaria. Health care reforms are meant to improve the quality of health care services, and address the state's inability to finance the entire health care system. The Health Insurance Act was a result of detailed analysis of the previous system, and builds upon the recent developments in other countries facing similar problems. It is the basis for the introduction of both compulsory and voluntary health insurance in Bulgaria.

Under the Health Insurance Act the Bulgarian National Health Insurance Fund (NHIF) was established and principles defining the relationship between the NHIF and the health care providers were set. 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 health protection of the population, which guarantees a basic package of health services, and is administered by the National

Health Insurance Fund. The Health Insurance Act regulates the signing of the National Framework Contract between the NHIF and the professional associations of the health care providers.

The National Framework Contract sets the parameters and procedures related to the functioning of the whole health insurance system. It defines the order, the contents and the payment of the health care activities and services to be provided to the insured population. The National Framework Contract is signed for a period of one year between NHIF and the professional associations of doctors and dentists, in favor of the insured persons. The first National Framework Contract was signed on 27 April 2000 and its term expired at the end of the year 2000. The second one, concerning outpatient care, was signed on 22 December 2000 and is effective until the end of the year 2001. In May 2001 an addition to the National Framework Contract 2001 was signed, which concerns hospital care.

The NHIF has a Central Office in Sofia and 28 regional structures (regional health insurance funds (RHIFs)). An additional number of 100 local offices are now to be established. To this moment, the NHIF has 1800 employees, 250 of them employed at the NHIF Central Office and the rest of them at its regional structures. Additional 300 employees will be employed at the municipal offices of the NHIF.

The managing bodies of the NHIF are the Assembly of Representatives, the Governing Board, the Supervisory Board and the Director. The Assembly of Representatives includes elected for a period of 4 years on quota principle representatives of the employers, the insured persons and the state. The Assembly adopts, adds and amends the Regulations on the structure and activities of the NHIF and the RHIF. Furthermore, it appoints and releases members of the Governing Board and the Supervisory Board, approves the draft annual budget of the NHIF and its annual report.

The Governing Board together with the Director of the NHIF represents the Fund in all negotiations concerning the preparation of the National Framework contract and signs it. The Board prepares the annual budget and the annual report of the Fund, and takes decisions for signing of the contracts.

The Supervisory Board executes general control over the activities of the Governing Board, the NHIF Director and the RHIF Directors.

The Director of the NHIF represents the Fund within the powers vested in him by the Governing board and organizes and directs the activities of the Fund in accordance with the law.

The organizational structure of the NHIF covers five main areas of activities — finances, medical and information activities, human resources, public relations and international cooperation, and general administration.

The main task of the NHIF and its regional structures is to ensure equal access to medical services for all insured persons and payment of the services provided by the health care providers.

The functions of the central management of NHIF include — overall management of the system and redistribution of revenues in accordance with the regional characteristics; evaluation of the health insurance costs; analysis and proposals for the prices of medical activities; preparation of the National Framework Contract; development of models for the impact of the price policy on the health and health insurance systems; preparation of the essential pharmaceuticals list; staff training, activities concerning legal issues and public relations; international activities and cooperation, as well as development of the policy, the strategy and the methodology of NHIF.

The functions of the RHIFs include — development of the regional health insurance scheme, including the regional health structures of outpatient and hospital care; number and structure of the covered population; distribution of revenues and costs; evaluation of the financial results of health insurance. In addition to that, the RHIFs define the specific duties and responsibilities of the local health insurance offices, control the implementation of individual contracts with the health service providers on the territory of the region, make evaluation of the health status of the population and of the volume of activities in the health institutions, as well as, analysis of the health needs of the respective region.

The functions of the local health insurance offices are connected with the preparation of registers of the insured persons and the health service providers, the preparation of the individual contracts with the outpatient and hospital care providers on the territory of the municipality, the control on the availability of medical care and its quality.

According to the Health Insurance Act the new health care system for outpatient cases is operational as of 1 July 2000. Nowadays, NHIF enters into contractual relations with 12 096 general practitioners, medical professionals providing outpatient services, dentists and laboratories. In addition, NHIF pays completely or partially for 1054 medicines and medical supplies for the outpatient health care service. On July 1, 2001 NHIF started financing the hospital care and currently pays the medication of patients for 30 clinical pathways, which cover 159 diagnoses. Since 1 July 2001 NHIF has concluded contracts with 140 hospitals in Bulgaria.

Addendum: An ambiguous reader can consult also the reports of *World Bank on Bulgaria's "Health Sector Reconstructing Project 1996-2002"*. On our behalf, we are not aware whether some public debate was carried on in Bulgaria regarding financial numbers and figures documented in those papers.

Here are some links:

http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/1996/03/15/000009265_3961019100302/Rendered/PDF/multi0page.pdf

http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2002/08/09/000094946_02080104011561/Rendered/PDF/multi0page.pdf

<http://go.worldbank.org/F5IHD23XY0>

<http://go.worldbank.org/TQSV4HUNZ0>