Country Study Paper,
Health Management Education in Bulgaria

Martin Gramatikov[1]
Nikolay Gavrailov, MD[2]

1. Introduction and Overview

The introduction of health care and public health education in Bulgaria is marked by profound changes in the political, social, legal and economic environment that took place in the last decade. As integrative part of the overall societal system the health care reform cannot be analyzed without linking it to the developments in the other interacting social phenomena, namely: the public administration system, the higher education system, social security system and the like. All of those sub-parts of the social network witnessed rapid and oftentimes contradictory changes and only through contemplating the overall picture one can fully apprehend the overall status quo in the health management education in Bulgaria.

The environment in which the health care reform in Bulgaria takes place is marked by two distinctive factors: the transition from a planned to a market economy and the integration of the country into international structures, most notably the European Union. With the transition to a market economy, we see dramatic divestiture of the state from its functions of sole provider of health care services and appearance of new forms of relationships in the process of delivery of health care services (WHO, 1999). The new economic environment led to the necessity for major transformation of the financing system for the health care sector. Prior to 1989, the health care was proclaimed free of charge and accessible for all citizens. With the profound changes, that paradigm could not be sustained anymore and under the pressure of the financial crisis and international donor organizations, the country took course towards an insurance-based health care where the accessibility of health care is based on contributions from employees and employers. Additionally, phenomena inexperienced before accompanied the transition effort: poverty, unemployment, and general reduction of quality of life.

The process of accession to the European Union affects the institutional and legislative domains. Under the European Agreement and the Accession Agreement Bulgaria assumed certain obligations that found reflection into externally provoked changes at organizational and policy level (Who/Euro, 1999). Some of the main health care policies were formulated in legal acts endorsed in the last 5 years: National Health Insurance Act (1998), Health Establishment Act (1999), National Framework Agreement between the National Health Insurance Fund and the Bulgarian Medical Association (2000). Aiming to bridge the gap between the EU countries and Bulgaria, the Government Program addressed the problems of the health sector and formulated five targets that must be covered:

- Mitigating the negative trends in the nation's health;
- Enhancing the health system effectiveness through institutional and structural changes in health services design and delivery;
- Promoting the quality of medical care;
- Increasing the health system effectiveness through change of the financing system;
- Adapting the human resources in health care to the new economic circumstances and the institutional and structural changes.

The reform of the health care system in Bulgaria was deemed to resolve numerous outstanding problems, which include but are not limited to:

[1] Public Administration Department, University of Sofia e-mail: martin@gramatikov.com
[2] Medical University, Sofia e-mail: n_gavrailov@hotmail.com

- Centralization and inflexible mechanisms of control;
- Corruption and unclear financial mechanisms for funding of health care;
- Unbalanced distribution of access to health care highly skewed toward the big cities;
- Lack of service delivery culture and managerial skills;
- Severely restricted budget foundations of the health care system.

Other aspects of the transition from planned to market economy are the public policies and programs aimed to change the scope, structure and perceptions of the system of public administration organizations. The efforts in that field span through the entire decade but only after 1997 the official public policies entered into integrated phase in which legal framework followed the declared public policy. Still these policies are not thoroughly implemented and many milestones are still not reached but the transition is in progress and has its implications on the health care reform and the related field of public health education. The most important legal acts that reshaped the public administration system and transcended through the change of the government in 2001 are:

- Law on Administration (1998)
- Law on Civil Service (1999)

The former stipulates for uniform and streamlined system of public organizations based on rather hierarchical than network structure. According to the law the administrative organizations differ from what is known in the Bulgarian administrative system as administrative authority and have as their main goal to support the administrative authority in carrying out its functions. With the Law on Administration in the Bulgarian public sector is introduced the concept of the executive agency which goals and objectives are to implements certain public policy. Many existing administrative authorities were accordingly transformed from mixed policy making and policy implementation organizations into strictly policy implementation units. Although legally endorsed the distinction is still not consistently made in the different levels of the public administration. For instance many of the ministries assume responsibilities in policy formulation, implementation and evaluation at the same time, which provides for dilution of responsibilities, subjectivity in the evaluation phase and general blurring between policy making and policy implementation.

The Law on Civil Service provided for establishment and development of corpus of professional civil servants as a mean for protection against the sins of the spoil system. With the law a clear distinction between the political and administrative positions in the public administration organizations was made. The separation between the two domains was deemed to reduce the negative impact of the political life-cycle and partisan appointments on the stability, consistency and knowledge-management potential in the public sector. Another aspect of the Law on Civil Service is the orientation towards career system based on relatively objective criteria for promotion. The law also provides for merit based system for selection of public servants. The Civil Service however is strictly limited to the so-called core civil servants and do not span to the domains of health care, education, public order and defense. Thus the Law on Civil Service governs a small number of the public health system – predominantly in the policy-making organizations while most of the medical professionals are not civil servants.

Along with the administrative reform a visible impact on the health care sector was rendered by the privatization policy that also was accelerated after 1997. Before the ruling of the Christian-democratic government of the Union of the Democratic Forces the privatization was largely debated at political level but insignificantly implemented in practice. After 1997 the process was bolstered and most of the state-owned enterprises were transferred to private investors through various schemes. The privatization gradually but consistently changes the attitudes toward the public sector in the country. From all-encompassing public sector the different social groups are getting accustomed with leaner public sector which has thoroughly different role in the society. Now the perceptions are that the public sector has to provide only a limited range of public services, although there is no consensus on the scope and dimensions of the public services (Kettl, 1988; Savas, 2000)

The demand for profound changes in the health care policies was accompanied by shortage of professionals with adequate skills and abilities in policy analysis and implementation, strategic planning of public health

policies, evaluation and appraisal of policies' outputs and outcomes (UNDP, 1999). The human capacity gap was accompanied by factors at personal level that impede the formation of strong body of health managers. On one hand, the social status of the public health officials does not contribute to the establishment of the discipline as a full fledge part of the health care system. Usually the public health specialists face the problem of unclear and ambitious identity. Though the vast majority of them are medical doctors with specialty of community medicine, occupational medicine and the like, the general perception is that the public health field is peripheral to the core medical fields. Also, the problem with the low remuneration of the public health professionals impedes the attraction of talented professionals to the sector (Apostolov and Ivanova, 1998).

One of the stated priorities of the National Health Strategy is to "improve the quality of education and convertibility of the medical education and post-graduate training with regard to the new priorities in the health care and the EU free movement of people policy." This priority should bridge the gap between the 'traditional' medical education and the emerging field of health management. As it will be exemplified bellow, the general perception of the public health professionals and the health managers in Bulgaria is one of peripheral importance to the health care system. Though not explicitly stated in the official public policy, the medical education and training should be the driving force in bridging that gap. The public health degree and training programs should find their identity in order to attract talented and capable people with potential to lead the public health initiatives.

Another misconception in the higher medical education in Bulgaria is the blurring between health care and health establishments management and the public health. Putting together these two different domains only contributes to the perception of remoteness of the two specialties from the pure medical education. In many of the current degree and training Bulgarian programs in public health, we see dysfunctional mixtures between the health management and public health. One sound explanation is the lack of theory and practice in the field though during the past decade we saw a rapid but somehow unsystematic progress. Another possible explanation can be the inconsistencies of the public policies in the health care sector and specifically the public health policies. The fact that the Draft Public Health Act is still in the Parliament is eloquent for the political will of the policy makers.

With the advancement of the health care reform, the role of the public health will probably not necessarily be explicit and evident. It is the public policies that must promote and advocate the principles and objectives of public health. In order to have these policies in place at first hand we have to have a critical mass of public health professionals with specific skills, attitudes and mindset. Here is the crucial role of the public health education – to provide that capacity of public health leaders who will have the capability, courage and drive to formulate, implement and evaluate public health policies as an integral part of the health care reform (Doelemen, 1997).

Through the development of degree and training programs focusing exclusively on health management and public health issues we shall also observe a gradual increase in the public health body of knowledge through the scientific research that will develop within the academic centers. That research will not only add upon the existing theory but through training of students will foster the translation of the theoretical public health into real-world applications.

2. Country Profile

Bulgaria is country located on the Balkan Peninsula with population of 8 million people and territory of 111 thousand square kilometers. For the last 12 years, the statistics show negative demographic growth with a peak of –5.1 for the year 2000. In the year 2000 there were 299 hospitals with 60 552 beds in Bulgaria (NCHI, 2000) of which 127 (37474 beds) are multi-purpose hospitals, 73 specialized hospitals (12186 beds), 11 psychiatric hospitals (3075), 50 dispensaries (4348 beds) and the rest being hospitals, attached to public authorities. Only 18 of the 299 hospitals were private in sense that the capital is completely in the hands of non-public actors. At the same time there were some 5619 GPs and 173 group practices for primary health care services. The number of individually practicing dentists was 6765 and the

group dental practices were 39. 5422 were the medical doctors who a registered as individual specialists and the group specialist practices were 42.

To put the facts in context we will briefly describe the public administration system in Bulgaria. Some general notes on the administrative reform were already given in the first Chapter. According to the Constitution of Republic of Bulgaria (1991) the country is parliamentary republic with strict separation of legislative, executive and judicial powers. The legislation is an exclusive prerogative of the Parliament, which consists of 240 MPs and has 4-year term of office. The Parliament is the only authority with powers to enact, change and repeal laws and make corrections to the Constitution. Except for its legislative powers the Parliament has authority to ratify certain categories of international treaties and conventions. Although proclaimed and deemed independent, the executive branch is directly subordinated to the Parliament through the act of appointment of Prime Minister and Government by the Parliament. Further on the Government is responsible to the Parliament for its policies.

The Government is entitled with responsibility for executing the public policies in the State. In order to do so it has authorities to enact bylaws to detail the existing laws and to direct the administrative system through decrees and executive orders. The administration itself is structured into ministries – currently 16 line and functional ministries. Furthermore the administration is divided into central and local units with the central administration directly subordinated through the chain of command to the Government. The central administration is organized into different types of organizations – ministries, state commissions, state agencies, executive agencies and other organizations. Adding to the comments on the Law on Administration we must point that there is not very clear from the legal provisions what is the structural and functional difference between these organizations.

At local level 28 regional governors, who are appointed by the Prime Minister and report directly to him, administer the central public policies. The local self-governance is organized in 262 municipalities, which enjoy certain level of decentralization but still depend on the budget allocations made by the central government. Most of the health care services that fall outside of the primary health care are in the responsibility of the local self-government, which causes constant tension because of the perception that these services are cost-burdens for the municipalities.

Essential for the perception of the context in which the health care reform takes place is also the functional reform in the Bulgarian public sector. The structural reforms outlined in the preceding paragraphs and the previous chapter play important role but in order to understand the environment in which the health care reform takes place one must also analyze the policies that guide the public administration system itself. The change of the principles of the public sector and the processes run in the public organizations are oftentimes referred to as "administrative reform" although most of the times the reform is being deemed as change of structure by legal means.

Most of the administrative reform ideology can be traced back to the New Public Management literature. In the public policies that govern the "re-engineering" of the public sector one can find the whole set of cliché phrases as: customer-centric governance, "more for less", output oriented public service, steering rather than rowing etc. Drawing the line between the guru-theories and the real transformation processes in the Bulgarian public administration we must say that the status quo is characterized by very legalistic rather than managerial approach to the governance. The stringent legal environment (Law on Administrative Acts and Law on Administrative Misdemeanors and Sanctions) makes the proactive and outcome-based governance hard to implement into the Bulgarian public sector. Moreover the shortage of human skills and abilities in public management contributes to that trend.

3. Health Care System

The health care system of the post-socialist Bulgaria was plagued by the legacy of ideology and health care market, which was characterized by planned supply of health care, bureaucracy, and redundancies in the system. Practically the ideology was realized by the total predominance of the public sector involvement in the health care. As a result, the whole process of planning, coordinating, financing, delivery, assessment and evaluation of health care services and public health promotion was input-based without any appraisal of the ratio between the resources allocated and the results achieved. Moreover, health services were

labeled as accessible to everyone and free of charge, which broke the connections between the supply and demand sides of the sector (Roberts, 1995). In the eyes of the beholders, the system provided accessible and free health care. On the other hand, however, this abundance and accessibility was provided at the cost of excessive and ill-planned investments in education, extremely large number of medical professionals, medical establishments and other important components of the health care sector. As evidenced by the statistical data, between 1980 and 1995 the usage ratio of the regional hospital beds decreased from 324 to 238 days per year and for the municipal hospitals – from 304 to 222 (Annual Book of Statistics, 2001; Lerer et. al., 1998). Logically, the increased priority of the hospital health care was at the expense of primary health care activities. Another distortion was the ratio between diagnostics and healing on one hand, and health promotion and prophylactic on the other. The former was considered priority, and hence developed rigorously, while the latter remained in a state of an ideological cliché.

With the profound political, economic, social, and legal changes of 1989, the old health care system had to be drastically changed in order to get in conformity with the new realities. The first measures were that the public monopoly on health care sector was abolished and the private initiative gradually started to develop. This process, however, took place not as a part of a systematic effort but as a contingency accompanying other processes. For instance, the private ownership of municipal hospitals was allowed by an act that regulated the administrative structure and mandates of the self-governance and not by a dedicated health policy document. The private ownership of medical establishments was accompanied by abolishment of the ban of private medical, dental and pharmacist practice. Because of the lack of political leadership and commitment, the reforms in the health care sector were stalled for more that 7 years at levels of quasi-market transformations, which caused many negative effects, and namely: unequal access to health care, low quality of services, "under-the-table" payments, low salaries in the sector, etc. In fact, although most of the healthcare services were *de jure* free of charge, *de facto* the users in one form or another had to pay them.

Radical changes in the Bulgarian health care system were introduced in 1997 by the then ruling right-wing government. Three fundamental acts were endorsed that allowed the acceleration of the health sector reform:

- Health Insurance Act (1998)
- Law on Professional Organizations of Physicians and Dentists (1998)
- Health Establishments Act (1999)

Primary principles of the health care public policies comprised insurance-based funding of the services, efficiency and effectiveness, sharing of responsibilities between decision makers, administrators, service providers and clients of health services (Rys and Rys, 1995; Walt, 1994). These principles were implemented at different pace and with varying success. In fact, the policy makers chose the gradual transition from a budget-funded to insurance-funded health care: from July 1, 2000, the primary and dental health care was reformed and the hospital health care was addresses as of July 1, 2001. The main pillar of the reform is the funding of the transition to contractual relations between the health care providers and the National Health Insurance Fund and commercial companies for voluntary health insurance. The Health Insurance Act stipulates that each and every Bulgarian citizen shall be insured for a minimum package of services, which is funded by the NHIF. Providers of health care can enter in contractual agreement with NHIF, according to which the services delivered shall be reimbursed on basis of predefined prices fixed in the National Framework Agreement between NHIF and the professional association of physicians and dentists. Along with the coverage of the insurance from the NHIF every patient has to make small cash payments each time he/she uses health care services: e.g. for visiting the GP or for spending a day in a hospital. The citizens can increase the coverage of the minimum health care package through voluntary insurance towards health insurance companies. These companies are allowed to enter in contractual relations with health care providers for reimbursement of the services delivered to citizens with voluntary insurance.

The Health Insurance Act regulates the institutional framework of the insurance-based funding of health services. The Act stipulates for conversion to compulsory and voluntary insurance schemes for covering the health care expenditures. A minimum package of services is guaranteed to every insured person under the

compulsory Health Insurance Scheme - Article 26: The citizens are entitled to accessible health care services in the medical institutions, which have dully signed agreements under the compulsory health insurance, and the free health care services enlisted in Article 3a. The National Health Insurance Fund (NHIF) and its regional offices with responsibilities to manage the newly adopted system are established by this Act. On the other hand, the voluntary insurance packages are in the competencies of private companies, which are regulated in a similar manner as the regular insurance companies.

On July 1, 2001, the new system of financing the hospital care sector was launched. Based on the Health Insurance Act a National Health Insurance Fund (NHIF) was established in order to develop and manage the system of compulsory health insurance that replaces the old budget, funded system of health cares. The NHIF enters into contract relationships with the health care providers and thus mediates the relation between the insured population and the providers of health cares. A National Framework Contract between NHIF and the professional associations of medical professionals provides the general context of the particular contracts with the providers and sets the scope of the services covered by the compulsory insurance.

The National Health Strategy

The health care reform is based upon new principles that are in conformity with the nation's health needs and therefore the economic relations in this field have to meet two major requirements:

- To be in compliance with the market conditions created in the economic and non-governmental sectors of our society; and
- To maintain an adequate correlation between costs and benefits.

The main accent of these requirements falls upon the de-monopolization of health care services through legislative provisions ensuring the conditions for stimulating private investments in pre-hospital and hospital care, as well as through privatization of health care establishments.

The maintaining of adequate cost-benefit levels requires the establishment of an overall investment system in the health care that covers activities related to the public health. Public health funding should be a function of the benefits obtained through the respective expenditures. Therefore, it would be reasonable to introduce a program financing system, where funds are granted against a proven appropriateness of a given promotional, prophylactics, medical, social or other program.

The application of the National Health Strategy and its Action Plan are expected to result in the following:

- Limiting the negative trends in the population's health status;
- Increasing the effectiveness of the health care system and bringing it closer to the standards adopted by the developed countries;
- Increasing the quality of the health care services in the field of promotion, prophylactics, treatment and rehabilitation;
- Stabilizing the health care funding system.

Public Health reform has been significantly supported and hence impacted by many donor driven projects. World Health Organization, EU PHARE Program, World Bank, Swiss Agency for Development and Cooperation, United States Agency for International Development and Government of Spain are among the foreign donors that provided training or technical assistance (Makara, 1998).

The Bulgarian health system administration is of the so-called 'integrated type', with health care officials designated by and directly accountable to the Ministry of Health. The structure of the public health service is predominantly hierarchical. Like many other Eastern European countries, Bulgaria currently devotes only 1% of the national health expenditure to health promotion and disease prevention.

Nowadays, the social status of the public health professionals has not been changed significantly despite the changes in the public health field. Public health specialists have no clear identity as such. They are

usually medical doctors with a specialty of community medicine, occupational medicine and similar specialties that are considered as peripheral in the medical field. The identity/image/status problem goes with improperly funded career structure.

In the public health sector the institutional reform took its shape in 1998 when the existing Hygienic-Epidemiological Service was transformed in a way to lead the implementation of the public policies in the health promotion and prophylactics, sanitation control and epidemiological activities. The Service has functional authority in the implementation of various public health policies: e.g. campaigns against HIV, smoking, sexually transmitted diseases, breast cancer, thyroid diseases, and many others. Hygienic-Epidemiological Service is supported by national centers with research and consultancy objectives: Public Health Center, Center of Hygiene, Medical Ecology and Nutrition, Center of Infectious Deceases and Parasitology and Center of Radiology and Radioactive Protection.

4. Overview of Public Administration Education Practices

Public Administration programs are relatively new phenomenon as far as before 1989 the discipline wasn't deemed as formidable part of the academic curriculum. Subjects relevant to the public administration field were scattered in different human and social science disciplines ranging from constitutional law to political science. Public administration programs at varying levels started to evolve in the middle of the 90s and continued to mushroom ever since. Vast majority of the public administration programs are integrated into the academic curriculum of public or private universities. The PA education follows the general framework of the Higher Education Act (1995), which sets out a three-tier degree system:

- Bachelor – min. 4 years of studies
- Master – 5 years long or as one year upgrade to the bachelor degree
- PhD – min. 3 years, additional to the master degree or as 4 year long degree after the bachelor degree

Although there are national standards for curriculum and content for the numerous specialties in the Bulgarian higher education the public administration programs in the different universities show stunning variance in the courses, which are offered to the students. Typically the students will have compulsory or voluntary classes on subjects like: Basics of Public Administration, Macro and Micro Economics, Research Methods and Statistics, Local Government, Political Theories, Administrative law, Constitutional Law, Tax and Financial Law, European Studies. Basically four disciplines dominate the curriculum – law, political science, sociology and various economic studies. As a general rule of thumb the focus is being put on the area in which the particular university has stronger background e.g. technical and business oriented universities emphasize on the management and economic courses, while the classical universities put the accent on law, political science and sociology. Depending on the availability and the capacity of its faculty the PA programs would offer a wide range of selective courses which basically follow particular policy area with emphasis on macro management e.g. Management of Criminal Justice, Management of Public Procurement, Management of Education.

Apart of the academic higher education another stream of public health education is the professional training and re-training education. According to the Civil Service Act the main prerequisite for promotion of the civil servants is the improvement of their skills and abilities. The Strategy for Modernization of the Public Administration also sets out the concept of life-long learning as basic principle of the modern public service. In implementation of these policy recommendations a training institution was established and organized as executive agency responsible for the training and re-training of the civil corpus[3]. At the same time many public or private universities, as well as commercial entities compete for the lucrative market of civil servants' training. The health management however is not on the curriculums of these organizations. The main reasons for that is the mere fact that medical professionals are not officially civil servants, which a priori excludes them from the target group of the training institutions.

[3] Institute for Public Administration and European Integration, http://www.ipaei.government.bg

In the university programs that grant Ba, MSc or PhD degrees in public administration we did not find any health management specialization or courses. At least two major factors contribute to that gap. First the above-mentioned specialization in the PA programs according to the university background explains the lack of public management specialization or programs. The old system of independent medical universities broke the links between the medical science and other sciences and consequently such multi-disciplinary field as the health management was regarded as peripheral if not alien to the PA programs. The second influential factor in the abstention of the PA programs from the health management field is the lack of qualified lecturers who can present the course in front of non-medical students.

Alternatively the health management training can be found as academic courses within the curriculum of the medical universities and schools. The curriculum development approaches and teaching methods in the public health degree programs are still heavily oriented towards theoretical and factual knowledge. Most of that tendency can be attributed to the legacy of the traditions in the academic education in Bulgaria, which is characterized by low focus on skills acquirement and training. Logically most of the public health courses are not tailored to the needs of the students but to teachers' styles and theoretical paradigms. Another consequence of the particular type of higher education structuring is the isolation of the medical education into separated medical science universities (Des Marchais et. al., 1992). Hence, the education provided by other universities and educational institutions is not sufficiently integrated in the public health education.

The program of the Public Health Faculty with the Sofia Medical University is a good example. The Faculty prepares specialists in the following fields: health care, health management, economics of health care, health care marketing, medical ethics, medical pedagogy, epidemiological methods, patient rights. Those diverse specialties, however, are not significantly differentiated from one another, and they are all oriented towards the practical aspects of health care delivery to hospitalized patients with very little or no attention to the original health management or public health disciplines, such as prevention, promotion, patient education, effectiveness, quality measurement, etc.

The content analysis of the public health degree programs and training programs shows a clear pattern in the existing curriculum towards emphasis on communicable diseases and hygiene. Des Marchalis et. al (1992) cleverly define the stage where the Bulgarian public health education currently is one of "curricolophathy". The concept defines a state of continuous disorder in the medical education programs and is characterized by "excessive course content, teaching nearly restricted to lecturing, and poor congruence between evaluation techniques and educational objectives" (Des Marchalis et. al., 1992).

As some authors pointed out (Apostolov, 1998), a serious problem of the medical education is the overproduction of physicians. This phenomenon directly contributes to the natural trend of staffing the public health institutions with physicians who generally have low level of formal training in public administration/management and policies. On the other hand, the good skills and abilities of the physicians in social medicine, hygiene, occupational medicine can be envisaged as potential for the development of a critical mass of public health professionals that will boost the implementation of the public health policies. On that base a strong human capacity in health management can be developed but only after considering the discipline as integral part of both PA and medical programs.

5. Conclusion and Recommendations

In general, the higher education in health management and public health in Bulgaria suffers from particularization and lack of multidisciplinary approach. The lack of health management courses and specializations is eloquent for the underdevelopment and immaturity of the field. After analyzing the content of the degree programs we can say that they are hardly oriented towards the existing public policies and put the emphasis on theoretical courses that predominantly belong to the fields in which the particular university has had developed expertise in terms of faculty, research and experience. The mere fact that the policy-based courses are usually selected and thus treated as peripheral by students and faculty is self-explanatory to the curriculum development processes in the PA programs.

The lack of experienced tutors, literature and research funding in the field of health management interacts with the fact that the medical professionals are not deemed as part of the civil service corpus. In that way the PA programs have little incentives to develop the field and to offer health management education. As it was mentioned above in the paper most of the health managers come from medical background forming a closed circuit that is difficult to penetrate. Hence it is practically difficult for the public administration students and scholars either to get empirical knowledge about the health management issues or to find practical application for such knowledge. Not surprisingly the motivation for teaching and studying health management is low.

Health management is currently being envisaged as part of the public health programs. In the traditional medical universities the medical programs (including dental and pharmaceutical programs) rarely if at all include courses on public health disciplines, such as health promotion, health prevention, and patient education. Where there are separately run public health programs the topic of health management emerges which mean that the course is deemed as part of the public health curriculum. That fact reinforces our belief that health management is not popular among the PA programs because it is regarded as rather medical than managerial discipline.

Furthermore the analysis of the public health programs in the medical universities reveals fairly comprehensive structure of courses, which are usually grouped around major course entitled health management. These courses introduce to the students major organizational, legal and economic concepts and strive to put these concepts in more integrated framework of health management. Within these programs, some of which grant Master of Public Health degree the internal tension is between the health management and public health streams. During the interviews with medical professionals we found out major discrepancies concerning the goals of the programs. One school of thought is that these programs must be overly oriented towards public health issues in order to prepare a critical mass of public health professional. The other stream asserts that there must be a balance between health management and public health in order to prepare a more diverse set of skills and abilities among the students of the program. One issue that emerged during the interviews was the notion that a separate health management program is not worth organizing because it would be too narrow and will lack applicability.

Recommendations

- Needs assessment of the skills, abilities and training gaps in the health management sector in Bulgaria should be carried out. The needs assessment results and analysis of the further developments in the health care reform will be instrumental tools in designing health management programs and assessing the current and prospective needs of such education
- Introduction and promotion of multidisciplinary approach in the health management education and training. The current practices of strict isolation between the medical and other sciences should be abolished in order to design full-fledged integrated health management programs.
- Introduction of learning-by-doing methods, distance learning approaches, more re-training of the existing human resources, emphasis to management and policy analysis and evaluation skills;
- PA programs should overcome the hidebound vision of the public sector as limited to the activities which are performed by civil servants and to embrace systematically the major public policies areas i.e. education, health, social security, public order etc. By the means of concentrating on the main public policies the health management education will gain its status in the PA programs and will provide a basis for more rigid focus, which eventually could entail to development of health management concentrations within the PA programs.
- Health management education should be based on iterative process in order to prevent re-discovering of the wheel. We recommend establishment of working group on health management at Central and Eastern European level (the NISPACee model) with main objective to provide for transfer of experience, knowledge acquisition and methodological guidance.
- More emphasis on information technologies applications in the public health as well as more IT in the education (e.g. statistical applications, Geographic Information Systems, data mining and warehousing etc.);

- More emphasize should be put on analytical skills to assess and evaluate public health care policies in the existing public health courses (i.e. policy analysis, cost-benefit analysis, program evaluation, project management, legal aspects of the public health, international health care).

Appendix A

Academic Programs in Public Health Management and Policy

1. Public Health Faculty, Sofia Medical University

The Public Health Faculty trains specialists in the following fields: health care (BSc); health management (MSc); economics of health care, health care marketing, medical ethics, medical pedagogy, epidemiological methods, patient rights (post-graduate courses).

The disciplines taught comprise:

- Health Management
- Social Medicine
- Medical Ethics
- Medical Sociology
- General Epidemiology
- Pharmacological Economics
- Health Management
- Critical Situations Medicine
- Organizational Behavior
- Health Care Economics
- International Health Cooperation
- Computer Sciences in Health Care
- Evidence Medicine
- Applied Epidemiology
- Health Legislation
- Communication Skills
- Optional Classes

2. Medical and Biological Sciences Department, New Bulgarian University, Sofia

The Health Care Management Master's Program trains health care managers by providing knowledge and skills in the mechanisms for establishment of favorable working environment; development of the health care reform and mechanisms for cooperation with the National Health Insurance Fund; logic and factors, predetermining the evolution of health care in a modern humanitarian context; working in the administration of the health care system.

Requirements:

- Preparatory Courses – 16 credits
- Compulsory Courses – 16 credits
- Optional Courses – 12 credits
- Workshops, Practicums, Research – 10 credits
- Master Thesis – 15 credits

Preparatory Courses:

- Management of Financial Resources in Health Care – 30 h., 2 cr.
- Health Projects: Methodology for Design, Implementation and Analysis – 30 h., 2 cr.
- Labor and Insurance Law – 30 h., 2 cr.
- Quality Evaluation and Management in Health Care – 30 h., 2 cr.

- Medical Law and Health Legislation – 30 h., 2 cr.
- Civil and Administrative Law – 30 h., 2 cr.
- Medical Deontology – 30 h., 2 cr.
- Ergonomy of Medical Labor – 30 h., 2 cr.

Compulsory Courses:

- Health Insurance (Bysmark system) – 30 h., 2 cr.
- Public Health Care (Beverage system) – 30 h., 2 cr.
- Private Health Care (USA health care system) – 30 h., 2 cr.
- Plural Health Care – 30 h., 2 cr.
- Applied Sociology in Health Care – 30 h., 2 cr.
- Operational Methods in Health Care Management – 30 h., 2 cr.
- Conflict Resolution – 30 h., 2 cr.
- Human Resources Management – 30 h., 2 cr.

Optional Courses

- Organizational Behavior in Health Care – 30 h., 2 cr.
- Studying Health Needs – 30 h., 2 cr.
- Health Policy in the Process of Reform – 30 h., 2 cr.
- Public Humanitarian Organizations – 30 h., 2 cr.
- Analysis of health Care Systems and Health Insurance – 30 h., 2 cr.
- Reproductive Behavior and Demographic Policy – 30 h., 2 cr.
- Modern Health Care System Reforms: Trends and Risks – 30 h., 2 cr.
- Euthanasia: Dilemmas and Reality – 30 h., 2 cr.
- Working with NGOs – 30 h., 2 cr.
- Social Gerontology – 30 h., 2 cr.
- Management of Private Entrepreneurship in Health Care – 30 h., 2 cr.
- Medical and Social Rehabilitation – 30 h., 2 cr.
- Computer Models in the Public Health System – 30 h., 2 cr.
- Medical Chronobiology – 30 h., 2 cr.
- Modern Technologies in the Health Care Management

3. Public Health Department, Varna Medical University

Training in Health Management

- Post Graduate Courses – 224 hours;
- MSc Program for medical doctors – 6 semesters, 1368 hours;
- MSc Program for economists – 5 semesters, 1074 hours;
- BSc Program

Academic Curriculum for the BSc Program in Health Management

Discipline	Hours Theory/Practice	Total
1. History of Medicine	30/15	45
2. Quantitative Methods	90/60	150
3. Informatics	60/60	120
4. Medical Terminology	/45	/45
5. Human Biology and Intro to Human Pathology	45/30	75
6. Foreign Language	/225	/225
7. Sport	/30	/30

8. General Medical Psychology	30/30	60
9. General and Special Economics	150/90	240
10. Management Basics	60/60	120
11. Law	90/90	180
12. Organization of Health Care Establishments and Health Professions	45/45	90
13. Organizational Behavior	30/30	60
14. Public Health	105/95	195
15. Medical Technique	30/15	45
16. Medical Ethics and Deontology	30/15	45
17. Local Dself-Government and Local Authorities	15/15	30
18. Finances	45/45	90
19. Business Communications	15/15	30
20. Office Equipment	15/15	30
21. Public Relations	30/30	60
22. Statistical Methods in the Management of Health Care Establishments. Medical Statistics	30/30	60
23. Hygiene of Health Care Establishments and Hospital Catering	30/30	60
24. Accounting	45/45	90
25. Organizing Care for the Patients	30/30	60
26. General Medical Sociology	30/15	45
27. Marketing	45/45	90
28. Business Planning	75/60	135
29. Quality Management	30/30	60
30. Data Bases and Hospital Information Systems	30/45	75
31. Basics in Pharmacology and Pharmacological Economics	30/15	45
32. Organization and Management of Insurance Funds	30/30	60
33. Human Resources Management	30/30	60

34. <u>Pleven Medical University</u>

Management of Nursing Care Specialty

- Education level: Bachelor of Science;
- Professional qualifications: 1. Manager in nursing care; 2. Lecturer in practice in a medical college;
- Duration of studies: 4 semesters for the full-time students and 6 semesters for the part-time students alternating study periods and work; the last semester includes 15 days of practical assignment in health institutions and 15 days - in a medical college.
- Curriculum: 17 obligatory modules: History of Medicine and Nursing Care; Medical Ethics and Deontology; Health Economics; Principles in Health Care Management; Management of Nursing Care; Epidemiology; Informatics and Statistics; Law; General and Medical Psychology; General and Medical Pedagogy; Public Health; Hygiene and Ecology; Ergonomics; Disaster Medicine; Introduction to Research, and some optional subjects.
- Certification: two final theoretical state exams - the first one in medico-social sciences, economics and law and the second one - in pedagogy and psychology. Practical assignment is certified by two practical state exams.
- Areas of activity: Graduates will be eligible candidates for the posts of chief nurses and nursing directors in hospitals, primary health care centers, nursing homes, managers of nursing care in hospital wards, etc. They also could apply for the faculty posts in medical colleges.

Academic Curriculum for the specialty "Management of Nursing Care"

I. Obligatory subjects	**Hours Full-time students**	**Hours Part-time students**
1. Management of Nursing Care with a module "Health projects"	270	120
2. Law (administrative, occupational and health legislation)	135	60
3. Health economics	135	45
4. Social medicine and public health	120	40
5. Health management	90	30
6. Medical statistics and informatics with a module "Introduction in methodology of health research"	90	45
7. Hygiene and ecology	90	30
8. Medical ethics and deontology	90	30
9. Pedagogy	60	20
10. Methodology of practice training in medical college	90	30
11. Psychology	45	15
12. Applied psychology	90	30
13. Medical pedagogy	90	30
14. Ergonomics in health institutions	45	15
15. Epidemiology	60	20
16. History of health and nursing care	30	15
17. Disaster medicine	30	15
Practical training in management	125	125
Practical training in pedagogy	125	125
II. Optional subjects		
1. Health promotion	15	15
2. Public relations	15	15
3. Communication skills	15	15

Appendix B

Training Programs in Public Health Management and Policy

Courses Taught at the Post Graduate Qualification Training:

1. Health Management Basics – module I; 12 days, 30 students
2. Health Management – module II; 12 days, 30 students
3. Management of Health Care Resource – module III; 12 days, 30 students
4. Innovation and Technologies in Health Management – module IV; 12 days, 30 students
5. Health Management – module IV; 12 days, 30 students
6. Computer Preparation of Scientific Publication and Posters – 5 days, 10 students
7. Biostatistics and Computer Methods for Data Processing – 5 days, 10 students
8. Computer Training – 12 days, 30 students
9. Introduction to Pedagogy - – 5 days, 20 students
10. Empathy – 5 days, 15 students
11. Docimology – 5 days, 20 students
12. Health Care Problems in Peace and War – 5 days, 10 students
13. Organization of Medical Insurance of the Population in Disastrous Situation – 5 days, 10 students
14. Empirical Sociological Surveys and Their Application in the Medical Practices – 5 days, 10 students

Appendix C

Bibliography

Annual Book of Statistics (2001). National Institute of Statistics. Sofia: NIS Publishing House, [in Bulgarian]

Apostolov M, Ivanova P (1998): History of Medicine and Nursing. Sofia: Gorex Press, [in Bulgarian]

Des Marchais JE, Bureau MA et al. (1992): From Traditional to Problem-Based Learning: A Case Report of Complete Curriculum Reform, Medical Education 26 (3): 190-199

Doelemen F (1997): The Dutch Experience with Regard to the Training for Public Health. Public Health 111 (3): 125-127Kettl, Donald F. (1988) Government by proxy: (mis?)managing federal programs, Washington D.C.: CQ Press

Lerer L.B., Lopez A. D., Kjellstrom T, Yach D (1998): Health for All: Analyzing Health Status and Determinants. World Health Statistics Quarterly 51 (1): 7-21

Makara P (1998): Health Promotion in Eastern Europe: A Regional Case Study of Economic Reform and Health Development. Health Promotion International 13 (3): 177-181

NCHI (2000) Healthcare. Short statistical handbook, NCHI: Sofia [in Bulgarian]

Roberts J.L. (1995): Training for Public Health Support for Countries of Central and Eastern Europe (CCEE), In: Laaser U, Leeuw E de, Stock C (Eds.): Scientific Foundations for a Public Health Policy in Europe. München: Juventa: 262-267

Rys A, Rys E (1995): The European Language of Public Health. In: Laaser U, Leeuw E de, Stock C (Eds.): Scientific Foundations for a Public Health Policy in Europe. München: Juventa

Savas, Emanuel S. (2000) Privatization and public-private partnerships, New York: Chatham HouseUNDP (1999): Human Development Report For Central and Eastern Europe and the CIS. New York: Regional Bureau for Europe and the CIS of the UNDP

Walt, G. (1994): Health Policy. An Introduction to Process and Power. (1st ed.). London: Zed Books

WHO (1999): Health 21 – Health for All in the 21 Century, European Health for All Series N 6. Copenhagen: WHO Regional Office for Europe

WHO/Euro (1999): Duran A. Better Health For a Better Future. A Health Policy for Bulgaria, Draft 2, February