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Review

INTERPRETIVE POLICY ANALYSIS (IPA) OF THE TRANSFORMATION IN THE HEALTHCARE MODEL IN BULGARIA

A. Ivanova*

Department of Social Medicine and Health Management, Medical University - Pleven, Bulgaria

ABSTRACT

The Bismarck model was adopted as the official health care system in Bulgaria, after more than forty years of using the Russian Semashko model. This essay examines the failed reform following Bulgaria's transition to democracy and the adoption of flawed practices that burden patients with direct and indirect treatment costs. The focus is on the functioning of the Bulgarian health care system and on whether it is possible to transform it from the officially adopted Bismarck model into a *de facto* American-type system based on direct out-of-pocket payments. By applying interpretive policy analysis and considering all arguments, viewpoints, official data, and interpretations, the paper highlights the errors in the organization and the attempted changes in the healthcare system, along with the reasons for their failure. Dissatisfaction with the unreformed system exists across all facets of health care - from the directors of medical facilities, doctors, and medical staff to patients. Patients pay for almost everything in health care, yet a significant portion of this money never reaches the attending physician. While the state claims that a reform has taken place with only minor flaws, the health care system itself is smoothly and steadily transforming into the American health care system. In a country with a low standard of living, high health care costs, paid by patients, decrease health status, quality and length of life negatively impacting the country's economy both directly and indirectly. This creates a vicious circle that is analysed here using IPA.

Keywords: IPA, Healthcare, Healthcare systems

INTRODUCTION

Through interpretive policy analysis (IPA), I will explore why the American healthcare system, though unofficially adopted, is prevalent in Bulgaria. This situation emerged due to the flawed implementation of the Bismarck model, largely driven by the Health Insurance Fund's (NHIF) monopoly and the influence of health commercial companies. Transitioning from the Semashko model to the Bismarck model presented significant challenges for Bulgarian politicians, who had to overhaul a healthcare system entrenched for nearly fifty years. The transition was complicated by the closed economies of the former socialist bloc, which mostly interacted within their own borders. The shift from a socialist regime to democracy demanded a fundamental restructuring of healthcare, and Bulgaria opted for the German Bismarck model, which is still the official system. Major financial resources were invested in establishing the NHIF and its framework, leading to hospital and specialist financing solely through the health fund, using "clinical paths" as reimbursement methods. However, in a country with a low standard of living like Bulgaria, the disparity between low incomes and high healthcare costs has profound effects on both individuals and the healthcare system, which characterizes the topic examined here as highly relevant.

Example

After the fall of the socialist regime in Bulgaria in 1989, extensive reforms were initiated across all sectors, marking a shift from a "planned economy" to a "market economy." This transition also prompted discussions on reforming the health sector, which had previously relied on the Semashko system. By 1996, politicians decided to base the reform on the German Bismarck model. Thirty years later, however, it has become evident that the private sector is playing an increasingly significant role

***Correspondence to:** *Ana Ivanova, Department of Social Medicine and Health Management, Medical University - Pleven, E-mail: Ana.Ivanova@mu-pleven.bg*

in the Bulgarian health care system, particularly in the hospital sector. According to the most recent data available from the National Statistical Institute (NSI), as of 31 December 2024 there are 319 hospitals operating in Bulgaria, of which 203 are public (state and municipal combined) and 116 are private health care facilities. In other words, 36.4% of all hospitals belong to the private sector. (1) The Semashko system, characterized by full state regulation and insufficient funding, is deemed ineffective. It is financed with "residual value", a grossly insufficient resource for this. The Bismarck model is one of the best practices worldwide, based on many health insurance funds that compete with each other. The American system, on the other hand, relies heavily on private healthcare and direct patient payments. Many stakeholders are of the opinion that the full transition from Semashko to Bismarck undoubtedly has failed over the past thirty years. This is a view also advocated in this paper which using interpretive policy analysis aims to support this statement.

One significant change in the Health Act was allowing the NHIF to contract with any medical facility, whether private or state-owned (2). However, the analysis reveals that the issue lies not in a theoretical misinterpretation of the healthcare model, but in its flawed application, lack of proper oversight, and self-altering nature in practice. Patients incur additional costs due to factors such as underfunded clinical pathways, limitations in outpatient diagnostic services, etc. Initially, patients' out-of-pocket payments were often informal, but over time, hospitals and outpatient practices began to officially charge varying prices for different services (3). Under the former Semashko system, no fees were required for doctor visits or hospitalizations, though patients occasionally made informal payments in cash. This vicious practice persisted after the transition to democracy, regardless of the new healthcare model. At a later stage, private (and even some state) hospitals found a legal reason to set an official price list in medical facilities and doctors' offices. For instance, general practitioners (GPs) have monthly limits for their outpatient activity. In case they exhaust their allocated quota, patients must pay for their examination in private practices, regardless of their health insurance status (4). Similarly, surgeries often require additional payments for essential consumables, such as a valve in brain operations, a canvas in surgical operations, joints in orthopaedic operations, etc. surgical materials, which are not included in the basic fees. A visit to a GP costs every patient, regardless of the reason for their visit, a "user fee" mandated by law but without proper accounting or reporting mechanisms, leading to unreported fees. This was not part of the model's intended implementation but rather an initiative by GPs to increase their income, citing high costs as justification. Although the law specifies the amount of this fee, it does not address who should regulate or report these charges. As a result, these fees have become "unreported." A similar fee is also applied in medical facilities, defined as "inpatient", which each patient pays upon discharge. There are also various other forms of payment such as "team selection", "VIP room" etc. (5). And these are just a few examples-there are actually many and varied ones.

MATERIALS AND METHODS

Theory of Interpretive Policy Analysis

The Theory of Interpretative Policy Analysis is founded on the adoption of various normative acts and policies aimed at guiding actions within a specific sphere or structure. This framework also relies on evaluations of these policies. Policy analysis, applicable in every field including healthcare (6), is defined by Fischer as an applied scientific activity commonly referred to as "policy analysis" or "policy science" (7). According to Fischer, policy analysis should provide insights into social and economic issues and assess their impacts.

At its core, Interpretive Policy Analysis (IPA) focuses on understanding the meaning and impact of policy decisions, whether positive or negative. In this sense, IPA builds on standard conventional and critical political analysis, which primarily examine objective facts. In this essay, I will use Dvora Yanow's (8) seminal work, *Conducting Interpretive Policy Analysis*, alongside other foundational theorists to analyse the transformation of Bulgaria's healthcare model from 1989 to the present. According to this theory, policies should be based solely on rational decisions, but should also consider social, cultural, and even demographic factors, to more precisely build these policies and achieve greater effectiveness in their impact on the relevant structures. Policy decisions must be based on the importance of social and other processes. In this regard, IPA diverges from strictly objective methods, such as critical or conventional analysis, which rely on precisely defined processes and

assumptions. For fields like health care, which are socially significant and essential, IPA proves more effective for evaluating the implementation and the impact of policies. It does not adhere to the strict evidence in policy research and in this sense, it embraces a more subjective perspective. This approach takes into account the social world in which we live and the possibilities for the many interpretations and variations of possibilities in policy analyses. "The interpretive approach is less an argument (at least in the context of policy analysis) that challenges the nature of reality than an argument about the human capacity to know the world around us and the nature of that knowledge" (9). This type of analysis engages with a diverse array of stakeholders: policy makers, analysts, experts, etc. The main point is that a particular problem can be formulated from different sides through debate and arguments from different sources. IPA is particularly adept at examining the internal dynamics involved in policy development and assessing how well the transition in Bulgaria's healthcare model reflects reality compared to the officially endorsed Bismarck system. Apart from the official sources of political analysis and assessments, when considering the opinion of various expert and non-expert groups, this approach provides a more nuanced understanding of the healthcare system's evolution, even if it appears subjective (8). This perspective aims to bridge the gap between bureaucratic frameworks and practical realities (10).

Traditional analyses rely on reason, science, and objective evidence to base their conclusions. In contrast, IPA incorporates diverse opinions and perspectives, going beyond straightforward objectivity of the listed arguments. Employing IPA, the analyst may not take a particular position, although we are all shaped by our own views and opinions (11). However, it is essential to identify the problem under investigation. For a comprehensive understanding of the healthcare reform in Bulgaria post-transition, interpretive policy analysis offers a broader perspective, providing insights that extend beyond the official legal framework.

Application of Interpretive Policy Analysis to the working model of healthcare in Bulgaria

Applying interpretive policy analysis to Bulgaria's healthcare model reveals several critical perspectives and issues. This approach evaluates the gap between the theoretically endorsed healthcare model and the actual system that has evolved due to various factors (12).

Firstly, differing viewpoints emerge from three key stakeholders: the state, medical professionals (including doctors, nurses, and midwives), and patients. There is a consensus between medical professionals and patients that the system requires significant reform. They argue that, due to organizational deficiencies and insufficient funding, the system does not resemble the officially adopted German Bismarck model. Meanwhile, the state acknowledges that the reform did not proceed as intended but continues to officially support the Bismarck model.

Transitioning from a planned economy to a market economy and democracy has posed substantial challenges for former socialist countries, with Bulgaria being a prominent example (13). Health care, on the other hand, is subject to reform everywhere in the world, as it is expensive and at the same time health is a basic necessity for life.

Until 1996, Bulgaria, like many Eastern European countries, used the Russian Semashko model, known for its inefficiency and state monopoly over healthcare services. After 1996, Bulgaria officially adopted the German Bismarck model (15). Due to the objectively evolving circumstances, is it possible for Bulgaria also to move towards a predominantly private health care sector? Until the beginning of the twentieth century, health insurance in the United States was almost non-existent, and medical services were paid for out of pocket on a fee-for-service basis. In the 1930s and 1940s, Blue Cross/Blue Shield plans and employer-based health insurance emerged and expanded; however, this coverage was voluntary and not mandatory in the way characteristic of the Bismarck-type systems. After 1965, the introduction of Medicare and Medicaid further complemented the system, which nonetheless remained a mixed, but predominantly private, model. (14)

In official and comparative classifications, the United States is therefore placed in a separate category of "private insurance". Interpretive policy analysis goes beyond standard evidence to incorporate diverse arguments and discussions about a given strategy, providing a more nuanced understanding of the healthcare system's evolution in Bulgaria.

Table 1. *Comparison of Official Parameters of the Bismarck System vs. Actual Practice of the Out-of-Pocket Model (American Healthcare System) in Bulgaria*

Bismarck model - main features	**Active model in Bulgaria based on the official Bismarck model**	**American healthcare system and its similarities with the reality in Bulgaria**
Many health insurance funds	One health insurance fund (National)	Private healthcare, settlements without access to healthcare
Health insurance (expensive method of financing)	Health insurance not suitable for countries with a low standard of living	High treatment bills based on the powerful intervention of the pharmaceutical industry and commercial companies that "trade" on the patient's health.
It is paid per reported case	Paid per clinical pathway (hospitals may perform unnecessary tests or admit patients excessively to increase revenue)	Additional payment by the patient for general practitioners, specialists in outpatient activities and different types of fees in the clinical base. Official price lists in private hospitals that also work with a public financial resource.
A whole administrative system is maintained at great expense	Supports a large administration, salaries, expensive cars, business trips, etc.	According to this indicator, there are no similarities, there are no effectively working alternative private or state health insurance funds.
Insufficient funding for preventive activities	Funds preventive activities mainly in theory	Preventive care is left to patients, who must seek and pay for specialists privately.

The Bismarck model of healthcare, officially adopted in Bulgaria following legal and regulatory changes, fundamentally introduced the National Health Insurance Fund (NHIF) and financing through health insurance contributions. However, the main similarity with the model is the creation of a National Health Insurance Fund and financing through health insurance contributions, and this is where the differences begin. First, the system remains largely unreformed. Second, the organization requires substantial restructuring. Third, financial resources are inadequate. Fourth, patients are increasingly responsible for out-of-pocket expenses. Last, but not least, there is a shortage of funds for healthcare (2).

The analysis focuses on the ongoing reform and the gradual, unofficial shift from the German Bismarck system, which relies on health contributions, to the American out-of-pocket model, (15) where patients pay directly for health services. The Semashko system had fostered problematic payment practices within the "shadow economy" (16). The roots of these issues lie in the old system’s insufficient compensation for medical professionals and the prevailing folk psychology that normalized unregulated payments.

Under the previous system, the state controlled all aspects of healthcare-managing, financing, and overseeing it as a complete monopoly (17). It dictated the number, type, and location of medical facilities, as well as the distribution of specialists. Medical training was also state-regulated, with graduates assigned to specific locations for fixed terms, usually for a period of between 3 and 5 years. The National Health Insurance Fund (NHIF) was established, which operates to this day and practically proved to be a monopoly in this activity. Private investors were given the opportunity to create alternative health funds (on the Bismarck model), but it turned out to be unprofitable for them. Reforms initially focused on pre-hospital care, introducing general practices and individual medical practices, and updating the Health Care Act to register all health professionals from hospitals to individual practices, as commercial entities. However, these reforms halted without further progress.

Private investors capitalized on the opportunity to profit from medical facilities, leading to a proliferation of hospitals in Bulgaria. Today, Bulgaria has one of the highest numbers of medical facilities per capita, significantly outnumbering countries like Germany, the United Kingdom, and even the USA. The NHIF budget has become increasingly inadequate to support this large number of facilities (18). In private medical institutions, patients are charged according to official price lists, paying on the spot. The poor policies implemented over the past thirty years have caused severe issues within the healthcare system, including the bankruptcy of state and municipal hospitals and the financial strain on private healthcare providers (19). This crisis is exacerbated by the country's low standard of living. Many treatments are paid for directly by patients, resembling the American model, with costs sometimes reaching as high as ten times the minimum wage. The biggest problem of healthcare is that Bulgaria is a country with a low standard of living, healthcare is expensive and patients are even forced to take out bank and non-bank loans for their treatment (20).

DISCUSSION

In addition to Interpretive Policy Analysis (IPA), various other analytical methods can be applied. Regardless of the approach, the outcome is clear: the healthcare system remains disorganized, shifting its focus from established methods and organizational structures to alternative funding mechanisms. The failed reform has resulted in patients paying not only their health insurance contributions but also for a wide range of medical services. These include preventive care, visits to private specialists, in-hospital activity (this happens due to the fact that there is limited activity on the part of the health fund through the GP), user fees for GP visits (which are unregistered and uncontrolled), payment for hospital stay, additional payments for private or luxury hospital rooms, additional payment for "per team" and costly consumables for urgent operations. Official price lists in hospitals further exacerbate the financial burden on patients (21).

The choice of the Bismarck system over the Semashko model was intended to promote social justice in healthcare funding. However, many hospitals are allocated budgets for more facilities than there are healthcare professionals, leading to inefficiencies. Underfunding and poor organizational structure have driven many doctors, nurses, and midwives to emigrate, primarily to Germany and the United Kingdom (22). Interestingly, both Germany and Bulgaria officially use the same healthcare model, yet our specialists prefer to work abroad. This highlights the systemic issues and the need for comprehensive reform, regardless of the chosen model (excluding the American model due to Bulgaria's lower population income) (23).

Another similarity to the American system is the uneven access to healthcare. Large hospitals and private facilities are concentrated in major regional cities, while many remote and impoverished areas lack even basic primary care services.

In conclusion, the large number of private hospital facilities, together with the various additional payments made by patients, including those who are health insured (treated under clinical pathways) but nevertheless compelled to pay - sometimes substantial amounts - create preconditions for a gradual and largely imperceptible transition of the country towards a predominantly private health care system.

CONCLUSION

Despite the varied perspectives and arguments presented through Interpretive Policy Analysis (IPA), the reality of Bulgaria's healthcare system remains unchanged. The persistent issues stem from poor practices, unmet priorities, and insufficient state commitment to healthcare. Over the past 30 years, despite changes in political regimes and policies, the transition to a radically different healthcare model has not occurred (24).

Different political parties, each with their own agendas, have come and gone, but the system has continued to evolve on its own, smoothly shifting towards private healthcare. The National Health Insurance Fund (NHIF) still reimburses budget treatments through patient health insurance contributions. Ultimately, patients bear the brunt of this failed reform, paying not only their contributions but also out-of-pocket expenses directly to healthcare providers.

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REFERENCES

1. National Statistical Institute, “Health Care” section.
2. Ivanova, A., Finansirane na sistemata na zdraveopazvane v RBulgaria – sastoyanie, tendencii, vazmojnosti za optimizirane. *Godishen almanah "Nauchni izsledvanija na doktoranti"*, 13(16), pp. 455-475, 2020.
3. Dimona, A., Rohova, M., Mutafova, E. & dr, Zdravni sistemi v prehod. *BulgariJa. Analiz na zdravnata sistema*. Bulgaria: Health System Review. Health Systems in Transition, 2012.
4. Petrov, M., Sistema za finansirane na zdraveopazvaneto v BulgariJa - kratak analiz. *Nauchni trudove na RusenskiJa universitet*, Tom 54, serija 5.1, pp. 87-88, 2015.
5. Djafer, N. &. V. E., Nereglamentirani plashtaniJa v bulgarskata zdravna sistema. *Bulgarsko spisanie za obshtestveno zdrave*, pp. 11(3), 3-9 r, 2019.
6. Heineman, R. A. B. W. T. P. S. A. &. K. E. N., (1990). The world of the policy analyst.. Chatham, NJ:, Issue Chatham House.
7. Fischer, F., 1995. Evaluating public policy., Chicago: Nelson-Hall.
8. Yanow, D., 2000. Conducting Interpretive Policy Analysis. s.l.:Qualitative Researd Oaks, CA: SAGE Publications.
9. Ivanova, A., 2022. The health insurance reform in Bulgaria –financing models and status evaluation. Economic archive, ISSN: 0323-9004-Book Edition 4, pp. 79-98.
10. PeattieL., 1968. PeattieL.34(2)(1968)80–88PengT., s.l.: s.n.
11. Terziev, V., Ninov, N. & Ivanov, I., 27-28 juni 2019. Situacionen analiz na zdravnata sistema na Republika Bulgaria. Veliko Tarnovo, s.n., p. Sbornik dokladi.
12. MF, 2005. Teoretichni osnovi, modeli i tendencii. Finansirane i upravlenie na zdraveopazvaneto.
13. Delcheva, E., 1998. Zdravnata reforma v BulgariJa. Ministerstvo na zdraveopazvaneto, Volume SofiJa, Princeps.
14. Social Security Amendments of 1965 (Public Law 89-97) – USA, Medicare and Medicaid
   - U.S. Congress. (1965). *Social Security Amendments of 1965, Public Law 89–97; 79 Stat. 286.* Washington, DC: U.S. Government Printing Office.
   - U.S. Social Security Administration. (1965). *Social Security Amendments of 1965.* Social Security Bulletin, 28(9).
   - U.S. National Archives. (2022). *Medicare and Medicaid Act (1965).* Milestone Documents. Retrieved from https://www.archives.gov/milestone-documents/medicare-and-medicaid-act
   - U.S. Congress. (n.d.). *H.R. 6675 – Social Security Amendments of 1965 (89th Congress).* Congress.gov. Retrieved July 30, 1965, from https://www.congress.gov/bill/89th-congress/house-bill/667
15. Academic, O., Out-of-pocket health care costs among older Americans. *The Journals of Gerontology: Series B*, Volume 55, Issue 1, 1 January 2000, Pages S51–S62.
16. Angelova, M., 30/2021. Vizionerstvo i zdrave: modelat "Semashko" i sovetizaciJata na obshtestvenoto zdraveozvane v BulgariJa (1944-1955). Balkanisticheski forum, Volume Jugozapaden universitet "Neofit Rilski", Blagoevgrad.
17. Davidov, B., Bolnicite v BulgariJa – makroikonomicheski pogled,. *Bulgarsko spisanie za obshtestveno zdrave*, pp. 5(2), 129-147, 2013.
18. Rohova, M., 2016. Chastni razhodi za zdraveopazvane i neravenstva v dostapa do zdravni uslugi v Bulgaria. Varnenski medicinski forum, Tom 5, broj 2.
19. Dimitrov, D., Bajmakova, M. & Popov, G., 2014. Razhodi za zdraveopazvanev v usloviJa na kriza. Ikonomicheski i socialni alternativi, Broj 4.
20. A., Z., Ikonomika i zdraveopazvane – poveche investicii v zdraveopazvaneto - po-dobra lokalna ikonomika. Zdravna ikonomika i menidzhment, Varna Broj 4 (74), 2019.
21. Dillender, M., Friedson, A., Gian, C. & Simon, K., Is Healthcare Employment Resilient and “Recession Proof”. *The Journal of Health Care and Financing*, Volume 58: 1–11, 2021.
22. Z., O., Ch., C., M., L. & etc, V. K., 2010. Are health problems systemic? Politics of access and choise under Beveridge and Bismark systems, Cambridge University Press: s.n.
23. Delnoij, D. M. J., Bismarck or Beveridge: primary care matters. European Journal of Public Health, Oxford Academic, pp. *European Journal of Public Health*, Volume 23, Issue 3, June 2013, Page 349, 2013.
24. S. Keremidchiev, M. N., Ocenka na korporativnoto upravlenie na darzhavnite bolnici. *Bulgarsko spisanie za obshtestveno zdrave*, pp. Tom 14, Kniga 1, 2022.