

BULGARIAN HOSPITAL REFORM AND THE NEW PUBLIC MANAGEMENT MODEL. A CHANGE OF ROLE OF STATE OR A CHANGE OF MIND?

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ABSTRACT

Nothing is simple in planning, financing, and delivering health care. Whatever changes in the system, it has both anticipated and unexpected consequences, which may be positive or negative. This makes reforming health care extremely challenging. Reforming the hospitals in Bulgaria is a difficult task, especially combined with the difficult transition process in all countries of Eastern Europe and the tendencies like growing costs of care, ageing of the population, higher levels of chronic disease and disability, increased availability of new treatments, rising public expectations, increased pressure to spend more on health care and use the available resources more efficiently. The present work uses the example of hospital change process started in newly accepted in EU European countries, particularly in Bulgaria, and proposes discussion about the potential of the “New Public Management” model as a mean of improvement the capacity of state to adopt the contractual approach of regulation. In conclusion, we stress that if the “control by state” was not the best solution, “market regulation” have also some limits so there could be a third way - the supervised competition – a possible cure for the success of hospitals and health care reform in Bulgaria.

Key words: *hospital reform, new public management, Bulgarian health care system*

INTRODUCTION

*It takes a big effort to begin,
It takes a big effort to terminate,
But the biggest effort is to continue!*

Vladimir Bashev, Bulgarian poet

Health care systems are facing incredible change in the last several decades. Different models and rules are widely discussed and implemented. The main reason that made the reforms in this field a special subject of interest and attention both for politicians and researchers is its specifics:

- ❖ Healthcare system is **important** for guarantying health and life - basic human rights and values of highest level, but also an economic resource on which depends the welfare of the state - more health means production of more GDP.
- ❖ Healthcare system is one of the most **sensitive** fields of public interest, often used in elections as a mean for drawing attention and attaining political victory through promising efficiency, quality, equity of care access, safety, continuity, legality, neutrality.

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Received: October 7, 2013

Accepted: November 15, 2013

- ❖ Healthcare is one of the most **complex** fields – it combines the requirements and interests of many different stakeholders (patients, payers, providers, pharmaceutical companies etc.) that evolve continuously.
- ❖ Healthcare is one of the most **expensive** fields in every economy – it spends a serious amount of the state budget and this defines the need for striving to efficiency and efficacy in its government.

During the period of change the theories for structuring the system had a long evolution, which finally led to the diversity of models – from the free market regulation (the example of USA) to state planning and regulation (Semashko model in former Soviet union, Beveridge model in the UK). Every model offers different possibilities and limitations – there is no a perfect one.

The change in Bulgarian health system started after 1989 – the year of beginning of a serious political and social shift, concerning every element of the social and economical sphere in the country. The state regulated health care system, financed through national tax payments (according to the Russian Semasko model) had led to many problems and were substituted by a public health insurance model. The health care reform gave autonomy of the health care establishments and put them in a completely new “market” conditions. The main changes affected the way Bulgarian hospitals were financed, managed, organized and structured. This new paradigm in hospital management intended to introduce the requirement for effectiveness and to turn hospital government into business-like management. In the present paper under “hospital reform” we have in mind the following definition (29): process, in which simultaneously or consistently changes in the health policy and law foundation in the hospital field were implemented, as well the examination of organizational relationships, institutions and the structure of the sector that influence and force the system to shift into completely new condition.

Although the experts said this model was the most appropriate for Bulgarian health care system concerning its historical tradition (First health insurance law was adopted in 1918) and the overall tendencies in the countries from the Central and East-

ern Europe, 17 years later it has become obvious that it didn't achieve the planned results. It turned to be that changing the role of the state was not the cure for the old and sick health care system, it was considered to be.

The changes in the economical conditions in Bulgaria as well accessing the EU make important the performance of a serious analysis of the present situation in every system of the national economy, including the health care. It is needed to assess the directions for the future and the completion of the set targets, the positive and negative effects and the achievements during the past period as well the failures from the previous years. The intention of the authors is to give a possible solution that could bring the vitality of the system and might preserve it from crashing down again through investigating the possibilities for implementation of the new public management model in Bulgarian hospital reform.

The New Public Management Model

The foundation of every health care system and the way it is organized and managed is unique. Despite it is not precisely, according to theory can be presented 4 basic, relatively pure and simple models of the health care systems which are (19):

- ❖ **The “Beveridge” Model** – named after William Beveridge, the social reformer who designed Britain's National Health Service, founded in 1944. In this model financing and insuring is performed by one institution, i.e. the processes of funding and delivering of health care service are not separated and are fully or partially bond with one organization. All the citizens receive health care, no matter of their financial status. The biggest system based on that model is the NHS in UK, as well the systems of Scandinavian countries, Italy, Spain, Portugal and Greece.
- ❖ **The “Bismarck” Model** – named after Otto Eduard Leopold von Bismarck-Schönhausen - Prussian and later German politician. The model was introduced in Germany in 1881. This is a health insurance model that had been more or less adapted in almost all Europe, including Eastern European countries. The main principle of the model is the so called “cross

subsidization”, i.e. the young and healthy pay for the old and sick.

- ❖ **The “Semashko” model** (33) – worked in the beginning of founding the Soviet Union. It was named after a Russian doctor, who founded a system in which there was a great number of doctors, a smaller number of medical staff, and a developed network of hospitals even in the most secluded settlements. Another special feature is the banning of private medical practice and the small salaries of the medical personnel. The financing of the system is centralized. The hospitals and maternity homes are spread to the smallest villages of the country and that provokes the excessive requirement of numerous personnel and resources of maintenance. This model was popular in Soviet Union and countries from the Eastern Europe, including Bulgaria to 1993.
- ❖ **The “Kennedy” model** - named after the American president John Fitzgerald Kennedy. This model is used in the USA since the 60s of the twentieth century. According to this model the health care is provided by the private sector by the regulation of the market. This model is applied mainly in the USA and Asia.

Every country around the world establishes its own health care system using one or a combination of several models, described above. In the same time lots of authors stress the common problem in all the countries: continuously growing health expenses and difficulties in controlling them. As the health-care arena becomes more and more complex, the population ages and the cost of technology increases, the efficient provision of healthcare within a globalized economy is more important than ever before (17). There is a growing understanding that health-care systems cannot be isolated from the rest of society and economy: in order to be more effective they must interact within other areas including but certainly not restricted to, education, employment, pensions, social welfare, science and competitiveness.

This is the reason public sectors of the developed world have undergone a remarkable two decades starting in the 80's of public management reform, variously labeled as “new public management” (13) (NPM), “managerialism” and “reinventing gov-

ernment” (32). As every new theory is has been developed in different variations. This led to a cacophony of voices that characterizes the discussions of administrative reform in Central and Eastern Europe – the strategies are so differentiated already that if we place them head-to-head they will form a nearly perfect circle that has no center or compass (21). In common case the purpose of this model for public management appeared to be improving the efficiency of the public structures. Situated on a crossroad, it provides the balance between two specific and problematic situations: the predominating role of the state and the free market adverse events (25). The engine of the reform of public sector government was the concern and need of public administration rationalization – a “Copernicus’s revolution” (36) of a “reinvention of role of state” (27).

The liberals, and also the new sociologic approach of organization (5), underline the lack of efficiency in the “Weber bureaucracy” (6), characterized by a hierarchy of functions, place of the professionals and the impersonality of rules. They propose the NPM as a possible cure that transfers market and business principles as well management techniques from the private into the public sector, symbiotic and based on the neo-liberal understanding of state and economy.

Changing the direction of the managerial logic of administration, which instead of privileging the rule and following the formal procedures, acts in its own interest regardless the satisfaction of the clients and the results, the new approach establishes itself as a mean of limiting the perverse effects of the relations dominated by the public service agents and which the bureaucratic model cannot control. The object is to introduce the spirit of venture in the public administrations (14) so that they are guided by their mission and goals and not by rules and procedures; the users are considered as clients and the aim is the final result, instead of resources.

This coherent model includes creating markets or quasi-markets for a category of services there, were exists a monopole of the state. It is based on the distinction of roles between the provider of the services and the decider/ controller (the new role of the state is to evaluate ex post and no long plan ex ante). It establishes as well competition between the public

and private sector for access to services agreements (23) by state. The manager occupies here an important function. He is responsible for preserving the right of the users with the obligation to take into account the results and the optimal use of empowered resources (11).

The new public model is build on the basis of the agency theory, that is directed at the ubiquitous agency relationship, in which one party (the principal) delegates work to another (the agent – an actor that solves an optimization problem), who performs that work (9). The theory argues that under conditions of incomplete information and uncertainty, which characterize most business settings, two agency problems arise (8): adverse selection (the condition under which the principal cannot ascertain if the agent accurately represents his ability to do the work for which he is being paid) and moral hazard (the condition under which the principal cannot be sure if the agent has put forth maximal effort). This agency dilemma leads to the need of control of the appropriateness of the actions of the agent from the principal and these costs increase with the distance between them (26).

As hospitals represent kind of social institutions, that interact with other institutions inside and outside the health care field it is important to study how this interaction influences the change process. This lies in the basics of the so called “New institutionalism” theory. According to it, in every institution there is institutional equilibrium and though not everyone is necessarily happy with the current institutional structure, a significant coalition is or else it would not, by definition, be stable. Once institution is stabilized, it becomes very difficult to change the rules because no one can be certain what the outcomes of the new structure would be. This is because institutions shape strategies, and the new institutional rules, imply new strategies throughout the system. Change thus implies enormous uncertainty. This is the reason that makes actors unwilling to change the structure (31). The effort to achieve rationality with uncertainty and constraint leads to homogeneity of structure. This phenomenon is called institutional isomorphism and it states that as an innovation spreads, a threshold is reached beyond which adoption provides legitimacy rather than improves performance (7). Isomorphism is a “constraining pro-

cess that forces one unit to resemble other units that face the same set of environmental conditions”.

The Role Of The State In Bulgarian Health Care System

Until 1996 Bulgarian hospital sector was organized as a centralized, state monopolized and consolidated command type administrative system by the example of Semashko model of central planning inherited from the communist era (the name Semashko came from the name of the author of this system in former Soviet Union). The main and only player in this system was the state – owner and manager of health care sector.

- ❖ **Law framework:** The law framework of the health care sector in Bulgaria was based on two main laws that formed the regulation and financing of the health care – “Law of population’s health” and “Law of the state budget”. According to the law there were National centres, University hospitals, Regional hospitals, Municipality hospitals.
- ❖ **Ownership:** After the nationalization in the health care field (since 1946-1949) until 1991 the all the structures and resources in the health care were owned by the state. There were two kinds of health establishments – owned by the state and partially owned by the municipalities. There were not private hospitals and subsequently – no competition.
- ❖ **Management:** The administration, management and planning of the whole system was centralized and performed by the state. There were only two levels of the health care system – ambulatory care and hospital care. Often the hospital provided both. The hospitals were managed by a head doctor, who didn’t have autonomy to act as a manager but as an administrator. There was not requirement for proper economical education for this position.
- ❖ **Financing:** With the «socialistic restructuring» in the health care since 1950 the health insurance was substituted by centralized state government and planning. The system was financed by general taxation through the national and regional (municipality) budgets. The main principle in forming those budgets was the extrapolation on the base of the previ-

ous fiscal year regarding the percentage of inflation. The amount of money that hospital did not spend was given back to the state budget.

- ❖ **Patient's choice:** There was not free choice of a doctor or health establishment – instead the distribution of patients was performed by national administrative system according the state planned areas. Practically all the population was secured by the state – basic right set in the Constitution of the country (4). All medical services and medicines provided were free for the patient and paid by the state.
- ❖ **Hospital professionals' salaries:** traditionally, Soviet Union countries the salaries of medical personnel were kept at 70-80 percent of the average salary (35). They were formed like constant salary plus percentage for years/length of service and adapted speciality.

The state monopolized system became slowly more and more bureaucratic (30). Because of the administrative regulating there were not mechanisms to link the interests of the citizens with those of the medical personnel; the invested resources in health care with the results. There were financed not results with certain qualitative and quantitative characteristics but institutions and structures. Together with the obligation for universal entitlement health care system became inefficient and underfinanced. In addition, the political and economic crisis in the 1990s resulted in financial malfunctioning within the sector, including increased public debt for the hospitals, corruption and informal payments. The several economical shocks during the transition period led to substantial decrease of the living standard and the health of population. The consequences were diminishing the ability of the system to provide health care and increased need for it (20).

The Scenario Of A Change

Since the start of the transition period in Bulgaria in 1989, all social systems have undergone dramatic changes. Since 1997 started a radical reorganization of Bulgarian health care. There were two main reasons that led to this process and that drove the change of the model of the health care system:

1. The analysis of health indicators showed that the health of the population was seriously damaged (22) – the data indicated high rates of social dis-

eases, disabilities, overall and childrens' dead, low health education and life style. It was obvious that the system failed to achieve its main target – preserving the health and preventing the disease to ensure healthy population.

2. The lack of effectiveness and the present inefficiency of the system led to the need of restructuring of the national law framework, management, structure, ownership, organization and financing.

Although the health care reform started in 1997 it concerned only the ambulatory care. Until 2001 hospitals remained intact. The only thing that changed was that their budget was linked with the number of the treated patients (number of hospitalizations). After 2001 the reform in hospital sector started. The changes concerned:

- ❖ **Model of the system:** The contract model, based on the public-private mix was introduced. It contained of public, regional and private sector as well social insurance sector (including public element, represented by the National Health Insurance Fund and corporate element – represented by the private health insurance companies). Ambulatory and hospital care were divided and registered as different establishment. The GP as a part of the health system and gatekeeper was introduced. The hospitals and other health establishments were put at a completely new market (quasi-market) conditions. An accreditation process for all health establishments was introduced but started first in hospitals as an instrument for assessment of capacity and quality management on institutional, structural and personal level.
- ❖ **Law framework:** Until the 2001 there was a significant development of the health law – the new era in health care system was paved with the newly created Law for the health establishments, Trade law, the Health insurance law, and the normative for Accreditation of hospitals etc. The hospital sector was diversified and new kinds of hospitals were introduced (like specialized hospitals for acute treatment, for long-term treatment and care, for rehabilitation, dispensaries with beds, hospices, houses for social-medical services (for old people or children)).

All of them had the right to be national, regional, interregional, municipality or university after the proper accreditation. All types of institutions, whether state-owned, municipal or private, have equal status and rights. As public remained psychiatric hospitals, emergency care centres, haemotransfusiology centres etc. National medical standards were introduced, concerning both ambulatory and hospital care.

- ❖ **Ownership:** the new structure of the hospital sector introduced the parallel existence of three equal forms of ownership (mainly corporative) – public private (state and municipality) and private. The design of hospital system, their distribution, planning and development were set by the National and Regional Health Maps, which are to be updated every 5 years. They included the number and types of health establishments in the different areas (regions and municipalities) that are allowed to sign a contract with the regional branch of the National health insurance health fund. The possibility for privatization started to be discussed.
- ❖ **Management:** The hospitals become independent. According the Trade law and the Law for the health establishments they were registered as trade companies, working for profit with considerable autonomy (2001). The requirement for education or qualification in health care management was set to the position of hospital director (18). He was expected to rule the hospital as a manager through setting a hospital strategy according to the national health strategy and regional needs of the population and conducting effective performance.
- ❖ **Financing:** Since 2001 was stopped the process of subsidizing of hospitals and hospital's financing was set on the contract model with the Ministry of health, 20% of which based on the performed activities according to certain quality and quantity. In 2002 started the financing based on contract between the hospital and the National health insurance fund for clinical pathways. Hospitals were allowed to have additional payments from private health insurance companies, cash from patients and companies, donations and etc.
- ❖ **Patient's choice:** it was given choice to the patients to choose their GP and together with him – the hospital; of course in relation of their condition (acute, chronic etc.) and the services they needed. A competition between the hospitals was started. They had to adapt to the new market conditions with more informed and free in their choice patients, requirements of the society and the continuous political changes – i.e. the interests of many stakeholders.
- ❖ **Hospital professionals' salaries:** Besides the old way of forming the salary an additional new element was added – an amount for medical activities performed for completing clinical pathways, financed by the National Health Insurance Fund. That allowed to hospital managers to bond the performance of the doctor with its salary.

The Final Results Of The Reform

The basic characteristic of the transformation of health system in Bulgaria was the radically changed legal status and the full juridical, financial and managerial autonomy of the hospitals. Twelve years after the start of the reform (1996-2008) in hospital sector, it turned to be that the hospitals are one of the weakest elements of the health system (2). Although all the pressures for change, the hospital sector reform still didn't achieve the set targets:

- ❖ **Worsening the health of the population** was slowed down but not stopped – the separate indicator's improvements are still not an evidence for a positive trend.
- ❖ **The state monopoly** was eradicated long after the 1990 – in 1996-2000 and it still continues to manifest. The formation of the new health system and hospital reform in particularly is done slowly, fragmented (outside the logic of the reform in the other elements of the health system) and not synchronized with the radically changing political, economical and social conditions in the country. There is no clear vision for the future in form of strategy for the health sector (despite several attempts were made in 2001, 2004 and 2006). The National health map is ready only as a framework but it is not published yet and is not used as a managerial tool, what it is considered to be. There is still

not a clear idea for the needs of the regions in the country and the functions of the hospitals so that they can offer accessible, adequate and qualified medical care (38).

- ❖ **Inadequate financing** (12) - in spite the adoption of the financing based on clinical pathways (close to the French model) there has been observed difficulties with the financial stability of the NHIF. The constraints on the health budgets are low allocations of capital investment and funds available for technology renewal (3).
- ❖ **Ineffectively structured hospital sector** (1) - despite about one third of the municipal and regional hospitals were closed since the beginning of the reform there still has been an oversupply of hospital beds; Bed occupancy is relatively low and the length of stay is high; the infrastructure of the hospitals as buildings, equipment etc. is old and needs serious investment programme; the distribution of medical staff is inadequate (too many doctors, but small number of nurses); Money did not always follow the patient. Often he was kept unduly in hospitals where the opportunities for diagnostics and medical treatment were exhausted, with the only purpose the capital of the track to be absorbed. The severe cases that were taken in big hospitals for treatment when there was no other option also increased.
- ❖ **A lack of managerial and administrative skills** - this problem has led to the accumulation of large debts by inpatient facilities, which are covered often from the state budget. There are no stimuli for responsible and accountable management of health-related institutions and measures for performance assessment (33). Most of hospital managers are doctors, working part-time in their wards and part-time as managers. Despite there was set an official requirement for a qualification or education in health care management for taking the position of hospital director, this is still not enough for proper hospital management. Lack of managerial skills and knowledge about the system is observed on every level of the system.
- ❖ **Law discordance** - there is an incompleteness and lack of co-ordination between the different normative documents (primary and sub-delegated legislation), that set the basic rules for action of health establishments. This leads to poor collaboration and bad interaction between the primary care (GPs and emergency care centres), secondary care (medical centres) and tertiary care (hospitals, dispensaries, etc.).
- ❖ **Transparency and corruption** - hospital sector has the biggest concentration of risks and corruption practices (28). Co-payments are increasing and informal payments are common - mostly for buying consumables, medicines, paying directly to the doctor for operation, for getting access to hospital, for birth and as a donation to the hospital. Making the health system more transparent continues to be a challenge (37).
- ❖ **Hospital accreditation** (started in 1997) - it didn't achieve its main purpose to improve overall quality and often was regarded as an administrative process that doesn't add value to the management of the hospital but as a pure (often corrupted) control process. The quality of care is one of the problems in Bulgarian hospitals that provoke a wave of unsatisfied patients and society as a whole. Although Bulgaria is on first place in EU as number of hospitals the quality of care is insufficient - that is why 7 000 people had died in 2007 and they wouldn't if they were treated in another country - for 7 years with no real hospital reform it makes 49 000 people.
- ❖ **Society expectations** - The various quality, equity, and efficiency problems and a substantial decrease in health outcomes (15) does not match the requirements and expectation of the society. The patients lost the privileges that they had in the previous system, dominated by the state (as total coverage and free access) but still don't feel the advantages of the reform (competitiveness, choice, renewed equipment, high technologies, quality) - in the opposite - significant part of the population lost access to health services and those that have are not satisfied with the offered level and quality of care.

DISCUSSION

The reform in Bulgaria didn't achieve its main purpose and all the local and foreign experts share the same point of view about the necessity of discussion around another way of transformation. Choosing the right solution for the change needs to explore the reasons for the crash down. After all publications in Bulgaria media presenting analysis of the health reform and the opinions of foreign experts from World Bank for urgent changes, the Government finally admitted that the health system is malfunctioning and it must be performed an reorganization (16).

There could be two main explications of the present situation in the health care in Bulgaria. We will represent them in two hypotheses: **First hypothesis**: the crash down is a consequence of the lack of knowledge of the new public management model by the specialists from state bodies and hospital management teams; or, **Second hypothesis**: it is a result of the market failure mechanism called also adverse selection mechanism.

FIRST HYPOTHESIS

Our observation showed that main actors in Bulgarian health care stage had not changed since the beginning of the reform. In the same time they weren't involved in specific education.

For instance, the main part of the young students who study Health care management in Bulgarian universities is now very pessimists about their possibility of integration in hospital management team or for responsible position in health care public administration. That is why they prefer working in pharmaceutical companies as well as different business orientation and a part of them choose to emigrate. This is a problem for the future development of the health care system and its management.

But who is responsible for that situation? At first place there is a simple answer – the state and the local actors. Part of the responsibility maybe could be placed on the international partners and experts because of the proposed methodology. For instance lots of the models that had been proposed by the experts were only “copy and paste” from the models of Western Europe or USA...

Of course we can't propose complete solution for this multifactorial problem. Perhaps a way

out could be the better mix between contribution of the local and foreign experts, having in mind that most of international consultants arrive in Bulgaria just for the duration of the project, they are working on. Another way could be the accent before implementation of any change in the system to create a independent team of health care management local specialists. We could add the example of France, where since 10 years lots of universities are involved in proving health care training.

Another reason for the crash down of the health reform might be explained with the new institutionalism model. The actors in Bulgarian hospitals use different organizational frameworks to resist to the change process – as excuses are used three popular frameworks (24) – charity framework, according to which hospital has the historically inherited noble role to serve to the health needs of population; professional framework, according to which the high level specificity of the knowledge of the doctors and their direct contact with the customer/patient deprives the hospital manager of its full control and the third framework – the socio-political framework.

Actually, we should take into account the profound change represented by the implementation of the New Public Management model within the framework of the Bulgarian hospitals. In the discourses of the international experts and as a result of the local political power, there appears the notion of market (quasi-market), present where all the accounts of power rest upon another model, the one of “confidence” form within an almightily bureaucracy. So, there is a displacement of objectives, without, however the change of actors, not even the elimination of the game of power. We notice then the superposition of the two incompatible logics - the one of an agency relation, with the attached obstacles, especially the one of the moral hazard, and the other of the bureaucratic relations, with its individual obstacle - the development of the vicious circles and the predominance of the rules over the result.

SECOND HYPOTHESIS

Perhaps here is the biggest problem. Bulgaria and in the same way the majority of Eastern countries follow the foreign models, especially the USA model, based on market regulation. The proof is the increasing number of private health establishments,

with a lack of control by the state. For instance, in Sofia, in the context of excessive number of beds in the acute hospitals, a new Japanese hospital was build with more than 1000 acute beds!

How could be explained this situation? Certainly the market regulation is not a good instrument in Bulgarian context. Obviously the opposite situation of full state regulation of health care system is not the right decision as well. The possible solution for Bulgaria is a model that combines the implementation of the new public management model with the existing capacity of the state. In this way would be introduced the supervised competition (10) as proposed by A. Enthoven in the reform of the National Health Service in UK. This model is perhaps the mean for better use of the local resources and the implementation of the contractual approach.

Another explanation could be that the reform failed because of the agency theory problems - adverse selection and moral hazard. These effects are especially strong when there are contradictions between the targets of the agent and principal, which differ a lot in Bulgarian context. The aim of the principal is profit and effectiveness of hospital, and the aim of the hospital, represented by its manager is to serve to the public needs and to provide qualitative care to population. Various mechanisms may be used to align the interests of the agent with those of the principal, such as piece rates/ commissions, profit sharing, efficiency wages, performance measurement (including financial statements), the agent posting a bond, or fear of firing.

The hospital is naturally a strongly institutionalized organization. In terms of the reform that has been described, the institutional staff seems to be used by the actors as a strong means of resistance to all the forms of change. Like within the other similar reform processes, as an example the hospitals or the universities in France, we notice that the values and the outlines, born by the universities, exist without having a precise formalization. It's in the moment of change when these values, which are landmarks for the actors in the activity, formalize themselves and occur to be used, not with the view to an objective research of a better combination of services to face the needs of the population, but simply to justify the repetition of the existing organizational routine, in

the course of which the actors find a form of safety of the uncertainty margin and gives them power. We explain thus the profound inertness of the system and, as well as we strongly underline - the absence of a true strategic approach of change. We notice at the same time different types of behavior, described by the many authors, like *disengagement* (it's impossible not to remark the number of alienations, of giving up the medical practice, in favor of positions in the pharmaceutical laboratories, the distribution and the commercialization), *negotiation*, and also with no doubts - *sabotage*, a major obstacle to the reform, easy to use within a framework where the lobbying policy is exploited.

CONCLUSION

The supervised competition could be a solution in Bulgarian context. Its main advantage is that the state could keep the main part of its authority, while continuing to preserve the adverse effects of the market. In the same time the reform in hospital sector is a necessity and for implementing the change effectively, the state needs to change its role.

From "controller" and "provider" it should adopt the "double role", proposed by the supervised competition model. This new role of the state includes:

- ❖ **Regulation authority** – the state, as a representative of the customers, controls the prices and quantity of the health services, number of beds, days of stay according to international and European standards.
- ❖ **Competition authority** – the state do not intervenes in the market, but only preserve the loyalty of competition, for example by adopting and publishing national law for forbidding the monopoly in the health care system.

Change is the basic characteristic of every system – it pumps progress, drives evolution and therefore is vital for life. The New Public Management model could be the driver for Bulgarian hospital reform that can give a possible cure trough changing the direction of the managerial logic and limiting the side effects of the relations, dominated by the public service agents, which the bureaucratic model cannot control. It will bring the spirit of venture in the public administration so that it can be guided by its mission and goals and not by rules and procedures. And all

this while the users will be considered as clients and the aim will be the final result, instead of resources.

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