

## **DISCUSSIONS ON LONG-TERM CARE IN BULGARIA - RESULTS OF THE FOCUS-GROUP STUDY**

**Teodora Dimcheva**

Department of Medical informatics, Biostatistics and e-learning, Faculty of Public Health, Medical University-Plovdiv, Bulgaria, [tdimcheva@meduniversity-plovdiv.bg](mailto:tdimcheva@meduniversity-plovdiv.bg)

**Radost Assenova**

Department of Urology and General Medicine, Medical University-Plovdiv, Bulgaria

**Gergana Foreva**

General Practitioner, 4002 Plovdiv, Bulgaria, [gerganeforeva@gmail.com](mailto:gerganeforeva@gmail.com)

**Nonka Mateva**

Department of Medical informatics, Biostatistics and e-learning, Faculty of Public Health, Medical University-Plovdiv, Bulgaria

**Abstract: Background:** Global and national health bodies are developing standards, norms and guidebooks to introduce programs to meet the challenges faced by health systems in providing efficient services to patients with long-term conditions. The ongoing supervision of chronically ill people in Bulgaria is called ‘dispensary treatment’. The purpose of this research was to study the experience and opinion of providers and users of medical services on the dispensary treatment – its organization, advantages and disadvantages.

**Material and method:** Qualitative research was conducted using focus groups of providers and users of medical services. Discussions were held in five groups, and the total number of participants was 60.

**Results:** Initially, the discussion concentrated on the current system for long-term care, but also considered how it could be improved. Particular attention was paid to the position of general practitioners, who are often viewed by patients as the most appropriate coordinators, around whom functional and multidisciplinary teams are formed. The groups also discussed lack of active participation by nurses and insufficient interaction between doctors and social services. The lack of a unified register was mentioned. The groups also considered inappropriate allocation of resources by the financing institution, which limits the number of consultations within particular timeframes, without flexibility.

**Conclusion:** The Bulgarian model for long-term care has kept its name since before reform of the health system. It was considered positive that dispensary treatment is organized nationally, but its monitoring is largely administrative at that level.

**Keywords:** chronic disease, focus group, general practice, long term care, public health.

### **INTRODUCTION**

An aging population and longer life expectancy lead to difficulties in the organization and provision of care for patients with chronic diseases. Different interventions are used to address these problems.

The diversity of healthcare systems means that there is unlikely to be a universal solution to the challenges posed by chronic disease. The broadly used as a conceptual framework is the Chronic Care Model (CCM) developed by Wagner and colleagues (1999), aimed improving care focuses on keeping a person with chronic condition as healthy as possible. The CCM identifies the six elements which encourage high quality chronic disease care - the community, the health system, self-management support, delivery system design, decision support and clinical information systems [1, 2, 3].

In response to the emerging challenge posed by chronic diseases, several countries have experimented with new models of healthcare delivery. The ongoing supervision of chronically ill people in Bulgaria is called ‘dispensary treatment’. The definition of the term dispensary treatment is given in the Law on Health and it states: “Dispensary treatment is a method for active investigation, diagnostics, treatment and periodic monitoring of patients with certain diseases” [4]. Dispensary treatment is provided for a large number of patients with chronic diseases and also for some acute diseases which present a danger to others, such as some infections and infestations.

The rules for this monitoring are described in regulations issued by the Minister of Health [5]. For each disease, the regulation sets out the necessary checkups, examinations and consultations with different specialists. The regulation also determines which diseases are covered by the National Health Insurance Fund (NHIF) and which by other sources. For those diseases which are covered by the NHIF, the National Framework Contract (NFC) provides information about all mandatory actions within each calendar year. The duties of general practitioners and specialists are described in two separate enclosures [6].

The purpose of this research was to study the experience and opinion of providers and users of medical services on the dispensary treatment – its organization, advantages and disadvantages.

**MATERIAL AND METHOD**

Qualitative research was conducted using focus groups. Preparation, including a literature review, enabled development of key questions on the care and treatment of chronic diseases. The participants were selected to form heterogeneous and informal groups. Potential participants, who included general practitioners, specialists from different fields, working in either hospitals or ambulatory care settings, health managers, health economists and patients, were sent written invitations. A form was provided with information on the process for the focus groups, including written informed consent.

The group discussions were held between January and June 2013, and took place in an appropriate environment which provided physical comfort for the participants, visual contact between them and audibility. The groups were moderated by a total of three researchers. As table 1 reveals the discussions were held in five groups, and the total number of participants was 60. The total discussion time was 06:09:17 hours. An audio recording of the discussions in the focus groups was made, which was later transcribed by one researcher.

The analysis was in several stages. In the first stage each moderator independently identified and encoded key phrases from the participants’ comments. In the second stage, the encoded phrases were sorted into categories. When the encoded phrases were compared, there was a high degree of agreement on the categories. In the third stage, the moderators discussed their categories and agreed on the topic areas to present as results.

Table 1. Distribution of the participants

No. of group	N of participants	GPs	Specialists	Patients	Institutions			Health managers
					RHI*	BMA**	RHIF***	
1	11	9		1		1		
2	11	7					2	2
3	10	1	4	2				3
4	13	1	4			1	2	5
5	15	3	2	1	1		1	7
<b>TOTAL</b>	<b>60</b>	<b>21</b>	<b>10</b>	<b>4</b>	<b>8</b>			<b>17</b>

\*RHI - Regional Health Inspection

\*\*BMA - Bulgarian Medical Association

\*\*\*RHIF – Regional Health Insurance Fund

**RESULTS AND ANALYSIS**

The focus groups here included contractors and providers as well as consumers of medical services. Qualitative research enables a direct discussion and bringing up of leading topics on a particular problem as a basis for further research and initiatives.

In the early stages, discussion focused on the system for care and treatment of chronic diseases. The term ‘dispensary treatment’ was perceived as ambiguous. The groups agreed that it would be more appropriate to use the term ‘disease management’.

Several themes of discussion mentioned “the role of general practitioners in the care and treatment of chronic diseases”. General practitioners are the main players in primary care, and patients have direct and easy access to them, which is very important for care and treatment. General practitioners often know patients and their families well, and have the most complete information on the social-psychological aspects of disease. They are therefore best-placed to monitor care for chronically-ill people. This type of activity is a major priority and forms a large part of the work of general practitioners. The groups agreed that this turns the general practice into the most appropriate coordinating institution, around which functional and multidisciplinary teams should form.

All focus groups discussed “access to specialists”. According current rules, diseases are separated in two groups: those monitored by a general practitioner and by a specialist. From one side, this separation shifts the family physician from their ideal role as coordinator and from the other consultation for dispensary treatment by specialist is paid lower than other consultations. Furthermore, these consultations are limited to fixed number, depending on the chronic disease. The groups discussed the importance of clearer vertical structures across all levels of the health

system, and the need for “cooperation and interaction among medical specialists” in the provision of care for patients with chronic disease.

One subject that was widely discussed was the lack of “active participation of nurses” and nurse monitoring of chronically-ill people.

The groups also felt that there was the “insufficient involvement of specialists such as psychologists and social workers”, who would be beneficial to patients with chronic disease, and a shortage of volunteers. The interaction between doctors and social services relies on an exchange of documents and places an additional burden on the patient and/or their relatives.

There is no unified “register”, which leads to inexact data, which in turn impedes planning. It can also lead to several courses of dispensary treatment for a single patient for the same disease, as well as repeated consultations and examinations if the attending physician changes. The groups therefore felt that it was important to set up a national information system.

The “financial resources” used for dispensary treatment are significant. The participants in the focus groups brought up the following difficulties:

- Inappropriate planning of resources by the financing institution/national health insurance fund, which limits the number of consultations and examinations available to chronically-ill people within a particular timeframe, without any flexibility or possibility for increasing, for example if the condition worsens;
- Determining the financing of care and treatment only by disease classification, regardless of the stage of the sickness, hinders care upon progression of the disease and also the care of multi-morbid patients, a common issue. The problem with multi-morbid patients and those who are severely ill is to agree which disease should be regarded as the ‘main’ one, for the purposes of treatment rules and financing. The principles of dispensary treatment by disease classification do not account for multi-morbidity, and the financing is not as clear when more than one illness is involved.

## **DISCUSSION**

The Chronic care model, involving different medical specialists and other resources in the community, with the active participation of the patient. This model serves as a basis for organizing care for chronically ill people in many other countries, enriched with the individual peculiarities, attitudes and traditions of each country.

In Holland, for example, the model for caring for patients with chronic diseases is also used as a basis for programs for disease management, including cardiovascular diseases, chronic obstructive pulmonary disease, diabetes, stroke, depression, psychosis and eating disorders. Barriers to applying the model are time and resource restrictions, necessity for additional training of medical specialists and the need to change the approach towards the patient, and focus on educating them to take an active part in their own care [7].

In Germany over the last ten years, a model to improve the care for chronic diseases has been developed, connected to changes in the legislative framework for the health system. The most recent innovations include a national program for disease, integrated contracts, programs for nurses’ activities in the community, contracts with general practitioners as coordinators of care and new possibilities for multi-disciplinary care in clinics [8].

The system established in Bulgaria for care and treatment of chronic diseases, called dispensary treatment, is organized on a national level via a statutory regulation. To a large extent, it is financed by mandatory health insurance. The regulation sets out a list of more than 300 diseases covered.

As discussed in the focus groups, general practitioners have a significant role in the care and treatment of chronically-ill people. Primary care teams face daily challenges in caring for chronically-ill people [9, 10]. More and more, the role of general practitioners is shifting from treating acute episodic diseases to managing chronic illness. It therefore seems likely that health results would improve if primary medical care was organized according to the model of care for chronic diseases. In Australia, general practitioners use public and private resources to provide multi-disciplinary care [11]. Mayes and Armistead suggested that the main role of primary care should be care of chronic diseases [12]. The key role of the primary care practice in the care of chronic diseases is clear.

Another qualitative study pointed out the difficulty of integration and communication among the medical specialists, a problem also stated with force in our focus groups [13]. The fragmentation of services leads to inefficiency. Patients may receive care from many different providers, often in different settings or institutions, even when they have only a single disease. In Bulgaria, obstacles are created by the requirements of the regulations that certain diseases should be treated by certain specialists, and also by the regulatory standards that limit the number of consultations [14]. This problem also exists in other countries [15].

The role of the nurse is also fundamental for case management. The primary care practice nurse has a key role in coordinating care and also makes health assessments, helps prepare individual patient plans, maintains a register, and prepares reminders and reports [16, 17, 18]. In dispensary treatment in Bulgaria, the role of the nurse is not statutorily defined and is therefore decided by the managers of individual health establishments. In most cases, the nurses' work is purely administrative. The focus groups suggested that nurses should be given a more active role in providing more efficient care for chronically-ill people.

It is essential that the model for care of chronic diseases views the health system as part of the wider community, and outpatient clinics as part of a single health organization, since the efficient management of chronic diseases requires planning and coordinating. Individual planning in the model is facilitated via a register, which includes clinical information for each patient, the services provided for them and the results obtained. In Bulgaria, a register of chronically-ill people is used as a database for public health insurance. The register contains a list of all patients, with their primary diagnosis, the name and specialty of the physician treating them, data on any examinations and consultations, and the treatment provided. This register is not accessible to medical specialists and is only used for planning under the national framework agreement. Any access to this register should be considered very carefully, given the personal data that it contains. There are also registers at health establishment level, containing the electronic patient records. As in other countries, these support systems to send reminders and call patients for regular checkups [11, 19].

The focus groups mentioned the restrictions of the model applied in Bulgaria, which is quite limited and schematic. Other countries have significantly more diverse and individualized models focused on the needs of the patient, and which optimize use of resources. In a piece of qualitative research from the USA, the need for a change in approach was discussed in connection with targeted training of patients, the participation of multi-disciplinary teams and the additional education of medical specialists. It was suggested that these characteristics are important for the success of programs for care of patients with chronic diseases in general practice [9]. Often are considered elements like infrastructure, personnel, financing, quality and safety. Different financial initiatives are used to encourage general practitioners to improve chronic disease management [18]. Programs for care and treatment of chronically-ill people consume a lot of time, but are not adequately financed. In both our research and elsewhere, the medical specialists discussed the importance of teamwork, but it was not clear how this should be applied practically or funded [13]. Significant expenses are accounted for medical care, indirect expenses including the expenses because of loss of workability. This imposes global re-considering of the financial tools for healthcare on a personal and public level [20, 21, 22, 23].

As a whole the participants in the study were united around the idea that the system of dispensary treatment is inefficient and bureaucratic. There are extreme forms of bureaucracy such as the need for the physician's diagnosis to be "certified" by the financing institution, before the patient can commence dispensary treatment. The system should give physicians more discretion at the consultation, and needs a coordinator, so that care for patients with chronic disease does not fragment, and physicians from different specialties are not fighting each other for resources.

The groups offered several possible solutions. These included creation of a new, special system for 'pathways' for chronically ill people, around groups of diseases. These pathways should be exempt from the maximum number of consultations allowed under the regulations, perhaps by determining a coefficient depending on age and sickness, and all the necessary consultations should be fully funded. The urgent need for a new framework for care and treatment of chronic diseases should be consistent with good practice from other countries, and also include some previous Bulgarian models to improve the scope and focus on an assessment of the results of treatment.

## CONCLUSION

The Bulgarian model for care and treatment of chronically-ill people has kept the same name since before the reform of the health system. Our focus groups agreed that it was positive that dispensary treatment is coordinated nationally. However, the monitoring of patients is largely administrative and consists of recording those activities listed in regulations. Participants identified significant difficulties around coordination between medical specialists and to a larger degree with social services. The system also does not give individual physicians much discretion in deciding what care to provide and financial assurance is inadequate.

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