

<b>MANAGEMENT IN HEALTH CARE PRACTICE</b> A Handbook for Teachers, Researchers and Health Professionals	
<b>Title</b>	<b>EVIDENCE BASED POLICY – PRACTICAL APPROACHES. THE BULGARIAN NATIONAL HEALTH STRATEGY 2007-2012</b>
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<b>Keywords</b>	health policy, evidence based policy, research, health strategy
<b>Learning objectives</b>	After completing this module students should: <ul style="list-style-type: none"> <li>• know the definition and characteristics of evidence based health policy;</li> <li>• be familiar with designing phase of health strategy;</li> <li>• be familiar with planning phase of health strategy.</li> </ul>
<b>Abstract</b>	In recent years we have seen the successful implementation of new methods in formulating health policy, based on sound research data – the so called evidence based policy. This new approach to health policy helps experts formulate decisions on the basis of good information concerning programs and projects, through presenting supporting evidence from research, which in turn becomes the core for political development and implementation. We decided to analyze the project for a National health strategy 2007-2012 of Bulgaria and see how well it corresponds to the principles of evidence based policy. Critical evaluation of the last draft of the National health strategy 2007-2012 reveals a number of weaknesses due to the documents' inconformity with the basic principles of evidence based policy making. We conclude with a discussion on possible implications for Bulgaria's health policy.
<b>Teaching methods</b>	An introductory lecture will gives the students first insight in characteristics of evidence based health policy. The theoretical knowledge is illustrated by a case study. After introductory lectures students should first carefully read the recommended readings. Afterwards they can discuss the case study with other students. In continuation, they need to find published materials (e.g. papers) on evidence based health policy and present their findings to other students.

<b>Specific recommendations for teachers</b>	<p>Work under teacher supervision/individual students' work proportion: 30%/70%;</p> <p>Facilities: a computer room;</p> <p>Equipment: computers (1 computer on 2-3 students), LCD projection equipment, internet connection, access to the bibliographic data-bases;</p> <p>training materials: recommended readings or other related readings;</p> <p>Target audience: master degree students according to Bologna scheme.</p>
<b>Assessment of students</b>	<p>Multiple choice questionnaires.</p>

# **EVIDENCE BASED POLICY – PRACTICAL APPROACHES. THE BULGARIAN NATIONAL HEALTH STRATEGY 2007- 2012**

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## **THEORETICAL BACKGROUND**

Policy (coming from the Greek word *politike*, meaning power) can be defined as the goal-oriented activities of empowered individuals or groups in a given society. Health policy in reality aims the distribution of a nation's limited resources in such a manner, so as to produce the best possible public health results. The state health policy represents the officially accepted long-term strategy for development of the national health system. It should be noted that a common weakness of many contemporary healthcare reforms is the insufficient attention paid to setting priorities and their ranking according to social significance. Possible priorities are essential public health problems, e.g. coronary incidents; sectors of the health system requiring high priority development, e.g. emergency care; population groups requiring guaranteed health services provision, e.g. retired persons. The process of policy formulation is so fundamental that any future steps become impossible until we have a clear idea what our goals are and to what end will certain strategic tasks lead us. Political consensus and the support of society and media are quite necessary in setting out public health priorities (2).

In recent years we see the successful implementation of new methods in formulating health policy, based on sound research data – the so called evidence based policy. This is a new approach to health policy, which helps experts to take decisions on the basis of good information concerning programs and projects, through presenting supporting evidence from research, which in turn become the core for political development and implementation (8).

Evidence-based policy is public policy informed by rigorously established objective evidence. From a historical perspective, it can be thought of as an extension of the idea of evidence-based medicine to all areas of public policy. Evidence based policy is particularly associated with the name of the distinguished British statistician Adrian Smith – a former president of the Royal Statistical Society. Smith is famous as a proponent of Bayesian statistics and evidence based practice — a general extension of the concept of evidence based medicine into all areas of public policy. In accord with Bayesian statistics the notion of policy based evidence making also emerged – this is a pejorative term which refers to the commissioning of research in order to support a policy which has already been decided upon. As the name suggests, policy based evidence making means working retrospectively from a predefined policy to produce underpinning evidence. Working from a conclusion to provide only supporting evidence in favour of already running policy should be distinguished from the method of research into the effects of a policy where such research may prove either supporting or contradicting.

The term 'policy based evidence making' was referred to in a report of the UK House of Commons Select Committee on Science and Technology into Scientific Advice, Risk and Evidence Based Policy Making issued in October 2006, but in a somehow negative light. The committee stated that ministers should not seek selectively to pick pieces of evidence which support an already agreed policy, or even commission research in order to produce a justification for policy (9).

A distinguishing aspect of evidence-based policy is the use of scientifically rigorous studies such as randomized controlled trials to identify in advance programs and practices capable of improving policy relevant outcomes. A very general definition of research would be ‘any systematic effort to increase the stock of knowledge’. According to the Oxford Concise English Dictionary ‘evidence’ means information indicating whether a belief or proposition is true or valid. Different types of evidence exist, like systematic reviews, single research studies, pilot studies and case studies, experts’ opinions, information available on the Internet. While randomized controlled trials are widely considered to provide the most reliable form of scientific evidence in the clinical care context, the complexity of the health policy context demands different types of evidence. Observational studies, qualitative research and even ‘experience’, ‘know-how’, consensus and ‘local knowledge’ should also be taken into account. It is often difficult to apply rigid hierarchies of evidence to health policy like this is practiced in evidence-based medicine. Evidence can be used to help improve understanding of an issue, influence policy thinking and assist in the communication and defence of decisions. It could be used in the different stages of the policy process: at the creation of the policy; in its development; in its implementation; and in its defence/justification. Probably most important, is that robust evidence gives government officials confidence in their decisions and the ability to defend these decisions in the face of possible criticism.

There is a long tradition of evidence-based and evidence-informed policy within the UK. Building on the thinking in the Modernizing Government White Paper, the Cabinet Office published ‘Professional Policy Making for the 21st Century’ in 1999 (11). This identified nine core competencies, sometimes referred to as the ‘nine principles’ of good policy making. The distinguished features of professional policy included “using evidence” as well. Throughout ‘Professional Policy Making for the 21st Century’, there is a strong emphasis that policy making should be based on evidence of what works and that the civil service must improve departments’ capacity to make best use of evidence. To enable this to happen, the report called on departments to ‘improve the accessibility of the evidence available to policy makers’. More recently, the ‘Professional Skills for Government’ initiative has been developed as a key part of the government’s delivery and reform agenda to ensure the whole of the civil service has the right mix of skills and expertise to enable department or agencies to deliver effective services (12). Within this framework of skills and experiences necessary for any civil servant to do their job well are four core skills, one of which is ‘analysis and use of evidence’. Under this core skill, policy makers are expected to:

- anticipate and secure appropriate evidence;
- test for deliverability of policy/practice – and evaluate;
- use evidence to challenge decision making;
- identify ways to improve policy/practice;
- champion a variety of tools to collect/use evidence;
- ensure use of evidence is consistent with wider government requirements;
- work in partnership with a wide range of experts/analysts.

A British report clearly identified the factors that facilitate the use of evidence and factors that impede it. The main factors associated with ‘useful’ evidence that can lead to better policy making were: good timing of the analysis with long-term data collection; resource availability, in terms of research budgets and policy and analytical staff capacity; quality of the evidence; availability of the required evidence; presentation of the evidence; focus of reports and other forms of evidence: analytical findings relating directly to the area of interest; trustworthiness of available evidence: is it from a credible source (4)?

Evidence based policy is generally a discourse or set of methods which informs the policy process, rather than one which aims directly to affect the eventual goals of the policy. It advocates a more rational, rigorous and systematic approach. The pursuit of such policy is based on the premise that policy decisions should be better informed by available evidence, and should include rational analysis. Policy and practice which are based on systematic evidence are seen to produce better outcomes. The desired progression is a shift away from opinion based policies being replaced by a more rigorous, rational approach that gathers, critically appraises and uses high quality research evidence to inform policymaking and professional practice.

The issues governments should consider when trying identifying what evidence is useful are:

- Accuracy: Is the evidence correctly describing what it purports to do?
- Objectivity: The quality of the approach taken to generate evidence and the objectiveness of the source, as well as the extent of contestation regarding evidence.
- Credibility: This relates to the reliability of the evidence and therefore whether we can depend on it for monitoring, evaluation or impact assessments.
- Generalisability: Is there extensive information or are there just selective cases or pilots?
- Relevance: Whether evidence is timely, topical and has policy implications.
- Availability: The existence of (good) evidence.
- Rootedness: Is evidence grounded in reality?
- Practicalities: Whether policymakers have access to the evidence in a useful form and whether the policy implications of the research are feasible and affordable (5).

According to the World Health Organization, one of the greatest challenges facing the member states is how to ensure access to safe and effective health services for those population groups most in need. Strengthening health systems is a core part of this challenge. However, more evidence is needed about what works in terms of health system strengthening, and under what conditions. WHO estimates that health policy and systems research (HPSR) was neglected for many years, and while some other areas, such as health financing, are nowadays much better understood than some 20 years ago, other issues, such as how to retain and motivate the health workforce or what service delivery models work best in resource-constrained developing countries, remain poorly understood. Unlike other types of health research, health policy and systems research needs to be rooted in and remain responsive to national needs. Health systems and social, economic and political contexts vary so widely that there is no ‘one size fits all’ solution for health system strengthening. Instead, every country needs sufficient capacity to analyze its own health system and, drawing on international experience, develop and evaluate its own health system-strengthening strategies. Developing national capacity for health policy and systems research is critical – but may not be enough. National governments also need to ensure that research gets synthesized, summarized and packaged in ways that policy-makers and civil society representatives can use, and that policy-makers have sufficient capacity to access and apply these research findings. As developing societies become increasingly democratic, it is even more important that research evidence is widely accessible and can be used by multiple stakeholders, both governmental and non-governmental, to inform of their policy positions. Capacity in itself is a widely but often superficially used term. Capacity issues mainly arise with the different aspects of the relationship between two key groups – policy-makers and researchers. The ability of policy-makers to draw on appropriate evidence is often restricted by its availability. Generating appropriate, trustworthy evidence depends in turn on the existence of good

research organizations. At present, the capacity of such organizations in low- and middle-income countries is generally inadequate. Founders' attention has historically focused on developing the skills of individual researchers. True capacity-strengthening strategies for the future, in contrast, need to focus on the comprehensive needs of academic and administrative institutions, including overall skills and career development, development of leadership, governance and administrative systems, and strengthening networks among the research community, both nationally and internationally. Over recent years there has been noted at least a proliferation of literature focusing on knowledge and how to get it into health policy and practice. Ever since the 1990s the 'evidence based medicine' movement has advocated the greater and more direct use of research evidence in the making of clinical decisions, and this was later broadened into a call for more evidence-based policy as opposed to policies determined through opinions or political biases. Much of this interest arose from the perception that even when research provides solutions, these are not necessarily translated into policy and practice. Health policy and systems research can address any or all of the 6 'building blocks' of health systems identified in the World Health Organization's Framework for Action on health systems from 2007, namely: service delivery, information and evidence, medical products and technologies, health workforce, health financing, leadership and governance. The conceptual framework developed by WHO proposes four main functions of evidence-informed policy-making: research priority-setting, knowledge generation and dissemination, filtering and amplification of evidence, and policy-making. Filtering is a function through which stakeholders determine which research is most relevant as the evidence base for their respective arguments in the policy-making process. Amplification is a function through which stakeholders seek to make the evidence base of their arguments generally accepted as a means of increasing influence on policy-making. This whole framework is supposed to help in developing and evaluating national strategies for enhancing capacity. Some important new considerations include: previous capacity development initiatives have tended to focus exclusively on the production of evidence rather than on capacity to use evidence in policy processes; greater investment is needed in assessing whether the currently employed capacity-building strategies are effective.

Policy-making is generally a complex, non-linear, incremental and messy process. Many factors have the potential to influence policy-making, including context (e.g. election cycles, state of government's finances, health systems governance structures, media hype and unforeseen political crises) and the ideologies and values of the policy-makers themselves. Indeed, although the 'engineering' model of how knowledge is incorporated into policy suggests a linear progression from identifying a problem that requires a policy solution to ranking the objectives and weighing alternative policy options, this is rarely seen in real life. The actual steps of the policy process depend on national features and especially on policy structures and mechanisms. Nevertheless, stages in the policy process typically identified are: agenda setting, policy formulation, implementation and evaluation. In fact, evidence can be used at any of these stages.

WHO has also proposed a tool for self-assessing the effective use of research evidence. The tool focuses on four different aspects of organizational capacity, each having its implications for staff skills: can the organization identify the necessary research; can the organization assess its findings in terms of reliability, relevance, and applicability; can the organization present properly the research to decision makers; does the organization possess the necessary skills, structures, processes and culture to promote and use research (6)?

At the World Health Assembly held in Geneva in May 2005, debates how to harness health research more effectively in order to achieve the United Nations'

Millennium Development Goals in low- and middle- income countries culminated in the passage of a two-part resolution that established specific accountabilities for developing mechanisms to support the use of research evidence in developing health policy. The first part of the resolution called on WHO member states to “establish or strengthen mechanisms to transfer knowledge in support of evidence-based public health and health-care delivery systems, and evidence-based health-related policies.’ The second part of the resolution called on WHO’s Director-General to “assist in the development of more effective mechanisms to bridge the divide between ways in which knowledge is generated and ways in which it is used, including the transformation of health-research findings into policy and practice.’ Organizations have already been established in many countries and internationally to support the use of research evidence. These include, among others, organizations that directly support the use of research evidence in developing health policy on an international, national, and provincial level (the so called ‘government support units’). While there are important differences among these organizations, there are also many commonalities and opportunities for existing and new organizations to learn from this collective experience. A recent Norwegian study has found seven main implications for those establishing or administering organizations to support the use of research evidence in developing health policy:

1. Collaborate with other organizations;
2. Establish strong links with policymakers and involve stakeholders in the work;
3. Be independent and manage conflicts of interest among those involved in the work;
4. Build capacity among those working in the organization;
5. Use good methods and be transparent in the work;
6. Start small, have a clear audience and scope, and address important questions;
7. Be attentive to implementation considerations even if implementation is not a remit.

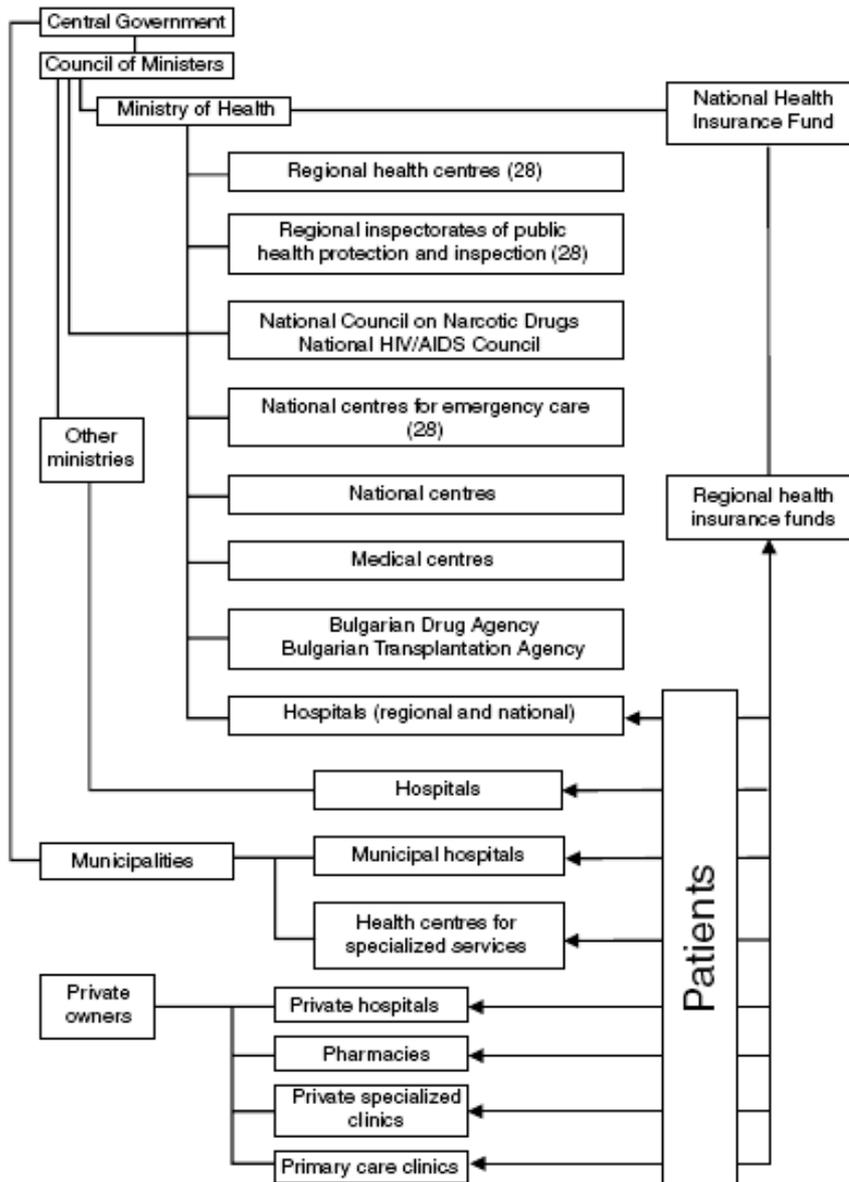
The study’s four main implications for the World Health Organization and other international organizations include: support collaborations among organizations; support local adaptation efforts; mobilize support; create knowledge-related global public goods, including methods and evidence syntheses (7).

## **CASE STUDY: THE BULGARIAN EXPERIENCE**

With all this in mind we decided to analyze the project for a National health strategy 2007-2012 of Bulgaria and see how well it corresponds to the principles of an evidence based policy. First, we would like to make several introductory comments on Bulgaria as a country in transition and the health system of Bulgaria in particular. Bulgaria is situated in the eastern part of the Balkans and has an approximate population of 7.8 million, with the demographic characteristics of a rapidly aging society. The establishment of a new constitution in 1991 set in motion the process of introducing a democratic form of government. Despite a large decrease in mortality since 1990, the country’s mortality rate is still high compared to old European Union Member States. Mortality rates from heart and circulatory diseases have increased, representing 66.1% of all deaths in 2005. The infant mortality rate in Bulgaria was 11.6 per 1000 live births in 2004, which was more than twice as high as that in the 25 European Union Member States.

Health reforms commenced in the 1990s brought about wide-ranging changes in health care organization, financing and delivery, and a new type of relationship was established between users, providers and payers. Reforms were aimed at making the health system more efficient and responsive to patients’ needs, by means of improvements in quality of service and delivery of care. The establishment of the National Health Insurance

Fund and a basic benefits package defined the services covered by the public sector and designated the revenue collection for health care allowing for more sustainability of the healthcare budget (Fig. 1).



**Figure 1.** Overview of the health system of Bulgaria (1).

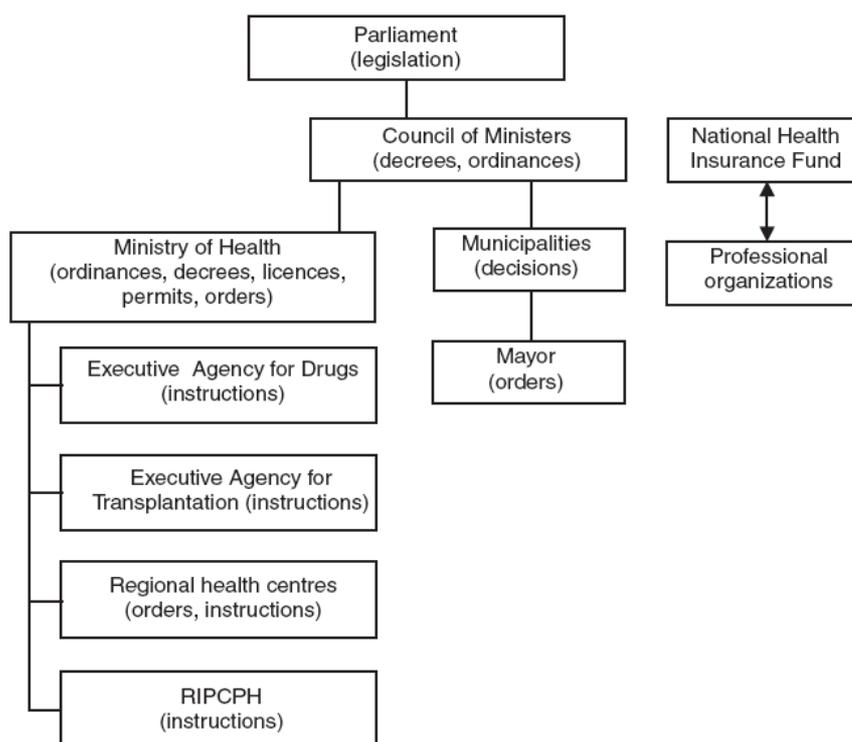
However, a financing system solely based on contributions failed to provide adequate funding for the system. Approximately one million people opting out of universal coverage meant that there were significantly fewer contributors than beneficiaries and this led to potential adverse effects on the financial balance of the National Health Insurance Fund. Legalization of private practice has had a positive impact on access to health services and the resulting competition among health care providers proved an incentive for higher-quality of service provision (Figure 2). However, widespread commercialization of health care and a growing focus on market relations exerted an overall adverse impact on the social functions of healthcare. A restructured primary care and the introduction of GPs as gatekeepers to specialized care allowed for cost-containment but led to ardent

discussions whether such policies violate the principles of free provision and access to health care for the population.

The restructuring of inpatient health care financing and provision was followed by the introduction of clinical pathways as a reimbursement instrument. This created better incentives for improving both quality and effectiveness of service provision.

However, the actual cost of implementing clinical pathways for the hospital is higher than the price reimbursed by the National Health Insurance Fund, which causes chronic financial instability in the inpatient sector. Insufficient funding of multi-profile hospital settings gave rise to a subsequent lack of motivation among medical care providers. Public health challenges and elucidated structural defects of the health system were supposed to be addressed by the new National health strategy of Bulgaria.

Critical evaluation of the last draft of the National health strategy 2007-2012 reveals a number of weaknesses due to the documents' inconformity with the basic principles of evidence based policy making. The document replicates to a large extent the preceding National health strategy 2001-2010 which in turn replicates the WHO paper "Investment in health" from the 1990s. The project pretends to constitute a health strategy but is, in reality, an action plan for reforming the healthcare system and is unrelated to the actual public health status of the nation. Further, we will comment on the major weaknesses of this paper in more detail.



**Figure 2.** Overview of Bulgaria's health system regulation (1).

This is a typical example of a document not based on evidence, i.e. research findings, but instead on the opinions of a group of experts or, the so called anecdotal evidence. The document goes in great detail describing the healthcare system of Bulgaria, its distinctive features and weak spots, but fails to pay any attention to the state of public health and the actual health needs of the citizens of Bulgaria. Such paper is clearly targeted

inside, at solving problems of structural defects of the health system; where it should be targeted outside, at tackling the population's health needs. The strategy doesn't even demonstrate intent to deal with the health and quality of life of Bulgarian population, instead focusing exclusively on intrinsic problems of the healthcare system. A retrospective depiction of the healthcare system and allowed weaknesses is provided, while it would be more useful to pinpoint essential problems in the nation's health state, as well as indicate ways of solving them in combination with short- and middle-term objectives plus clear indicators for evaluation.

The strategy doesn't engage with a single feasible goal related to improved population health, a goal furthermore administratively and financially backed; unfortunately the strategy sounds rather like the paper of an administration thinking that public health is entirely a product of the health system's functioning. The proposed strategy neither protects the rights, nor defines the health-related responsibilities of Bulgarian citizens; instead it stipulates the way in which, according to the Ministry of Health, this system should be structured, without taking into account the interests of these same citizens. Going into even more detail we can easily note that: the introduction does not make reference to the health state of the nation, but it takes several pages to describe all systemic defects of the healthcare system. A strategy with such accent and scope should be named more properly a strategy for restructuring the health system and not a national health strategy. A passage states that "The result of this strategy should be a reformed, financially stable and effective health system, capable of providing quality care in prevention, prophylaxis, treatment and rehabilitation..." clearly indicating that the expected outcome is a systemic change and not improved health and quality of life.

The section "Health state of the population" does not provide actual data, instead citing data ranging from 2000 to 2005 which speaks of unfamiliarity with the real health problems of the population; this is despite the fact that the last revision of this paper is dated September 2007. This is a good illustration of the point that the National health strategy does not refer to actual health needs and is not founded on scientific evidence. The section on social determinants of health sets out a very bad example as it quotes no single result or conclusion, instead stating pointlessly that "The relation between health and socio-economic medium in a state is direct. Consequently, to achieve positive results we need direct actions to improve the medium in which a man lives, works and realize his social contacts." Another unfortunate example of the way a strategy is being mechanically filled with meaningless phrases is "realizing the significance and need for timely measures" in the section "functioning of the healthcare system – system management." An example of the lack of ability to create a coherent text and "jumping to conclusions" is the following text taken from the section "Financing the health system": "In comparison to the average parameters of the insurance contribution in the EU which ranges from 8 to 12%, the insurance contribution in Bulgaria is 6%. The combination of low insurance contribution, lack of guarantees for complete fundraising and a high dropout rate from the insurance system (about 1mln Bulgarian citizens) is defining." The authors of the draft strategy do not leave the impression of truly knowing the Bulgarian health system and understanding its hierarchical structure. For example they conclude that the increasing number of patients seeking specialist and hospital care can be attributed to a deficit of financial resources in outpatient care. The introduction of a uniform emergency number 112 is erroneously set as a goal of the National health strategy when it is in fact an element of Bulgaria's accession to EU and is of little importance for public health issues in itself. Throughout the entire text the terms "stomatology" and "dental medicine" are being mixed up. According to the new legislation only the use of the second term is correct. This

mistake may be illustrative of the rash and incoherent manner in which such an important document has been prepared.

It is a little surprising to find in section “Hospital care’ the comment that some hospitals have social functions (e.g. care for terminally ill patients, long-term medical care and continuous rehabilitation) as well, which depletes their financial resources. However, these functions are their legal obligation according to Bulgarian health legislation. The heavy usage of hollow terminology, unsupported by concrete examples or proposed measures does not increase the credibility of the document. This can be noted on numerous occasions, e.g. with terms used like “creating democratic medium for population inclusion and transparencies in taking political decisions’; “raising capacity of all stakeholders for performing political analyses aimed at improving inter-sector dialogue’; “forming knowledge base for population health and its determinants.’ A striking example of the National strategy’s superfluous and emptied of essence language is the expression “a build-up of a system of criteria for defining priorities in implementing market control, based on risk evaluation...’ Typical of the proposed strategy is the constant usage of the terms “implementation of a national program’ and “implementation of a national plan’, meaning the strategy has as its goals the realization of certain programs; when in reality a strategy is supposed to serve as a basis for establishing such national strategies and action plans. High immunization coverage is set as a goal without even specifying what communicable diseases are meant, where immunization coverage could be deemed insufficient and what should be achieved. In this line of thought all mentions of socially-significant diseases go without unequivocally declaring what diseases in Bulgaria are meant and what are the related problems for society. Without even mentioning previously problems of children health and children risk groups in Bulgaria, the strategy jumps to the establishment of health cabinets in schools, i.e. a structural problem of the health system. Some technical mistakes raise doubt if the proposed texts have been reviewed after their initial formulation. For example, the section concerning socially significant diseases confuses program and grant principle of financing – the authors seem unaware of the difference between program planning and participation in financing based on the grant scheme.

The introduction of a European health insurance card is proposed in the strategy, but in fact this card has already been introduced in Bulgaria. A very disturbing tendency in Bulgaria is the preparation of important documents by small groups of low-profile or completely anonymous experts, working hastily on political errands. This is how we explain the appearance in the proposed national health strategy of a number of new ideas, bringing radical changes to the existing health system. It comes as no surprise that immediately after its presentation the draft strategy gave rise to heated disputes. Several representative examples follow. The document introduces a new type of health facilities – one for health tourism; unforeseen by the existing Bulgarian legislation. The strategy indicates an upper limit of 1500 patients in the list of a GP and a number of other measures which have not been discussed with the Association of general practitioners in Bulgaria like the introduction of stimuli to form group practices (again failing to mention any particular and feasible measures) and increasing payments for service, as well as lowering payments per capita for a listed patient, a measure which, by the way, is clearly going to lead to a surge of costs.

The section “Restructuring and effective management of hospital care’ foresees the establishment of a package of outpatient services to be concluded in hospitals and reimbursed by the health insurance fund which comes again as a surprise since it contradicts all common to this day practice in Bulgaria. A new type of hospital financing suddenly appears in the text – one through a global budget. The explicitly mentioned regulation and limitation of new contracts of the National Health Insurance Fund with

health services providers is an outright violation of the legislation in force and the right of a free initiative for providers. This measure, if enacted, will most probably strip citizens of their right of choice of provider and will exacerbate corruption problems in the Bulgarian healthcare system. The role of professional organizations like the Bulgarian Physicians Union and the contracting principle in relations between the National Health Insurance Fund and such organizations is completely ignored or nullified throughout the whole text. A change in the form of relations is stated without even bothering to mention what will change and why should it change. A significant change in the health insurance model is the declared introduction of complementary universal health insurance. It remains unclear whether such a step is really necessary and where to should this additional financial resource be directed. An interesting goal of the strategy is the creation in Bulgaria of a uniform methodology for pricing of medical services, such methodology is supposed to serve then as a basis for forming all financial plans in the healthcare sector. This sounds like a worthy goal, but since such methodology doesn't exist anywhere else worldwide, we get the impression that many declarations in the strategy are present there simply because they sound good.

The strategy proposes also the refinement of the existing instruments for price formation in hospital care. In reality, such an attempt will bring forth an even greater dissent among the medical community in Bulgaria. The currently used clinical pathways (which were never meant as financial instruments at their creation) proved very unsuccessful; perhaps it will be a better idea to abandon them completely and continue with the preparation for the adoption of Diagnostic Related Groups. A wide consensus has already been formed on that matter in Bulgaria. However critical we have been so far, the section "Indicators for evaluation" is clearly the weakest part of the strategy. Curiously, the section that should have been most specific and demonstrate the serious intentions of the state in implementing the national strategy, contains no single fact or number. It remains a mystery how to evaluate the implementation of this strategy when there are no milestones and final goals. The standard for monitoring should be described in the strategy but instead we learn from the text that the monitoring mechanism will be created at some later stage. The text is abundant in formal phrases like 'Standards for measuring the achieved progress will be in conformity with the set goals. The chosen standards should be feasible. They will be defined on the basis of concrete data...' A set of public health indicators is nevertheless enumerated but not a single indication from where we come and where we will end. For example birth rate and infant mortality are among the chosen indicators, but they are just listed, without concrete values (even at present) and the values we desire to reach in 2013 as a result of the implementation of the national strategy.

To summarize, in our opinion the proposed strategy is elaborated in a very formal manner, bears the marks of wishful and bureaucratic thinking, does not demonstrate good knowledge of the Bulgarian health system and does not live up to the contemporary standards of policy making in developed countries. It will be hard to find justification for the existence of this document and the proposed strategy cannot be expected in good conscience to be ever implemented and yield any useful results (3).

The fate of the proposed national health strategy is to this day unenviable. Perhaps this should come as no surprise in view of its numerous weaknesses (13). The currently active National health strategy is dated 2001-2010. The enactment of a new health strategy has been the ambition of the Bulgarian government, dominated by socialists, which came in power in 2005. This logical step has been in line with the declared ambitious plans of socialists to restructure public sectors. The strategy itself was written in 2006 and is a product of experts working for the Ministry of Health or affiliated with it. An interesting fact is the unwillingness of these experts to have their names associated with this program

document consequently it remained an anonymous creation. The Prime Minister made a public promise to have the strategy operational since March 2007, an ambition which proved ungrounded. Ever since its first presentation (end of 2006) in front of a wider audience, the strategy attracted only harsh critiques. It has been consequently rejected by all stakeholders in Bulgaria's healthcare sector. One such example follows. The document was presented by the Minister of Health on May 09 2006 in front of an extended National Council of the Bulgarian Physicians Union, including also representatives of the academic community, ministers, deputies and representatives of patients' organizations. Following the discussion the National Council made a statement rejecting the proposed strategy and citing its numerous weaknesses. The Bulgarian Physicians Union considers a main weakness the preparation of the strategy without any participation from physicians and patients. Other cited weaknesses coincide to a great extent with our own findings: health needs, priorities and concrete steps are omitted from the strategy. Furthermore, the strategy speaks of essential administrative reforms in Bulgarian healthcare without a preceding proper public discussion. Financial parameters are missing. The national council proposed scrapping the existing project and the preparation of new one by a workgroup, including representatives from the Ministry of Health, the Bulgarian Physicians Union and patients' organizations. The final draft should contain clear responsibilities of all institutions implementing the strategy, as well as explicitly stated terms and necessary resources (10).

In 2007 the draft of the new national health strategy has been rejected three times by the Council of Ministers. Regardless, the strategy draft is proposed again and again with minor corrections, a good indication of the limited capacity of the Ministry of Health in preparing such documents.

## Discussion

The technology traditionally used widely in Bulgaria to prepare important political documents is outdated and the case of the National health strategy 2007-2012 clearly illustrates that. Institutional capacity – the ability of government experts to find and incorporate evidence, is very weak and so is interface – the ability of these experts to communicate with the academic community as a possible source of such evidence. Wider adoption of the principles of evidence based policy making can do much to advance Bulgarian health policy.

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