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Control of Medical Care within the System of Mandatory Health Insurance in Bulgaria

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Abstract: The aim of the study was to analyze the regulatory framework and the practice of control activities within the system of mandatory health insurance in Bulgaria, carried out by the National Health Insurance Fund (NHIF) and the Regional Health Insurance Funds (RHIFs), with a focus on the mechanisms for controlling medical care and the expenditure of public funds. Methods: A documentary and regulatory analysis was conducted, covering the current legislation, secondary regulatory acts, the National Framework Contract, the NHIF Budget Act, and official strategic and institutional documents related to healthcare control in Bulgaria. Results: The control system is implemented through preliminary, current (on-site/sudden), and subsequent control, planned and unplanned inspections, as well as budgetary and financial mechanisms at both micro- and macro-levels. Patient participation plays a significant role through the Electronic Health Record and the possibility to submit complaints and signals. Despite the well-developed regulatory framework, structural limitations were identified, particularly the shortage of controllers with medical education and the limited capacity for real-time control. Conclusion: The control activities of the NHIF and RHIFs represent a key instrument for ensuring transparency and financial sustainability in the Bulgarian health insurance system. Further improvement requires strengthening human resources capacity and the development of digital control tools.

Keywords: Mandatory health insurance, NHIF, Control of medical care, Financial control.

Introduction

Under conditions of limited resources and increasing public expectations, the control exercised by the National Health Insurance Fund should not be viewed merely as an administrative function, but as a strategic instrument for ensuring the quality, accessibility, and transparency of healthcare services. The subject of the present study is the control mechanisms within the healthcare system in Bulgaria related to the expenditure of public funds by the NHIF. The object of the analysis is the functions of the National Health Insurance Fund as the main institution responsible for exercising control over the use of public financial resources in healthcare.

The aim of this study is to analyze the existing control practices of the NHIF, to identify their weaknesses, and to propose directions for improvement through digitalization, enhanced institutional coordination, and regulatory changes aimed at increasing accountability and preventing abuse. In this context, control should not be considered solely as a sanctioning mechanism, but also as a tool for optimizing management processes, protecting patients' rights, and ensuring the sustainability of public healthcare financing.

Method

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The present study was conducted through a documentary and regulatory analysis of the current legislation in the field of healthcare and mandatory health insurance. The analysis covered the Health Act, the Health Insurance Act, the National Health Insurance Fund Budget Act, secondary regulatory acts, the National Framework Contract for Medical Activities, as well as official strategic and institutional documents related to control activities within the Bulgarian healthcare system. The analysis was aimed at identifying the main forms, mechanisms, and limitations of control over medical care and the expenditure of public funds.

Results and Discussion

Institutional and Regulatory Frameworks for the Control of Public Funds

The regulatory review demonstrated that control in the Bulgarian healthcare system is organized within a multilayered institutional structure based on specific financial and organizational principles aimed at ensuring adequate, accessible, and high-quality medical care for the population. This structure reflects the complex and multi-component nature of the healthcare system, in which medical and non-medical activities operate under different regulatory regimes.

In this context, control in healthcare is established as a systemic mechanism for monitoring, evaluating, and regulating compliance with legal requirements, medical standards, and the efficiency of public resource utilization. As emphasized in scientific literature, the primary objective of control is to ensure quality, safety, and equitable access to healthcare services, while simultaneously limiting abuse, inefficiency, and financial risks within the system (Georgieva et al., 2007).

The findings demonstrated that control functions in healthcare were distributed among several key institutions with clearly defined competences. Central roles are assigned to the Ministry of Health, the Regional Health Inspectorates, the Executive Agency Medical Supervision, the National Health Insurance Fund, the National Audit Office, the Public Financial Inspection Agency, and the National Revenue Agency, each operating within a legally defined scope of authority (Health Act, 2004; Health Insurance Act, 1998). National health policy is formulated and coordinated by the Council of Ministers, which, upon proposal by the Minister of Health, approved the National Health Strategy and national health programs. Legislative and parliamentary oversight was exercised by the National Assembly through its Standing Committee on Health, which participated in the development of legislative initiatives, reviewed the activity and budget reports of the NHIF, and, when necessary, established ad hoc committees to address specific issues (National Assembly, 2023).

With regard to control over the quality of medical care and the protection of patients' rights, the analysis identified the leading role of the Executive Agency Medical Supervision. The agency exercises continuous oversight over the activities and organization of healthcare establishments regardless of their ownership and performs control over the management of public funds, including those allocated for medicinal products fully financed by the state (Executive Agency Medical Supervision, 2023).

Control over the revenue side of the system is carried out primarily by the National Revenue Agency, which is responsible for the collection of mandatory health insurance contributions and exercises control over NHIF revenues through tax audits and inspections (National Revenue Agency, 2023). The National Social Security Institute performs a complementary control function regarding the insurance status of economically active individuals (National Social Security Institute, 2023). Financial control over NHIF expenditure was also exercised by the National Audit Office and the Public Financial Inspection Agency, which monitored the legality, expediency, and effectiveness of public spending (Agency for State Financial Inspection, 2023; National Audit Office, 2023).

Established Control Functions and Powers of the National Health Insurance Fund

The analysis of regulatory documents showed that the National Health Insurance Fund occupied a central position in the system of control over the use of public funds for healthcare services. Its primary control function was directed at monitoring the lawful expenditure of resources derived from mandatory health insurance contributions collected by the National Revenue Agency, as well as at ensuring their targeted and efficient use within the system of mandatory health insurance (NHIF Budget Act, 2025; National Revenue Agency, 2025).

The study identified that the NHIF exercised direct control over its contractual partners-healthcare establishments, pharmacies, and providers of dental care-through inspections focused on the volume, legal basis, and compliance of reported medical activities with the services contracted and reimbursed. This control covered both the medical and financial aspects of provided care and aimed to prevent unjustified payments and deviations from contractual conditions (Health Insurance Act, 1998).

The results of the regulatory analysis also indicated that the control powers of the NHIF were clearly defined within the framework of the current health legislation governing the organization, operation, and financing of the healthcare system in Bulgaria (Health Act, 2004). According to Article 2 of the Health Act, health was defined as a state of physical, mental, and social well-being and was recognized as a national priority to be guaranteed by the state. Within this regulatory context, the control exercised by the NHIF was based on principles such as equal access to healthcare services, prioritization of prevention, protection of vulnerable groups, state participation in healthcare financing, and the guarantee of accessible medical care (Health Act, 2004; Health Insurance Act, 1998).

In this sense, the findings suggest that the control activities of the NHIF extended beyond the scope of purely financial supervision and functioned as an institutional mechanism for the implementation of state health policy and the protection of citizens' constitutional rights to healthcare. Control over the expenditure of public funds was thus established as a key instrument for balancing the financial sustainability of the system with the social and health objectives of mandatory health insurance.

Organizational and Administrative Control Mechanisms

The organizational framework of control within the National Health Insurance Fund was structured around a two-tier governance model comprising a Supervisory Board and a Governor. The Supervisory Board performs key strategic and control functions and includes representatives of the state, employers' organizations, trade unions, and representatives of patient rights organizations. This structure created institutional conditions for the participation of multiple stakeholders in the management and control of public funds in healthcare (Health Insurance Act, 1998).

Within its statutory powers, the Supervisory Board adopted internal regulations governing the activities and structure of the institution, participated in the preparation and approval of the National Framework Contract, adopted the draft annual budget, and approved reports on budget execution and institutional performance. Since 2021, these functions had been complemented by mechanisms aimed at ensuring greater predictability and financial sustainability of the NHIF budget, including the non-payment of activities exceeding the volumes and values specified in the contracts of healthcare establishments (Health Insurance Act, 1998).

Control over the implementation of contracts for the provision of medical and/or dental care, pursuant to Article 72 of the Health Insurance Act, was carried out by NHIF employees designated by order of the Governor, as well as by controlling officials within the respective Regional Health Insurance Funds. This organizational arrangement allowed for the combination of centralized management with decentralized implementation of control mechanisms at the territorial level (Health Insurance Act, 1998).

The general and specialized administrations of the Regional Health Insurance Funds supported their directors in exercising control functions through budget planning, contractual activities, reporting, legal representation, analysis of court disputes, and information services for insured people. In this way, the administrative capacity of the regional funds was established as a significant factor for the effective functioning of the control system.

The control exercised by the bodies of the NHIF is structurally and functionally integrated into the public finance system and represents a specific form of financial supervision over the expenditure of public funds. Depending on the stage of the control process, this supervision could take the form of preliminary, sudden (on-site), or subsequent control (Chilova, 2018).

Forms and Practical Implementation of Control over Medical Care

Control over the implementation of contracts with the National Health Insurance Fund is carried out through a system of inspections performed by NHIF employees and controlling officials of the Regional Health Insurance Funds. The analysis showed that the existing control framework encompassed various types of inspections differing in scope and purpose, which, according to the NHIF's approved internal instructions, could be planned

or unplanned, comprehensive or thematic, independent or joint, as well as primary and secondary (National Health Insurance Fund, 2020).

The practical implementation of control included preliminary, current (sudden/on-site), and subsequent control, carried out at different stages of the provision and financing of medical care. Preliminary control was conducted prior to the reimbursement of reported activities and included on-site inspections, documentary checks, and remote control through the NHIF Personalized Information System. Its primary objective was to verify the compliance of reported activities with regulatory requirements and contractual parameters before financing was granted.

Current or sudden control was carried out during the provision of medical care and was aimed at verifying the actual performance of medical activities. Evidence from the review suggests that this form of control assessed whether the patient was physically present at the healthcare establishment, whether approved medical algorithms were followed, and whether the reported activity met the criteria for reimbursement by the NHIF. Subsequent control was conducted after payment had been made and aimed to identify cases of unjustifiably received funds subject to recovery in accordance with the Health Insurance Act (Health Insurance Act, 1998; National Health Insurance Fund, 2020).

The study additionally identified significant limitations in the practical application of control related to the staffing of control bodies. The shortage of controllers with medical education—who were exclusively authorized to assess the quality of provided medical care—represented a serious structural problem (Health Insurance Act, 1998). The low attractiveness of these positions, driven by comparatively lower remuneration than clinical practice, high administrative workload, and the risk of professional conflicts, hindered the development of sustainable and effective control capacity. As a result of these limitations, there was a risk that control activities would focus predominantly on formal and documentary aspects of accountability rather than providing an in-depth assessment of the actual quality and medical justification of delivered care.

Financial and Budgetary Control Mechanisms at the Macro Level

The financial framework of framework contracts within the mandatory health insurance system is determined annually by the NHIF Budget Act adopted by the National Assembly, which assigns the budget a key role as an instrument for controlling public healthcare expenditures (NHIF Budget Act, 2025). Preliminary financial control was exercised already at the contracting stage, as financing was granted only to activities included in the operating license of the respective healthcare establishments. In cases of expansion of hospital medical care through the inclusion of new activities, an opinion from the NHIF regarding the feasibility of financing was required, further limiting the risk of uncontrolled expenditure growth (Health Establishments Act, 1999).

The findings demonstrated that macro-level control exercised through the NHIF budget functioned as a primary mechanism for limiting and forecasting public expenditures in the sector. Budgetary limits could be applied both at the system level and across specific subsectors, including inpatient and outpatient medical care, as well as pharmaceutical expenditures (NHIF Budget Act, 2023). Within the mandatory health insurance system, the allocation of funds for inpatient and outpatient care was carried out through specialized rules adopted by the NHIF Supervisory Board in accordance with the NHIF Budget Act for the respective year.

With regard to inpatient medical care, the rules under Article 4 of the NHIF Budget Act provided for the allocation of funds by specific activities, including clinical pathways, clinical and outpatient procedures, as well as by distinct groups of activities with indicative values, such as childbirth, hemodialysis, and oncological treatment (National Health Insurance Fund, 2025a). Exceeding the established values required additional approval, and payments were directly linked to reporting compliance and contracted financial parameters, thereby strengthening the role of the budget as a control instrument.

Amendments to the Health Insurance Act in 2025 introduced additional mechanisms aimed at limiting budget deficits, including payments to healthcare establishments only up to the contracted values and the establishment of the position of a second Deputy Governor of the NHIF to improve governance and strengthen financial control. The analysis indicated that these measures were directed toward enhancing budgetary discipline and reinforcing the sustainability of the mandatory health insurance system at the macro level.

Regulatory Restrictions as an Instrument for Cost Control

Alongside direct control mechanisms, the mandatory health insurance system also operated through indirect regulatory restrictions aimed at managing and limiting public expenditures. The analysis showed that one of the main such mechanisms was the regulation of hospital capacity through the determination of the number of hospital beds included in contracts between healthcare establishments and the National Health Insurance Fund.

After 2018, a regulatory restriction was introduced in the National Framework Contract limiting the possibility of increasing the number of beds used for activities financed by the NHIF. This restriction functioned as an instrument for controlling the volume of inpatient medical care and preventing uncontrolled growth of expenditures in the hospital sector (National Health Insurance Fund, 2023). At the same time, Article 37b of the Health Establishments Act provided for the possibility of increasing bed capacity when introducing new medical activities but only following an administrative procedure and an assessment of population needs conducted by the Ministry of Health (Ministry of Health, 2024). In this way, the regulation of hospital capacity was established as a balancing mechanism between ensuring access to medical care and maintaining the financial sustainability of the system (Chilova, 2018).

An additional regulatory mechanism concerned restrictions on physicians' participation in contracts with the NHIF. Generally, physicians were allowed to conclude no more than two contracts, with exceptions for certain medical specialties defined in the National Framework Contract for Medical Activities (National Framework Contract for Medical Activities, 2023–2025). This mechanism aimed to prevent excessive simultaneous engagement of medical professionals across multiple healthcare establishments, which could compromise the actual performance of contracted activities. In this sense, the restriction supported both more efficient allocation of human resources under conditions of workforce shortages and compliance with structural and professional standards within the system.

In response to the established shortage of medical professionals, the NHIF Supervisory Board allowed exceptions for specific specialties in which physicians could work in two inpatient healthcare establishments, typically on a part-time basis. These specialties included anesthesiology and intensive care, diagnostic imaging, clinical laboratory medicine, microbiology, clinical pathology, hematology, and nuclear medicine (National Health Insurance Fund, 2023). Compliance with these requirements was monitored at the contracting stage through verification in the NHIF information systems, including the register of medical care providers (Health Insurance Act, 2004).

Digitalization and Patient Participation as Elements of Control

The analysis showed that digitalization represents a significant factor in the development and improvement of the healthcare control system. The National Health Information System enabled the collection and processing of data on performed medical activities in both outpatient and inpatient care, while the Electronic Health Record allowed patients to monitor in near real time all medical interventions provided to them, regardless of the source of financing (Ordinance on the Functioning of the National Health Information System, 2021). In this way, conditions were created for increased transparency and more active patient participation in control processes.

The existing regulatory framework provided insured persons with the opportunity to submit complaints to the director of the respective Regional Health Insurance Fund in cases of suspected reported but not performed medical activities, low-quality care, unlawful collection of payments, or refusal of access to medical documentation (National Framework Contract for Medical Activities, 2023–2025). The findings suggest that this form of civic control remained predominantly reactive and was activated mainly after violations had already occurred, while patient participation was not sufficiently institutionalized or systematically encouraged. Despite the possibility of submitting signals in cases of discrepancies or missing data in the Electronic Health Record, the role of patients in the control system remained limited and complementary to institutional control.

As of 2025, additional electronic mechanisms for near real-time control over the prescribing and dispensing of medicinal products and medical devices had been introduced through electronic prescriptions, electronic prescribing, and integrated data exchange between healthcare establishments, pharmacies, and relevant institutions (National Health Insurance Fund, 2025; Ministry of Health, 2022). Despite the progress achieved, a fully implemented central analytical module enabling automated real-time control over all inpatient activities was still lacking. The analysis showed that such functionality was envisaged in strategic documents for the development of the National Health Information System but had not yet been fully implemented (Strategy Portal of the Republic of Bulgaria, 2023).

In view of the presented results and with the aim of systematizing the identified mechanisms, effects, and limitations, Table 1 summarizes the main forms of control over public expenditures within the system of the National Health Insurance Fund.

Table 1. Main mechanisms for controlling public expenditures in the NHIF system – summary of results

Level of control	Main mechanisms	Practical implementation	Key effects	identified	Main limitations
Institutional and organizational	Supervisory Governor, Health Insurance Funds (RHIFs), administration	Board, Adoption of budget Regional allocation rules, National Funds Framework Contract, internal contractual activities and reporting	Ensures formal governability and regulatory compliance	Complex structure, risk of administrative burden	
Financial and budgetary (macro level)	NHIF Budget Act, budget ceilings, indicative values	Expenditure limitation by subsectors and activities	Controls growth of public expenditures and budget deficit	Limited flexibility in relation to actual healthcare needs	
Contractual and operational	Planned, unplanned, preliminary, current, and subsequent inspections	Control of reported medical activities and payments	Reduces the risk of unjustified payments	Predominantly documentation-based control	
Regulatory	Restrictions on hospital bed capacity, limits on physicians' participation	Regulation of hospital volume and workforce allocation	Balances of access to care and financial sustainability	Dependence on administrative assessments and exceptions	
Human resources	Requirement for medical qualification of controllers	Assessment of the quality of medical care	Ensures professional evaluation of healthcare services	Shortage of qualified personnel	
Digital	National Health Information System, electronic health records, e-prescriptions	Real-time or near real-time monitoring and transparency	Increases accountability and traceability	Lack of a centralized analytical module	
Citizen (patient) participation	Complaints, signals, access to electronic health record	Complementary institutional control	Limits informal and non-compliant practices	Depends on patient awareness and engagement	

The summarized results indicated that the healthcare control system functioned as a multilayered mechanism combining institutional, financial, regulatory, digital, and citizen-based forms of control. Although this model contributed to limiting financial risks and increasing accountability, the analysis also identified a number of structural constraints related to the predominantly documentary nature of control, shortage of qualified control personnel, limited flexibility of budgetary mechanisms, and incomplete digital integration.

On this basis, attention should be directed toward strengthening the analytical and qualitative component of control, developing centralized digital tools for real-time analysis, improving the staffing capacity of control authorities, establishing a clearer link between regulatory restrictions and the actual healthcare needs of the population, and enhancing patient involvement in control activities. These directions provide a logical foundation for a subsequent discussion on the effectiveness of the existing mechanisms and for formulating recommendations for their improvement.

Conclusion

The control activity of the National Health Insurance Fund plays a key role in the management of public healthcare funds and in ensuring legality, accessibility, and quality of medical care. The analysis showed that Bulgaria has developed a relatively advanced regulatory and institutional framework for control, including preliminary, current, and subsequent inspections, budgetary mechanisms, regulatory restrictions, electronic traceability systems, and formally regulated opportunities for patient participation.

At the same time, the system faces a number of challenges, including a shortage of medically qualified controllers, limited capacity for real-time control over inpatient care, incomplete integration of information systems, and the

need for more effective inter-institutional coordination. The analysis also showed that, despite the existence of legally established mechanisms, patient participation in control remained limited and predominantly reactive, not sufficiently institutionally supported or systematically utilized as a source of control information. This highlights the need for modernization of the control function not only through regulatory amendments, but also through strategic development of human resources, implementation of automated analytical tools, and a targeted expansion and structuring of the patient's role in the control process.

The study contributes to the systematization of NHIF control mechanisms and outlines specific directions for their improvement in the context of the digital transformation of healthcare. Further development of control within the mandatory health insurance system represents a necessary condition for building a more transparent, sustainable, and socially legitimate healthcare system that simultaneously protects patient rights and ensures efficient management of public resources.

Recommendations

Based on the findings of the present study, several key directions for improving the control system within the mandatory health insurance framework in Bulgaria can be formulated. First, it is recommended to strengthen the analytical and qualitative dimension of control by shifting the focus from predominantly documentary verification toward outcome-oriented and clinically meaningful assessment of medical care. This requires the development of more advanced methodologies for evaluating medical necessity, treatment effectiveness, and quality of care. Second, the establishment of a centralized digital analytical platform within the National Health Information System is essential. Such a system should enable real-time data processing, cross-institutional integration, and automated detection of irregularities in the provision and reporting of medical services, thereby enhancing preventive control capabilities. Third, improving human resource capacity within control structures is necessary. This includes increasing the number of medically qualified control specialists, introducing targeted incentives to attract healthcare professionals to control functions, and ensuring continuous professional training in both clinical and regulatory aspects of healthcare oversight. Fourth, regulatory mechanisms should be more closely aligned with population health needs. In particular, restrictions related to hospital capacity, resource allocation, and contractual limits should be periodically reassessed based on epidemiological data, regional needs, and healthcare demand indicators in order to ensure a better balance between financial sustainability and access to care. Fifth, patient participation in the control process should be strengthened and systematically institutionalized. This may be achieved through improved accessibility and usability of electronic health records, structured feedback mechanisms, and the integration of patient-reported data into formal control procedures. Finally, inter-institutional coordination between all bodies involved in healthcare oversight should be enhanced. A more integrated approach involving the National Health Insurance Fund, Ministry of Health, National Revenue Agency, and other control institutions would reduce fragmentation, improve information exchange, and increase the overall effectiveness of the control system. These recommendations aim to support the transition toward a more efficient, transparent, and technologically advanced control system that ensures both financial sustainability and high-quality healthcare delivery.

Scientific Ethics Declaration

* The authors declare that the scientific ethical and legal responsibility of this article published in EPHELS journal belongs to the authors.

Conflict of Interest

* The authors declare that they have no conflicts of interest.

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