REVIEW REPORT

External Review of the project "Home Care towards an Independent and Dignified Life"

Bulgarian Swiss Cooperation Programme

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Executive summary

The external review of the project “Home Care towards an Independent and Dignified Life” of the Bulgarian Swiss Cooperation Programme aimed at providing an independent assessment of the project’s major outcomes. To this end the external review is framed around the OECD Development Assistance Committee’s criteria for evaluating development assistance: relevance, effectiveness, efficiency, and sustainability. These four domains are assessed at both the project and national level using both existing secondary (e.g. documents generated during the project) and primary data (e.g. interviews with key stakeholders).

Concerning the **relevance** at both project and national level, the external review concluded that the services are recognised as fulfilling needs that are priority for all stakeholders involved, such as providing integrated home care services to older people, people with chronic diseases and disabilities and other vulnerable groups such as Roma population. Home-based medical and social care services are generally recognised as a viable alternative to institution-based services for the provision of adequate care in the community.

As far as **effectiveness** is concerned, there is evidence that the project has successfully improved access of older people, disabled persons and other disadvantaged groups to home care services, while at the same time providing employment opportunities for unemployed people and members of the Roma community. Furthermore, the care provided seems to be of a good quality standard. There are still, nonetheless, some gaps in needs covered, namely palliative care, and care provision on weekends. Due to the lack of a comparison group it was not possible to fully determine the impact of the project on health-related quality of life of users.

At the time of the external evaluation there is little available data that allows for the assessment of the **efficiency** of the project. An earlier cost-pricing study estimated the average monthly cost per patient to range between 184 and 268 Leva, depending on different scenarios. This cost was considered high, but it was not possible to compare it with other services addressing similar needs (e.g. hospital settings or institutional care). One possible factor impacting the efficiency of the project is the time spent by staff travelling between users, due to the lack of adequate means of transportation.

Finally, concerning **sustainability**, the amended Health Law of 2015 created the legal condition for providing nurse-led services at users’ homes. The required ordinances regarding education, quality standards and financing models are still being developed. There were concrete measures implemented in terms of the defining quality standards and measurements in the home care centres and adapting the legislation to reflect training needs of homehelpers. The financial sustainability of the project has not yet been assured as the necessary legislation regulating the financing of home care services has not yet been passed and it is unlikely that users or municipalities will be able to finance home care services in the future. The current lack of data on the efficiency and cost-benefit of the project *vis-à-vis* other forms of care has also limited the possibility of the National Health Insurance Fund and other national funds to finance home care services. Such information would also aid the development of a flexible model of integrated services for scaling up beyond the four centres, taking into account different demographics, needs and infrastructure.

1. Introduction

1.1. Project outcomes

The external review of the project “Home Care towards an Independent and Dignified Life” (2012–2017) of the Bulgarian Swiss Cooperation Programme provides an independent assessment of the project’s three major outcomes with the overall objective “to improve quality of life of elderly people with chronic diseases and disabilities through the provision of institutionalized home-based health and social care”:

> Outcome 1: Advancing the institutional framework for sustainable provision of home care services in Bulgaria
>
> Outcome 2: Improving access to home care services for older people with chronic diseases and disabilities, including other vulnerable communities (Roma)
>
> Outcome 3: Introducing quality measurements in the provision of home care services in the model project in Vratsa

The reviewers relate these outcomes to indicators of both qualitative and quantitative nature and investigate whether the project made progress towards these outcome indicators if data are available. The review serves learning, capitalization and accountability purposes.

The review is organized around the OECD Development Assistance Committee’s criteria for evaluating development assistance: relevance, effectiveness, efficiency, and sustainability at both the project and national level:

1. **Project level:** The external review assesses the relevance, effectiveness, efficiency and sustainability of the Home Care Centres within the four municipalities of Vratsa. The review team visited two centres, the one in Vratsa and the one in Oryahovo.
2. **National level:** The external review assesses the national relevance of the pilot project for implementation at a large scale. The external review also investigates the reform efforts and advocacy work towards legislating sustainable provision of home care and assistance services as well as the reform efforts towards national quality standards for health and social care at home. One goal of the review was to assess how advocacy efforts influenced the policy dialogue.

Table 1: Organization of topics

	Project level	**National level**
Relevance	Relevance on project level	Relevance on national level
Effectiveness	Effectiveness on project level	Effectiveness on national level
Efficiency	Efficiency on project level	Efficiency on national level
Sustainability	Sustainability on project level	Sustainability on national level

1.2. Core topics of the review

The review team identified the following core topics underlying the review:

1. **Cross-sectoral integration**: the degree to which health and social services are integrated. In addition to the health and social sector, cross-sectoral issues may also include the education sector, especially when integrated services are expanded to include young adults and children.
2. **Sustainability** of home-based medical and social care services for older people and people with disabilities developed by the project, in a long-term perspective at both local and national level.
3. **Financial viability:** Sustainability also includes the issue of financial viability as models will need to be developed that financially anchor the integrated services in Bulgaria, at the community, local, and state level.
4. **Cost-effectiveness measures:** relating costs to various outcomes. Furthermore, cost-benefit studies would reveal evidence on cost-saving for society, by improving independency, prevention or postponement of functional decline and reducing major risk factors (e.g. hospitalization, institutionalization) in the long run.
5. **Quality of service delivery**: measurements of quality are a necessary condition for scaling up and large-scale implementation.
6. **Addressing needs of target groups**: includes the elderly, people with chronic diseases and disabilities, vulnerable groups (Roma population, people below the poverty line).
7. **Reform efforts**: in providing nurse- or social worker-led (instead of physician-led) services in the home environment, thus promoting the deinstitutionalizing and decentralizing of health and social care services.

2. Review methodology

The methodological considerations are based on the handbook by M. Bamberger, J. Rugh, L. Mabry (2006). *Real World Evaluation. Working under budget, time, data, and political constraints.* One goal of the external review was to optimize available resources (financial, time limitations), given data and political constraints for providing the best evidence for the project outcomes.

2.1. Data Sources

Documents and interviews are the main data sources. Furthermore, existing quantitative data such as demographic information or cost-estimations may serve as additional sources.

2.1.1. Documents

Documents include annual reports, progress reports, legislative and strategic documents, as well as consultancy reports, as provided during the desk review and during the missions to Switzerland and Bulgaria.

Documents represent already existing information and therefore minimize cost and effort for data collection. Documents containing personal or sensitive information were treated confidentially. Documents available in Bulgarian language only, such as the National Health Strategy, were analysed by the Bulgarian expert.

2.1.2. Interviews

During the field mission to Bulgaria, the review team conducted individual and group interviews. The goal was to elicit information about the different stakeholders' understanding and assessment of the project. The interviews followed a semi-structured format. The review team prepared an interview protocol with carefully drafted interview questions tailored to each interviewee group (cf. Roster of interviewees in Appendix 6.3 Mission Programme to Bulgaria). The semi-structured protocol allowed for flexible use in order to focus on topics emerging during the interview process. Ms. Kahlert was the primary conductor of the interviews, while Ms. Peteva asked follow-up questions. Both reviewers took notes. Upon obtaining consent, interviews were audio-recorded. All but one interview were permitted to be recorded. The recordings were not transcribed, but served a backup purpose during data analysis. To make the schedule work, Ms. Kahlert and Ms. Peteva split the load of the interviews with home-care users and conducted them independently. Interviews were not recorded to reduce user anxiety.

Individual interviews lasted between 45 and 50 minutes. They allowed for an in-depth focus on one person.

The group interviews lasted between 60 and 75 minutes. They allowed interviewees to hear and respond to each other's statements as well as to further their understanding of the issues. Most interviewees of a group interview knew each other from committee work and other settings. One drawback could

be that less outspoken individuals may be more silent. The interviewer may therefore directly prompt those individuals.

In the review report, interviewees are quoted by their role followed by the date.

2.2. Comparative data analysis

Data analysis was based on documents and interviews as the main sources and therefore is qualitative and inductive in nature. In an iterative effort, the different data sources were compared with each other and weighted in order to create a comprehensive picture of the project and its outcomes. The external review captures the project outcomes in relation to their institutional framework and socio-political context.

2.2.1. Triangulation

The external review is strengthened by triangulation of various sources and informants, data collection and analysis methods, and of reviewers. According to the OECD definition (cf. box), triangulation seeks to overcome bias that stems from just one source or method.

Triangulation

The use of three or more theories, sources or types of information, or types of analysis, to verify and substantiate an assessment.

Note: By combining multiple data sources, methods, analyses or theories, evaluators seek to overcome the bias that comes from single informants, single methods.

OECD DAC 2002, 37

- **Triangulation of sources and informants:** The review team utilized various secondary – i.e. already existing – data sources including monitoring data (annual reports, progress reports), legislative and strategic documents, as well as consultancy reports. The review team also gathered primary data via interviews. The interview data stemmed from various stakeholders and informants who reported about certain issues from different viewpoints. The review team discerned and reconciled the informants' positions between each other to arrive at a comprehensive understanding of what the project is about, what it has achieved and what its challenges are.
- **Triangulation of data collection methods:** During the field mission to Bulgaria, the review team utilized two primary data collection methods: the individual interview and the group interview.
- **Triangulation of analysis methods** took place using document analysis during the desk review, qualitative analysis of interview data, as well as quantitative analysis of available data across the various sites if available.
- **Triangulation of reviewers** was built into the review. The Bulgarian expert noticed different things than the international team consisting of three persons with multidisciplinary backgrounds.

2.2.2. Evaluation norms

Following the *UN Evaluation Group's Norms and Standards for Evaluation* (2016), we stressed the following norms during the evaluation process:

1. **Independence and impartiality:** The members of the external review team are independent and approach the project from an external, unbiased perspective.
2. **Utility:** The review team ensured the review findings to be useful for the stakeholders. The findings should inform the decision-making process in a timely manner.
3. **Human rights and gender equality:** The review team integrated principles of human rights and gender equality into the review stages. The interviewers conducted the interviews with the highest standard of integrity and respect.

2.2.3. Limitations

The review took place at the end of the project implementation, at which stage all primary data were collected. Longitudinal data collection such as about the change in user's perspective was not possible. Equally a comparison group of elderly not using the services for the purpose of effectiveness analysis was also not available. Findings are based on one point in time as well as historical documents obtained primarily via SDC.

The interviews during the field mission provided information about the perspectives, perceptions, and judgments of the interviewees (cf. Bamberger et al., 284). They did not directly answer questions regarding cause and effect of the project, e.g. with respect to effectiveness of services. Questions surrounding sustainability and outcome regarding the advancement of the institutional framework are more answerable as these are based on people's perspectives.

Due to time limitations, the review team only visited two of the four home care centres. The users and other stakeholders were selected by the centre staff and thus did not represent a random sample of users and other stakeholders. However, they still provided an initial overall impression of how project services are accepted in the community.

Some selected participants could not be interviewed. In particular, the interview with Dr. Daniela Daritkova, Head of the Health Commission of the Bulgarian Parliament, scheduled for 27.10.2016, could not take place. Furthermore, Penka Nikolova and Dilyan Borislav, representatives from the National Agency for Vocational Education and Training, and Dr. Stoyan Borissov, Chief Secretary of the Bulgarian Doctors' Union, did not participate in the group interviews on 26.10.2016. These individuals could not be asked at a later point in time. The missing perspectives of these stakeholders could slightly affect the tendency of the findings.

3. Review findings by topic

The review findings are organized by the OECD Development Assistance Committee's criteria for evaluating development assistance: relevance, effectiveness, efficiency, and sustainability at both the project and national level.[1]

3.1. Relevance

The relevance is about the extent to which the project is suited to the priorities and policies of the target group, recipient and donor. The relevance at the project and the national level are congruent. The challenging issues of an increasingly ageing population compared to a declining working population, the growing number of socially disadvantaged people, the closing of hospitals and the shortage of GPs lead to an insufficient number, reach and type of services for the elderly with chronic diseases and disabilities, in particular for vulnerable groups including Roma. Integrated home-based health and social services respond to this need and therefore are highly relevant to the target group.

These integrated services are especially relevant in the Vratsa region because it is one of the poorest regions in Europe, having low socio-economic indicators including high morbidity rates and a high population of disadvantaged Roma.

3.1.1. Relevance at the project level

> *"It's not just a project, but a mission.[..] I cannot imagine that it will go to the dogs."* – Manager, Vratsa, 26.10.2016.
>
> *"We have a moral feeling that we are useful to society"* – Staff, Oryahovo, 27.20.2016.

All four centres are well-established in serving the local needs and therefore highly relevant to the local communities. The Vratsa staff is highly motivated by the usefulness and relevance of its service provision, which is much more than a regular job. Users welcome them into their homes like relatives.

In the Vratsa region, local stakeholders could not identify any comparable project or programme that would simultaneously address health and social needs. There is currently a home assistant project funded by the Human Resources Development Operational Programme (HRDOP), but the medical component is extremely small, averaging merely 20 hours per month for 195 users, which would be an average of 6 minutes per month per user (Representatives, Municipal Services & Regional Health Inspectorate, Vratsa, 26.10.2016).

A high need for integrated services is found in Oryahovo where the local hospital closed five years ago. The elderly were left without a "safety net", which the home-care programme has been able to provide (Mayor, Oryahovo,

[1] Impact as the fifth DAC criterion was not mentioned in the Terms of Reference and would also cover unintended, negative consequences. The review team subsumes impact under effectiveness.

27.10.2016). The Mayor of Oryahovo reported that only 30 to 40 percent of the current needs may be addressed with local services.

Home care services are recognized at the project level. In the final debriefing of the Bulgaria mission (28.10.2016), the home care project was regarded as very visible and successful at the project level according to the Council of Ministers. The services are recognized as an appropriate model among the public and various stakeholders in the two communities that the review team visited. A GP in Vratsa mentioned how she is confronted with the need for this project on a daily basis because her elderly patients are in dire need of such services (26.10.2016).

Services are tailored to the needs of Roma communities and are accepted by them. Roma users in Oryahovo expressed their heavy reliance on and satisfaction with the services. In fact, they also expressed their willingness to financially contribute to the home care services if necessary because they reported that they could not live without them (27.10.2016).

Home care services integrate representatives of the Roma community by training and employment. Interviews in the Vratsa community indicated that the project team is effectively integrating Roma staff as valuable team members (26.10.2016). In fact, the presence of Roma staff also raises awareness of the needs of Roma users.

Home care services satisfy the demand for integrated services. Demand for integrated services seems to have been met to the most of the capacity of the home care centres. There is, however, still some unfulfilled demand in the local communities and some of the neighbouring, remote localities, as attested by the presence of waiting lists to access the services. Potential users of certain remote localities cannot be accepted into the project due to transportation challenges and access problems (c.f. 3.3.1).

3.1.2. Relevance at the national level

According to the Social Assistance Agency of the MLSP, there is a high number of people in Bulgaria who need home care services (State Expert on Social Inclusion, MLSP, 25.10.2016).

Home care services are widely recognized at the national level with some public hesitation. The services are already widely recognized as an appropriate model among national and regional partner institutions and relevant stakeholders. A national information campaign (national TV and radio reportings) aimed at broad popularization of home care services among the public and relevant institutions, was carried out (Annual Report / AR 2015).

However, according to the Director of the Medical Activities Department of the Ministry of Health, home care services are still not the preferred way of elderly care in the Bulgarian communities (25.10.2016). She also mentioned that Bulgarian families still seem to prefer placing the elderly in nursing homes, according to a poll by the Sofia municipality.

Furthermore, the old system of home care during the Communist Regime was doctor-led. Bulgarian users still want a doctor to be part of home care, as they would expect it for medical emergency situations, and/or a nurse – for medical observation and prevention services. According to the Director of the Medical

Activities Department of the Ministry of Health (25.10.2016), clients eventually started accepting paramedics as part of the emergency team, and a similar approach may be used for home care, similar to the UK example where paramedics are used.

Home care services are differentiated from other services. The Health Act Amendment (Article 125b, cf. Appendix 6.5) was adopted in September 2015 allowing for integrated medico-social services in the home environment, which not only included services to the elderly, but also to children, pregnant women and people with disabilities and chronic conditions. Before, nurses were operating in a grey area of providing services at people's homes without supervision by a physician (Manager, Vratsa, 26.10.2016). The National Health Strategy 2014–2020 calls for cross-sectoral, integrated services including social and health services. The National Strategy of long-term care is already developed, which includes integrated cross-sectoral services and efforts to transition from institutional care to community-based, integrated services to improve quality of life. A plan for its provision is at the stage of preparation.

The differentiation from other services is still regarded as a continuing challenge when people are not yet familiar with the concept of integrated home care services (Head of the Central Coordination Unit of the Swiss-Bulgarian Cooperation Programme, Council of Ministers, 25.10.2015). But as soon as they learn about it and understand it, they realize how important integration is (Deputy Director, BRC, 24.10.2016). Integration occurs at several levels: Whereas nurses accompany the user to the GP and check their medications, home helpers bring the prescription to the pharmacy to obtain the medications as well as remind and prompt users to take them (Manager, Oryahovo, 27.10.2016). Collaborating as a cohesive team, nurses and home helpers interact on a daily basis as regards the health and general status of users, especially when a problem arises.

Relevant stakeholders are committed to and involved in the reform process. Working groups in health and social policy include representatives from various ministries, unions and professional organizations, which the review team talked to during the Bulgaria mission (see also 3.4.2 sustainability at national level).

3.2. Effectiveness

Effectiveness is a measure of the extent to which a project has attained its objectives. Effectiveness could not be assessed by using baseline and follow-up data for the project users, as well as for a group of elderly who did not receive services. Therefore, assessment of effectiveness is primarily based on a general impression of the review team. The project appears to have a positive effect on users.

3.2.1. Effectiveness at the project level

"The people brought me back to life" – User, Vratsa, 26.10.2016.

The user explained how sickness and a blow of fate made her unable to leave the bed, let alone her home. After one year of practising with nurses and home helpers, she is

now capable of leaving the house on her own and visiting the nearby park. The length of each home helper's visit could be gradually reduced.

> *"The project is vital and life-saving for many people… Keep fighting the good fight!"* – General Practitioner, Vratsa, 26.10.2016.

During the roundtable at the Vratsa region in June 2016, local and regional stakeholders expressed their satisfaction with the project. The three mayors present expressed high approval of the project.

Home care services facilitate access for the elderly, including elderly from the Roma community and distant locations. According to the latest available information (Semi-annual Report, September 2016), a total of 432 persons receive care from the four home care centres at the time of the report, of which 85% are above 70, 10% are Roma and 28% live in distant locations. The latter two figures provide some indication of acceptance by the Roma community and of coverage of needs in isolated areas, respectively. Some needs for care remain unmet in the community. The demand for the services provided by the home care centres currently outweighs the supply, and there is a waiting list. However, it is worth bearing in mind the dearth of incumbent providers at the start of the project and the level of unmet needs at the baseline.

The home care centres focus on employing the unemployed and Roma. All of the Oryahovo staff were unemployed due to the closure of the local hospital a year earlier (Manager, Oryahovo, 27.10.2016). One centre had difficulties recruiting medical nurses from the community as none were available. About a quarter of the staff employed is of Roma origin, which further attests to the ability of the project to integrate this community into the wider beneficiaries of the project. At first, working with long-time unemployed was challenging at the Vratsa Centre, as they had lost their work habits and had hardly ever worked in a team before, but over time the integration succeeded by sharing a common goal and mission (Manager, Vratsa, 26.10.2016). The turnover rate among nurses and helpers is low, with the exception of the centre in Krivodol.

Quality standards and a system of monitoring exist for the provision of home care at the project level. Based on the available documents and according to the project's medical coordinator (24.10.2016), there is a system in place to document and monitor the quality of services provided. Quality is ensured at the four centres via several tools: Protocols for actions and handling of users, technical steps for actions, algorithms of actions during defined (crisis) situations, monitoring visits on behalf of the centre manager with family members and users, direct feedback from the users, as well as the selection criteria used by local committees for users' and staff selection. Home helpers follow protocols as well as a text book and are supervised by nurses. The Regional Health Inspectorate monitors the safety of devices and work in all four centres including sterilization of instruments and disposal of hazardous waste. Accessible safety instructions are mounted to the walls, log books are utilized for recording the sterilization of instruments. There have been no written complaints regarding hygiene and safety since the project start in 2012 (Deputy Director, Regional Health Inspectorate, Vratsa, 26.10.2016). According to Andrea Hornstein, a Swiss expert from Spitex, the quality and standards of care provided by staff of the home care centres were assessed as being of sound quality (13.10.2016).

A software system for the organization of the services, documentation and reporting was developed and applied in the work of the four centres. It helped the local management teams to analyse and plan the service provision in a more effective way with regard to the users' health condition, the time needed for the services and the transportation time. The review team got acquainted with the software system in Oryahovo.

The home care centres operate from Monday to Friday from around 9am to 5pm. Because they cannot operate around the clock during each day of the week, some users may not always have their ends meet. To that purpose, home helpers ensure on Fridays that sufficient food and supplies are available, but ideally neighbours and relatives care for the users on the weekend. Fridays and Mondays therefore often require a higher workload for centre staff due to additional tasks to be performed (Nurse, Vratsa, 26.10.2016).

The Swiss and Bulgarian Red Cross provide training for nurses and home helpers according to standards. The BRC has a National Training Centre for nurses and home helpers in Lozen, near Sofia, licensed by the National Agency for Vocational Education and Training (NAVET). Staff members undergo a mandatory training (160 hours for nurses and 120 hours for home helpers) and receive continuous training in additional competencies such as palliative care and dementia care by Swiss experts (Spitex representative, 13.10.2016). Training for care managers is still needed (AR 2015). The training provided to staff allows not only for health but also social needs to be met – both of which are at the core of long-term care. The needs for further training of personnel include Kinesthetics.

Innovative systems were piloted. The home care centres also allowed for the pilot experiment of tele-monitoring initiatives, which were linked with medical facilities. These initiatives not only hold some promise in themselves (e.g. to address current unmet needs concerning around-the-clock care), but also show the potential of the home care centres to act as hubs of innovation in the area of care in Bulgaria.

3.2.2. Effectiveness at the national level

Effectiveness at the national level has not been assessed yet, but could be extrapolated from the experience of the four communities served. Improved access to home care services for older people with chronic diseases and disabilities including vulnerable communities such as Roma, would most likely occur if services were offered.

Quality standards at the national level are not yet developed for providing integrated home care services. Mechanisms of monitoring, control and quality management are called for in the NHS 2014–2020. Quality standards are currently being developed as ordinances by MLSP. Those standards would also make it easier to assess the quality of service delivery in the current four centres (Deputy Director, Regional Health Inspectorate, Vratsa, 26.10.2016).

Educational requirements for service providers are ready for approval. State Educational Requirements for the Social Assistant profession were approved by the Management Board of the National Agency for Vocational Education and Training (NAVET) in November 2015 and wait for the already

delayed approval by the Ministry of Education and Science, still expected to occur in 2016 (Deputy Director, BRC, 24.10.2016).

The dual vocational education system (Swiss system) is on its way. On the one hand the dual education system is still unattractive and would be insufficiently paid in Bulgaria (AR 2015). At the same time, in April 2015 the Thematic Fund Agreement for the implementation of the project "Swiss support for the introduction of the dual system of vocational training in Bulgaria" under the Bulgarian-Swiss cooperation programme was signed (http://archive.eufunds.bg/en/page/816). The main objective is to create a working model to build the required capacity for introducing a dual system of vocational education in Bulgaria using relevant Swiss experience. The project will be implemented by the Ministry of Education and Science in partnership with the Ministry of Labour and Social Policy (MLSP) and the Ministry of Economy. Major partners are the Swiss Federal Institute for Vocational Education and Training and the Bulgarian-Swiss Chamber of Commerce. The project will be implemented by the Ministry of Education and Science in partnership with the MLSP. In addition, the new Act for Preschool and School Education (October 2015) and the Strategy for Development of the Vocational Education for the period 2015–2020 both declared the dual education as a form of education and as one of its priorities (http://www.mon.bg/?go=page&pageId=7&subpageId=57).

3.3. Efficiency

Efficiency measures outputs – qualitative and quantitative – in relation to inputs. It signifies that a project uses the least costly resources possible in order to achieve the desired results. This generally requires comparing alternative approaches to achieving the same outputs, to see whether the most efficient process is adopted. In the case of this project, this comparative approach has not been performed due to lack of sufficient information. In this report, efficiency also includes the issue of cost-effectiveness as relating costs to various outcomes.

3.3.1. Efficiency at the project level

Transportation time has declined since 2012 due to optimization of logistics, but remains a source of inefficiency. The centres increased the number of users served with the same number of staff members by over 25 percent from 341 in 2013 to 432 in 2016 (AR 2013, Semi-AR 2016). The reports indicate that in the beginning a significant share of the staff's working time was spent travelling by foot from one user to another. According to home helpers in Vratsa, walking time between users can be still as much as 20 minutes (26.10.2016). The transportation time increases in winter as the weather deteriorates the walking conditions on roads and paths (Manager, Oryahovo, 27.10.2016). Although the project operates with one vehicle per centre, it seems clear that this is insufficient and further means of locomotion would be needed in view of the limited accessibility of public transportation in the area. This could contribute to increasing the supply of care by the home care centres and to serving more distant and isolated locations. One centre is able to use bikes from early spring to late autumn. As a mitigating circumstance, it is worth

bearing in mind the effort by the centres to reach more isolated users in view of the absence of other care providers, which also has an impact on transportation costs.

The home centres have not implemented a formal referral system. Potential users are referred to the centre through various channels, such as word of mouth, GPs or other service providers including the municipality. The centres have established a certain profile in their service area (BRC Regional Director, 26.10.2016). The local commission for users' selection selects the applicants that are in greatest need based on predefined criteria. These criteria include level of income, health status, age, and participation in concurrent services.

An informal system of feedback by users and their relatives exists. The degree of involvement of users or their relatives in the provision of feedback varies. The centre manager makes control visits to obtain direct feedback from users. The software system of the centres contains the contact information of relatives, which is used in emergency situations or when care changes need to be implemented with respect to the users. Many relatives live out of town and entrust the care to the staff. Sometimes relatives call when they are unable to get in touch with the elderly person. If relatives are nearby, staff informs them how to stimulate and care for the elderly user in between visits by centre staff. This holds especially true for users with dementia (Manager, Vratsa, 26.10.2016). Nonetheless, the involvement and targeting of informal carers remains a weak point in the care process. The inclusion of informal carers in the scope of the home care centres is not only relevant in view of their importance for the provision of care and as users of care themselves, but could also improve the efficiency of care provision and enhance the social impact of the centres.

Volunteers are not yet involved in the two centres visited. In fact, the recruitment, training, quality control and retaining of volunteers is regarded as an added burden to the home care centres. One centre cooperates with a Swiss-funded volunteer project where young retirees get trained by the Bulgarian Red Cross to provide comfort and company to the elderly (BRC Regional Director, 26.10.2016).

There is a system of communication and information exchange established between the home care centres. Regular exchanges and communication take place between the existing home care centres about two to three times a year (e.g. two such meetings took place in 2015). In between meetings, centres keep in touch via Skype, email and phone. Topics of discussion are primarily user situations and how to best address them (Manager, Vratsa, 26.10.2016). With respect to the software documentation system, the information from a particular centre is not directly accessible to the other centres, but the information flows via the BRC-based coordination in Sofia. The communication and information exchange between home care centres therefore seems to be used more in the context of improving effectiveness rather than as a tool to improve efficiency and benchmarking between the centres.

Home care centres cooperate with GPs. There is evidence of linkages being established with other health care providers, namely GPs. At the beginning, the relations were strained due to misunderstandings by the GPs that services were

a competition to them (Manager, Vratsa, 26.10.2016; Manager, Oryahovo, 27.10.2016). From one GP's perspective the nurses are now regarded as competent in working with patients at home and carrying out such tasks such as giving injections, changing bandages and administering therapy (GP, Vratsa, 26.10.2016). Furthermore, in one centre the linkages with GPs may have also evolved to include some task-shunting such as laboratory work to the centre's nurses – with an added burden for the latter.

There is not necessarily a system of coordination between home care centres and medical facilities. Hospitals seem aware of the services, but do not refer potential users (BRC Regional Director, 26.10.2016). Typically, potential users are released from the hospital and upon visiting their GP may be then referred to home care services. In Oryahovo the hospital closed prior to the opening of the home care centre, so there is no local hospital, for which the home care centre is partially compensating. The Vratsa Centre has a contract with the local hospital regarding the hazardous waste.

Rotation of staff. All four centres implement the rotation principle of staff. The reasoning behind this practice is to manage the potential emotional burden or attachment of nurses and home helpers who are frequently in contact with users who have no family members close by (Staff, Vratsa, 26.10.2016; Manager, Oryahovo, 27.10.2016). The rotation also aims to ensure flexibility in scheduling and optimizing transportation time as each user has his/her own schedule.

At the same time, there are no data about the users' opinion and satisfaction related to the rotation principle of staff. The staff was faced with some complaints in the beginning of the service provision regarding the rotation, but hadn't analysed what was the continuing tendency during the project lifetime. During the review visit, one user explicitly expressed dissatisfaction with rotation:

> *The home helper has to be one and the same for one user. It takes me time to explain what I need for the day each time to a different home helper. This is not a problem for the nurses, they know what to do and how. But this is not a serious problem; it is only my proposal… The end of the service would be my emotional death…* – User, Vratsa, 26.10.2016.

From the perspective of service quality, rotation of staff did not seem to impair service quality, with following quality standards and regularly communicating among staff. However, from the perspective of personal preference, users would prefer staff continuity over staff rotation. This tension still would need to be resolved.

Recording actual service provision seems to be an inefficient process. Centre staff record their service provision four times, indicating a duplication of efforts. First, they record information about their services provided in their paper notebooks and on the user form at the user's home. At the centre's office, they enter the same information on a paper form as well as electronically on a shared computer. Only one shared computer is currently provided to nurses and home helpers respectively, so they need to take turns after their work day with users to enter the information. Staff expressed their desire for an electronic hand-held device that would allow them to enter the data only once and thus reduce the administrative burden (Vratsa staff, 26.10.2016).

3.3.2. Efficiency at the national level

The cost-effectiveness and cost-benefit of integrated home care services are not yet fully established. A study on cost-effectiveness by the Swiss and Bulgarian Red Cross (2015 & 2016) was conducted with data from the start of the project. The average monthly cost per patient was perceived as rather high, equalling between 184 and 268 Leva, depending on different scenarios. Institutional care per elderly is typically above 500 Leva per month, according to a study by the Council of Ministers. Regarding effects of home-based care on health care utilization, initial findings show that use and frequency of clients' visits to a General Practitioner as well as ambulance calls significantly declined after enrolling in home care services. In order to calculate the exact cost savings for the health care system, one would need to conduct cost-benefit studies, which would provide valuable evidence for justifying public health funding (e.g. from the National Insurance Fund) for home care services in the future. By the end of February 2017, a cost-pricing and -effectiveness study with newer data is expected to be ready, according to Dr. Todorovska of the Bulgarian Red Cross (27.10.2016), that will compare integrated services to services addressing similar needs (see also 3.4.2 sustainability at the national level).

3.4. Sustainability

Sustainability is concerned with measuring whether a project's benefits are likely to continue after donor funding has been withdrawn. Projects need to be structurally as well as financially sustainable. In the case of the home care project, the question arises what will happen to the four home care centres after April 2017 when SDC funding will cease. Furthermore, sustainability also relates to the question whether the expansion of the services to other regions would be feasible.

Regarding financial sustainability, one needs to distinguish between the mid-term and long-term perspective. According to the Head of the Central Coordination Unit of the Swiss-Bulgarian Cooperation Programme (25.10.2016), steps on a mid-term level have already been taken (still without official decision) in order to continue and enlarge the BRC project with external funding until national funding would start, presumably in 2020 – the latter would be the long-term, Bulgarian-funded perspective.

3.4.1. Sustainability at the project level

Regarding structural sustainability, the four centres have built the required infrastructure and staffing to continue quality services. In fact, their efficiency and effectiveness has most likely increased over time.

With respect to long-term financial sustainability, two sources at the project level were discussed during our visit:

Municipality. According to the Head of the Health and Social Activities Department of the Municipality of Vratsa, no resources will be available from the municipality once the project will be discontinued in April 2017 (26.10.2016). Compared to other municipalities, Vratsa is extremely poor and therefore cannot afford to contribute financially to an additional service. Instead, the

municipality proposes to augment the already existing municipal hot meal delivery service by including a health component.

Facing the end of the project, the Mayor of Oryahovo stated that they would retarget other expenditures to this project (27.10.2016). Currently, almost 80 percent of municipal funding goes to young people, such as in form of coaches and sports, which he would need to cut and redirect.

The municipalities are currently providing the funding for the centres' office buildings. They financed the initial restoration of the buildings and just would need to cover maintenance costs.

User contribution. Users stressed their willingness to contribute to the home care services if those were to be discontinued (Users, Oryahovo, 27.10.2016). In fact, at the beginning of the service, they were sceptical about the service quality because the service was offered for free. They did not trust a free service and thought this would be of low quality or later demand a higher financial contribution from them (Users & staff, Oryahovo, 27.10.2016). Users recognized the Bulgarian Red Cross as a trusted provider and were willing to let their staff work in their private homes (Users, Vratsa, 26.10.2016; Mayor, Oryahovo, 27.10.2016; Head of Bilateral Programmes Unit, Council of Ministers, 25.10.2016). Users realized that the staff could be trusted and provided high-quality care. At the same time, given the lack of economic resources of most users and the estimated full costs of service provision (see 3.3.2), it is unlikely that the contributions of users could cover any significant share of the costs of care.

3.4.2. Sustainability at the national level

> *„Integrated services are high on the agenda and on top of the pile"* – Denitsa Sacheva, Deputy Minister, Ministry of Labour and Social Policy (28.10.2016).

For the Swiss funder it was clear from the beginning that this project ought to be a project of Bulgaria with Bulgarian ownership. Only then can the Swiss investment show sustainable results. While ownership is present and the legislative process moves into the right direction, the process is taking more time (Head of Swiss Contribution Office, 28.10.2016).

The Health Act of September 2015 created the precondition for sub-legislative acts on quality standards and financing mechanisms. The act allows for integrated health and social services in home environments for adults (elderly, pregnant women, people with disabilities and chronic conditions) and children (cf. Appendix 6.5). This legal change took three years, thus much longer than originally planned (Deputy Director, BRC, 24.10.2016), but is a milestone for further standardization via ordinances. As article 125d states:

The types of [integrated] services […] and the conditions and procedure for their provision, as well as the criteria and standards concerning their quality and the procedure of controlling their observance, shall be regulated by an Ordinance adopted by the Council of Ministers upon a proposal by the Minister of Health and the Minister of Labour and Social Policy.

Expected timeline. The Deputy Minister stated that the MLSP, together with the Ministry of Health and Ministry of Finance, is currently working on the new

Social Services Act, which will include integrated services (health-social and educational-social). A draft is expected for public consulting by the end of 2016, the bill should be on the floor of the Parliament by March 2017 and approved by Parliament by January 2018. Financed by a Human Resources Development Operational Programme (HRDOP) in 2017, the MLSP will develop quality standards for social, but also integrated, inter-sectoral services across Bulgaria, as well as develop different models for social and integrated service provision and their financing, including state, municipal, user and private-sector funding by the end of 2017 (representatives from MLSP, 25.&28.10.2016). This will also include integrated services for children and pregnant women. The MLSP is currently developing a map of services including integrated services for the elderly.

Standards for Social Assistants. According to Stefka Limanska, Head of the Unit "Professional Qualification" of the Ministry of Labour and Social Policy, the state educational requirements for acquiring professional qualifications from the list of professions for vocational education and training (LPVET) have been developed (The SER are under Art. 6 of the Vocational Education and Training Act http://www.navet.government.bg/en/ser/). The official document of the standards for social assistants is currently awaiting approval from the Ministry of Education and Science (25.10.2016). The timeline seems somewhat unclear because many different stakeholders are involved.

With respect to financial sustainability, relevant stakeholders at the national level cooperate regarding sustainable financing, but it is still work in progress. An Action Plan for Implementation of the National Strategy on Long-term Care with financing by the MLSP is under way, which will pave the way towards financing the long-term care system in Bulgaria. Input from BRC is sought (AR 2015). The National Health Strategy 2014–2020 calls for the diversification of financial sources and for the development of models for medical-social care. According to the Council of Ministers (25.10.2016), integrated, mixed financing models with per-person costs need to be developed for the Ministry of Finance, where health and social care funds are pooled which may also include a share of private payments. The Director of the Medical Activities Department of the Ministry of Health (25.10.2016) stressed the importance of showing that integrated services would lead to a better health care system and a better society while conserving resources that could be used otherwise at a national level.

Payment of users should be part of the plan in order to foster their commitment and ownership (State Expert Social Inclusion, MLSP, 25.10.2016). The user's contribution of a fixed percentage of the pension was also recommended by the Head of the People with Disabilities Department, Regional Department of Social Assistance, Vratsa (26.10.2016). A minimum fee to be paid by users is deemed necessary to manage demand (Head of the Social Assistance Department at the Agency for Social Assistance, MLSP 25.10.2016). Furthermore, other services such as continuous treatment in a hospital setting also require payment from users and it would seem appropriate to apply the same principle to integrated care services (Deputy Director, Regional Health Inspectorate, Vratsa, 26.10.2016).

Financially vulnerable people, for example those receiving pensions under 200 Leva (ca. 100 Euros) per month, may be very limited in their ability to contribute

to the costs of care (Manager, Oryahovo, 27.10.2016). Costs for medication alone could sum up to 70 to 100 Leva per month in some cases (Staff, Oryahovo, 27.10.2016). In addition, some users already pay about 40 Leva per month for the municipal hot meal delivery.

Municipal resources are not yet made available for integrated home care services. Municipal resources have been fragmented into different sectors and services, but municipalities have the discretion and liberty to combine and integrate the resources at the municipal level (Representative, National Association of Municipalities, 25.10.2016). However, prior cost-pricing of comparative services would need to be carried out in order to inform a reallocation of services. In the mid-term, municipalities may be able to apply for funds under the Human Resources Development Operational Programme for developing centres for complex support.

Central government resources could be a possible source in the long term. Dr. Galya Yordanova from the National Health Insurance Fund (25.10.2016) emphasized that the National Health Insurance Fund only covers physician-led services, but currently does not cover services through home care centres led by nurses or midwives. She calls it a “deficit in our health care” that these services are not covered.

Another funding source could be to draw resources from **mental health care**, which is currently funded by the Ministry of Health and not by the National Health Insurance Fund. The Director of the Medical Activities Department of the Ministry of Health (25.10.2016) communicated with the National Association of Municipalities how to apply patronage care for mental health patients including dementia patients who often end up hospitalized for a prolonged time because of lack of support in their community. Psychiatric nurses may be required for the care of those patients.

Scaling up at the national level would be highly relevant, but will only be viable once the financial sustainability has been addressed.

4. Conclusions and lessons learnt

The external review concludes that based on the available information and the information gathered purposely during the mission, the project has for the most part been able to accomplish the majority of the outcomes that it aims to achieve.

In particular, the project has improved access to home care services for the target groups that it defined as a priority. Among them, the addressing of unmet needs of the Roma community and its involvement in the provision of services is particularly noteworthy.

The project has also successfully introduced quality measurements and monitoring of care provision. Furthermore, the assessment of care provided by external Swiss experts and users seems to attest to its overall high quality, despite resource constraints.

The project also seems to have made a positive impact in establishing home care services as an appropriate type of service to address the needs of its target groups. Despite initial distrust among potential users and outside medical professionals, it has also raised the profile of home care services as an alternative valued by users for providing home care in the community. At the legislative level, the Health Act Amendment adopted in September 2015 allows for integrated medico-social services in the home environment. Before, nurses and home helpers were operating in a grey area of providing services at people's homes.

Despite promising progress and the achievement of some of the outcomes that were the aim of the project, there are still some areas that could be improved in the current project or taken up as lessons for future similar projects financed by the funder. These are listed here:

The need for demonstrating cost-effectiveness. The question of whether integrated services lead to better outcomes while conserving resources that could be used otherwise, remains unanswered at this point in the project. Providing proof that the services offered by the project are cost-effective (e.g. are reducing hospital costs or specialized institutional costs), would be a powerful argument to: i) advocate for sufficient funds to be allocated to the project and thus ensure its financial sustainability; and ii) to scale up the project to the national level. In the future, adequate emphasis and resources to carry out cost-effectiveness analysis should be integrated into the project design. Furthermore, a cost-benefit study could be employed to focus on potential cost-savings, which will support the decision-making process of policy-makers.

The need for a greater involvement of other stakeholders. One of the weak points of the implementation of the project is the limited links established with volunteers and informal carers. Relatives and informal carers are mostly contacted in an emergency or for a necessary change of service. Volunteers are regarded as a potential burden as they would need to be trained and retained. This limited involvement may have curbed the effectiveness and efficiency of the project and limited its ability to address unmet needs. The lack of involvement of informal carers is particularly worrying, given the services in question (integrated care in the community) and the target groups (e.g. older people and people with disabilities). Similarly, the linkages with local hospitals

could be strengthened to include a formal referral service to improve the discharge process and streamline access to the home care services.

The need for a greater investment to ensure sustainability. The inability at this stage of the project to ensure procedural regulations that guarantee its financial sustainability – despite the positive outcomes generated by the project – is a clear sign of the difficulties in implementing changes at an institutional level. This is further complicated by exogenous factors to the project, such as political instability. In the future, the funding agency should consider other strategies to ensure that institutional change is achieved. This could include accompanying the institutional process from an earlier stage with a clear timeline against which to check progress of the legislative process; or/and the engagement of the Swiss Embassies or higher-level officials in the Swiss Federal Government with their counterparts in the beneficiary countries. This could include an „ex-ante evaluation" of projects – (a) to check beforehand whether sustainability can be achieved and (b) to ensure that ex-post evaluation can be meaningful.

The need for greater emphasis on quality management, beyond quality monitoring. While the project successfully implemented quality measurements and quality monitoring, much less emphasis was placed on quality management as a whole, for example, concerning the implementation of quality management at the organizational level. While there are regular meetings between managers of the four home care centres and exchange of practices, there is little evidence of benchmarking or quality management taking place (e.g. definition of targets, assessment of results, involvement of staff in quality management, use of the Plan-Do-Check-Act cycle of management). It should be considered to strengthen this area in future projects to ensure efficiency and sustainability of quality improvements. Furthermore, the documentation mechanisms seem to be relatively cumbersome and involve unnecessary duplications. As the centres expand their work, this can become detrimental for both efficiency and working conditions of front-line staff.

5. Recommendations

The recommendations are addressed to specific stakeholders both at the project and at the national level. The first set of recommendations is short-term – until the end of the SDC period in April 2017. The second set of recommendations pertains to a long-term perspective with a national focus.

Stakeholders	Recommendations until April 2017
Council of Ministers, BRC, Swiss Red Cross	**Secure interim financing**, while the project is still running. Interim financing will require a different approach than long-term financing, and could include foreign sources. This would allow the current project to be continued without interruption until Bulgarian funding sources have been secured.
Legislative working groups, BRC	**Develop a road map for next steps on the national level.** Develop and implement short- and mid-term steps at the ministry and cross-ministry levels in the context of preparing bylaws, as well as develop and implement a timeline for those steps. This also includes developing a flexible model of integrated services beyond the four centres, taking into account different demographics and infrastructure.

Legislative working groups, BRC	**Commission cost-benefit studies.** In addition to cost-effectiveness studies, cost-benefit studies may be more valuable as they provide monetary value of the effects and what is being saved. The cost-comparative advantage of different services can be easier determined. For example, this could include determining how much money the prevention of emergency hospitalization (the effect) may be saved per user. In order to guarantee this, ex-ante evaluation would be needed. Cost-benefit data could show how the Ministry of Health could alleviate the state budget and/or transfer resources to integrate care.
BRC, NGOs	**Create platform with organizations engaged in similar activities.** Including stakeholders from NGOs, professional organizations, and the association of municipalities, this platform could help lobby for financing and implementing integrated services at the national level.
Stakeholders	**Long-term recommendations**
Ministries, legislative working groups	**Develop models for long-term financing.** Develop financial models for sustainable integrated service provision by involving different relevant stakeholders. Ideally test mixed financial sources, considering possible effects of user contributions on demand for services (e.g. shifting demand to/from hospitals due to differences in the costs borne by users) and on access to care (i.e. make sure user contributions are set at a level that does not constitute a barrier to the use of necessary services by those in need).
Ministries, Council of Ministers, Commission of Bulgarian Parliaments	**Consider expanding provision of integrated services beyond initial target group,** for all who need them in line with the 2015 Health Act. This could include people with disabilities and chronic conditions below 65 years of age. This expansion would help obtaining wider societal acceptance of integrated services beyond the project level. The expansion would also make integrated services financially more sustainable as additional funding sources might be available.
Association of municipalities	**Prioritize local communities for implementation.** Vratsa was identified as a high-needs district. In particular in Oryahovo, the project served as a safety net after the closure of the local hospital. The need for this programme is likely highest where the medical service provision is being reduced or where there is a higher concentration or share of vulnerable groups.
Municipalities	**Engage trusted providers when scaling up.** Providing services at private homes requires trust by the users. This issue of trust is important in terms of scaling up because only trusted organizations will be accepted by the users. From the beginning, the Bulgarian Red Cross has been regarded as a trusted organization.
Legislative working groups, BRC	**Develop strategies to address sustainability beyond political instability.** This will be a difficult issue due to changing stakeholders in the legislative and ministerial processes. However, organizations such as the BRC have shown continuity and consistency despite political changes. Such institutions may capitalize on their special position and become a crucial stakeholder in the policy process.
BRC, service NGOs	**Create an umbrella organization** that could unite individual service partners who could negotiate at the national level – similar to the Spitex umbrella of individual providers in Switzerland.

6. Appendix

6.1. Abbreviations

AR	Annual Report
BRC	Bulgarian Red Cross
GP	General Practitioner
HRDOP	Human Resources Development Operational Programme
MLSP	Ministry of Labour and Social Policy
NAVET	National Agency for Vocational Education and Training
NHS	National Health Strategy
SCO	Swiss Contribution Office
SDC	Swiss Development Cooperation

6.2. References

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6.3. Mission Programme to Bulgaria

Visit of review team to Bulgaria

"Home Care towards an Independent and Dignified Life" Project

24 – 28 October, 2016

Date	Schedule
Sunday, 23rd October 2016 12.45 pm	Arrival in Sofia Pick up at the airport Accommodation in Marinela Hotel, 100 James Boucher Blvd.
Monday 24th October 2016 **1.00 pm** **7.00 pm**	Meeting with the Home Care Project team at the BRC Headquarters *(76 "James Boucher" Blvd.):* • Dr. Nadezhda Todorovska – Deputy Director General of the BRC and Manager of the Home Care Project • Siana Karsheva – Senior Expert at the Health and Social Policy Department and Assistant in the Home Care Project • Margarita Koteva – Head of Home Care Unit at the BRC and Medical Coordinator in the Project • Rumyana Milanova – Financial Officer Dinner with BRC team, Tabiet Restaurant, address: 76 James Boucher Blvd. Overnight in Sofia (reservation to be made by the Bulgarian Red Cross)
Tuesday, 25th October 2016 **9.00 am – 10.30 am**	*1. Meeting with partners on national level, BRC Headquarters, group interview:* 1.1. Ministry of Health: Dr. Ivelina Georgieva – Director of Medical Activities Department, member of the project's Advisory Board 1.2. Ministry of Labour and Social Policy: Stefka Limanska, Head of Unit "Professional Qualification", Teodora Lyubenova – State Expert, Social Inclusion Department Rumyana Georgieva – Head of Social Assistance Department at the Agency for Social Assistance *Meeting at the BRC Headquarters:*

11.0 am – 12.00 pm	2. National Health Insurance Fund: Dr. Galya Yordanova – Head of Department and Ms Irina Tsalova – Head of Unit Lunch
12.00– 1.00 pm **1.30 pm – 2.30 pm** **3.00 pm – 4.30 pm**	3. *Meeting at the Council of Ministers*: Ms. Malian Kroumova – Head of Central Coordination Unit of the Swiss-Bulgarian Cooperation Programme /CCU/; Mrs. Mariana Kordova – Head of Bilateral Programmes Unit in the CCU, Mr. Nikolay Yonov – State expert in CCU *4. Meeting at the BRC Headquarters; Group interview with representatives of associations/professional organizations:* 4.1. Milka Vassileva – Chairperson of the National Association of Professionals in Nursing Care 4.2. Dr. Stanimir Hasardjiev – Chairman of the National Patients' organization 4.3. Maya Vassileva – Head of Department, National Association of Municipalities 4.4. Daniela Wushatova, National Association of Municipalities Overnight in Sofia
Wednesday, 26th October 2016 **9.30 am** **1.00 pm** **2 pm – 3.00 pm** **3.00 pm – 4.00 pm** **4.00 pm – 5.30 pm**	7.30 am - Departure to Vratsa (110 km from Sofia), Accompanied by Dr. N. Todorovska, Siana Karsheva and interpreter Visit to the Home Care Centre in Vratsa. Meetings with: • Mrs. Gergana Mihalcheva – Director of the BRC Regional Branch • Mrs. Olga Petrova – Manager of the Home Care Centre • Members of the team – 1 nurse and 2 home-helpers • Visit to beneficiaries of the Home Care Centre: ✓ Vasilia Krasteva – 79 years old (Kahlert); ✓ Borislav Todorov – 67 years old (Peteva). Lunch Meeting with Dr. Sonya Yordanova – family doctor, Vratsa Meeting with Mrs. Iva Stancheva – Head of Health and Social Activities Department, Municipality of Vratsa • *Group interview*: • Dr. Irena Vidinova – Deputy Director of Regional Health Inspectorate /RHI/, Mrs. Olya Nikolova – Chief

	Inspector, RHI and Mrs. Natasha Georgieva – Head of People with Disabilities Department, Regional Department for Social Assistance
7.00 pm	Dinner Overnight in Vratsa, Hemus Hotel
Thursday, 27th October 2016 **07.30 am**	Pick-up from hotel and trip to Oryahovo (70 km from Vratsa)
9.00 am	Visit to the Home Care Centre in Oryahovo ✓ Meeting with Mrs. Rumyana Dekova – Manager of the Home Care Centre in Oryahovo
10.00 am	Meeting with the Mayor of Oryahovo – Mr. Rosen Dobrev
11.00 am	Visit to beneficiaries: ✓ Nadezhda /65/ and Yordan Yordanovi /69/ /family/ (Peteva) ✓ Gugutka /67/ and Mitko Hristovi /69/ /family, Roma origin/ (Kahlert)
12.00 pm	Meeting with 1 nurse and 2 home helpers
1.00 pm	**Lunch**
2.00 pm	Trip back to Sofia: way to Sofia is 2 ½ hours from Oryahovo!
4.30 pm	Meeting with Dr. Todorovska, BRC, to ask follow-up questions
06.30 – 07.30	Brief meeting with Mr Roland Python to exchange first-hand information and prepare for the debriefing next day Overnight in Sofia
Friday, 28th October 2016 **Morning**	Time for the review team to prepare the validation workshop
13.00 – 16.00 BRC Headquarter	**Debriefing (organized by SCO)** Final meeting for presentation of results with the

Sofia, 76 James Boucher Blvd., Washington Hall **6.00 pm**	participation of project stakeholders: *<u>Participants:</u>* *Bulgarian Red Cross:* Prof. Dr. Krassimir Gigov – Director General, member of the Project Advisory Board /AB/ Vassilka Kamenova – Deputy Director General, member of AB Dr. Nadezhda Todorovska – Head of Project Siana Karsheva – Project Assistant Rumyana Milanova – Financial Officer Margarita Koteva – Medical Coordinator *Swiss Red Cross:* Jürg Frei – Head of Division Asia/Europe, International Cooperation, Swiss Red Cross. *Swiss Contribution Office:* Roland Python – Head of Swiss Contribution Office; Gerassim Gerassimov – Programme Director, Embassy of Switzerland in Bulgaria; *Ministry of Labour and Social Policy* *Denitsa Sacheva* – Deputy Minister, member of Advisory Board *Central Coordination Unit of the Swiss-Bulgarian Cooperation Programme at the Council of Ministers:* Malina Kroumova – Head of CCU; Mariana Kordova – Head of Bilateral Programmes Unit …..Nikolay Yonov – State Expert *Consecutive translation from English: Georgi Pashov* Departure to the airport, trip back from Sofia to Vienna

Consecutive translation was provided from English to Bulgarian and vice-versa by Mr. Georgi Pashov on Tuesday, Wednesday and Friday, and by Mr. Viktor Donkov on Thursday.

6.4. Division of Work

The external review team consisted of a Bulgarian expert, Steli Peteva, Ph.D, and three international experts from the European Centre for Social Welfare Policy and Research in Vienna, Austria: Ricardo Rodrigues, Ph.D., Rahel Kahlert, Ph.D., and Kai Leichsenring, Ph.D. Their respective expertise and roles/responsibilities/tasks were divided as follows:

Name	Expertise	Roles/responsibilities/tasks
Ricardo Rodrigues	Long-term care systems Financing and equity of care Comparative policy approach	Planning review approach, designing instruments Analysing field data and developing findings Co-writing inception and final report
Rahel Kahlert	Evaluation approaches Public policy analysis Health and social policies	Planning review approach, designing instruments Collecting data: visit to Switzerland, field mission to Bulgaria Developing preliminary findings for validation workshop Analysing data and developing findings Co-writing inception and final report (editorial responsibility)
Kai Leichsenring	Long-term care Comparative policy perspective	Providing expert input throughout all stages of the review process Providing guidance on developing findings
Steli Peteva	Long-term care models Health and social policy frameworks in Bulgaria	Providing expert input to institutional framework in Bulgaria Providing feedback to inception report Collecting data/interviewing in Bulgaria Developing preliminary findings for validation workshop Contributing to final report

6.5. Integrated Health and Social Services, Amendment of Health Law, Section Ia (New, SG No.72/2015)

Article 125b. (New, SG No. 72/2015) (1) Integrated health and social services shall be activities through which medical and social service specialists provide healthcare and medical supervision and perform social work, including in home environments, to support children, pregnant women, people with disabilities and chronic conditions and older people who need assistance in the performance of their daily activities.

(2) The services under Paragraph (1) may be provided by municipalities, medical treatment facilities and the persons under Article 18(2) of the Social Assistance Act.

(3) Municipalities and the persons under Article18(2) of the Social Assistance Act may provide the services under Paragraph (1) after notifying the regional health inspectorate in whose territory they perform the services, in accordance with the procedure provided for by Article 36.

(4) Medical treatment facilities may provide the services under Paragraph (1) subject to the conditions of Article 18(2) and (3) of the Social Assistance Act.

(5) Services under Paragraph (1) provided to children shall meet the requirements of the Child Protection Act.

Article 125c. (New, SG No. 72/2015) (1) Integrated health and social services under Article 125b(1) may be funded by:

1. the state budget;
2. municipal budgets:
3. national and international programs;
4. persons under Article 18(2) of the Social Assistance Act;
5. other sources.

(2) Integrated health and social services shall be provided in return for payment by the persons under Article 125b(1).

(3) The integrated health and social services funded by the state budget and provided for free to the persons under Article 125b(1) shall be determined by an act by the Council of Ministers.

Article 125d. (New, SG No. 72/2015) (1) The types of services under Article 125b(1) and the conditions and procedure for their provision, as well as the criteria and standards concerning their quality and the procedure of controlling their observance, shall be regulated by an Ordinance adopted by the Council of Ministers upon a proposal by the Minister of Health and the Minister of Labour and Social Policy.

(2) The observance of the criteria and standards concerning the quality of the services under Article 125b(1) shall be controlled jointly by the authorities under Article 31(2) and (3) of the Social Assistance Act and the regional health inspectorates.