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CONTRACTING PUBLIC HEALTHCARE AND SOCIAL SERVICES TO CSOs: framework, opportunities, lessons learned

Eurasian Harm Reduction Network

2017

Contents

I. INTRODUCTION

The assignment

This analysis is assigned by the Eurasian Harm Reduction Network in 2017 within the Global Fund's Community, Rights and Gender Technical Assistance Program. The following text is prepared by team of researches: Nadia Shabani (BCNL[1] expert, lawyer), dr. Vasilev (CHP[2], expert, psychiatrist, public health specialist), assistant researcher Pavleta Alexieva (BCNL expert, lawyer).

The first part of the analysis describes the context in Bulgaria with regard to the provision of services for prevention, treatment and reduction of HIV/AIDS: current state policy, problems that are faced and challenges that have to be addressed. It also reflects on the main advocacy actions in the past several years as well as the main stakeholders positions' on the issue. The second part is analyzing the possibilities for contracting out public services to private providers with main focus – social services, healthcare services, and other relevant to them. The social and healthcare spheres are included in the research field because the above mentioned HIV/AIDS services mainly belong to these systems of interventions. The last part of the analysis consists of recommendations on how to develop mechanisms that will ensure public funding for the researched services, what could be applied from the existing experience and practices, what the lessons learned and possible obstacles are that have to be taken into account.

The analysis has two specific focuses:

a) the role of civil society organizations (CSOs) as a potential partner to the state authorities in providing the services;
b) the main characteristics of the social contracting concept and the preconditions that should be in place in order to achieve better social impact using the partnership approach.

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Methodology

The analysis is made using desk research of legal documentation[3] and interviews[4] with key stakeholders.

The methods that have been used are:

[1] BCNL has worked effectively to facilitate public-private partnerships in the social sphere through various projects which have established legal mechanisms for public/private partnerships, improved government contracting procedures, and increased NGO capacity in the social sphere. In 2002 BCNL helped with developing the social contracting mechanism in Bulgaria by proposing amendments to the Social Assistance Act and its Regulation. Since 2003 BCNL has organized over 80 trainings, dedicated to the contracting of social services in Bulgaria.

[2] Foundation Center for Humane Policy–Sofia is a newly-established non-governmental, non-profit organization, which was created at the beginning of 2016 with main goals to promote, facilitate and support the development of effective drug policies in the field of public health, social care and education

[3] The legislation that was revised for the purposes of the present analysis is the one applicable till June 2017.

[4] Interviews with NGOs and government officials representatives.

- **Research approach:** analysis of legal acts related to contracting out social services and relevant spheres to private providers on the basis of which recommendations are developed;
- **System level approach:** analysis of the possibilities for integrating support between social and healthcare sectors;
- **Pragmatic approach:** the main problems of the analyzed social systems are outlined, so the pre-conditions that need to be set up for contracting healthcare services to CSOs can be identified.

II. CONTEXT

Throughout the whole HIV epidemic worldwide, Bulgaria has remained a low prevalence HIV country. The first case of HIV in Bulgaria was confirmed in year 1986, and during the first 15-20 years the prevalence was low and the main way of transmission was heterosexual. The situation changed in 2004, when after the increase of the mobility of the Bulgarian population due to the opening of the country and the accession process to EU, a concentrated HIV epidemic occurred in the vulnerable group of Injecting Drug Users (IDUs) that was increasing in the period until 2009 and then leveled off. It is important to note that this epidemic is concentrated in several cities (Sofia, Plovdiv and Peshtera) and is related with local Roma communities ("Stolipinovo" in Plovdiv, "Fakulteta" in Sofia, etc.) Another vulnerable group that is currently involved in the new HIV cases is the group of Men having Sex with Men (MSM). The number of new HIV cases among MSM group remain relatively high and the epidemic among this group is far from control. At the end, it is important to mention that still the heterosexual way is the main form of HIV transmission during all these years.

The HIV prevention efforts started very early, and in year 1996 the National Committee on the prevention of HIV and STIs at the Council of Ministers was established and the First Bulgarian National Strategy on HIV and STIs was adopted in 2001. From the beginning, the involvement of NGOs in the harm reduction activities among the most vulnerable groups was high – the first NGOs performing outreach activities among IDUs – "Initiative for Health" Foundation was founded in 1998 and in year 2000 there was a small network of four NGOs working in this field. These organizations were funded by international donors such as Open Society Foundations and others. Similar to that small one, networks of other NGOs were starting to provide HIV prevention services to other key vulnerable groups – MSM, CSW, Roma youth, etc.

An important condition for the future successful development of the HIV prevention harm reduction activities was the introduction of the legal and normative base for their development. As early as in year 1999, the adopted Drug and Precursors Control Act stated in Article 84b and 87 the development of regulations for provision of harm reduction for IDUs and the organization and provision of opioid substitution therapy (OST). As result, the Ordinance No 24 and Ordinance No 30 were adopted and they served as a base for the development of adequate services. Later, Ordinance 24 was replaced by Ordinance 2 from 2012 for the conditions and the rules for implementing programs for treatment of persons addicted to opioids with agonists and agonist-antagonists and Ordinance 30 was replaced by Ordinance No 7 from September 7, 2011 for the conditions and rules for performing harm reduction programs related to drug abuse, which reflected the new developments and the experience in organization and functioning of these programs through these years.

Therefore, since year 2004 the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) grant support for the HIV prevention in Bulgaria came in a very timely moment and contributed very significantly for the successful scaling up and implementation of the prevention activities. The program "The prevention and control of HIV/AIDS in Bulgaria" was funded by GF for the period 2004 – 2008 with the total amount of 15,7 million USD and the high appraisal for implementation was reason for the grant continuation through the Rapid Continuation Channel (RCC) with additional funding for the period 2009 – 2014 as the total amount of disbursed GF funding for Bulgarian HIV/AIDS program reached 49,566,271 USD[5].

The Program "The prevention and control of HIV/AIDS in Bulgaria" supported by GF had 9 major objectives:

1. To create a supportive environment for a sustainable national response to HIV/AIDS in Bulgaria;
2. To strengthen the evidence base for a targeted and effective national response to HIV and AIDS;
3. To scale up coverage of testing and counselling services provided through the low-threshold VCT network with a focus on most-at-risk groups;
4. To reduce HIV vulnerabilities of IDUs by scaling up population coverage of a comprehensive package of prevention interventions;
5. To reduce HIV vulnerabilities of most-at-risk Roma people (aged 15-25 years) by scaling up population coverage of community-based prevention and referral services;
6. To reduce HIV vulnerabilities of female and male sex workers by scaling up population coverage of comprehensive package of prevention interventions;
7. To reduce HIV vulnerabilities of at-risk youth (aged 15-24 years) by scaling up coverage of comprehensive youth-friendly programmes and services;
8. To improve the quality of life of people living with HIV/AIDS (PLHIV) by guaranteeing universal access to treatment, care and support; and
9. To reduce HIV vulnerabilities of MSM by scaling up population coverage of a comprehensive package of prevention interventions.

The involvement of Bulgarian NGOs in the implementation of the Program was significant and resulted in the involvement of number of NGOs in the provision of HIV prevention and harm reduction services (more than 50 as total – 10 NGOs working with IDUs, 9 NGOs working with sex workers, 5 NGOs working with MSM, 10 NGOs working with Roma youth, 4 NGOs providing support to PLHIV, etc.). In addition, 17 Mobile units + number of low-threshold centers operating with different risk groups were established and run by different NGOs.

The importance of the "The prevention and control of HIV/AIDS in Bulgaria" GF funding for the sustainable implementation of harm reduction activities may be seen when we analyze the

[5] https://www.theglobalfund.org/en/portfolio/country/grant/?k=47fbf118-1620-476b-85b9-70ed3ce5f69d&grant=BUL-202-G01-H-00

Bulgarian HIV/AIDS state expenditure by category. While it is clear that the total amount of state money is increasing for the period, at the same time that money is spent for very specific targets: 1) blood safety; 2) AIDS treatment and diagnostics; 3) Opioid substitution therapy, etc.

It is evident that the GF funding was fundamental for the sustainable development and provision of HIV prevention services by NGOs as the resources for these services were absolutely dependent on the provision of donor money. After the finishing of the second phase of GF financial support, a series of no-cost extensions were granted to take advantage of the remaining of the previously unspent GF grant money but the last extension ended on May 31, 2017. Now it is expected that Bulgarian state should provide the necessary money from the state budget. The main purpose of the no-cost extensions was to give space and time for the development and implementation of a Transition Plan ensuring the sustainable civil society engagement and public financing for the NGO harm reduction activities among the key vulnerable groups. Unfortunately, such Transition plan is still not adopted and not enforced in practice despite the creation of a special working group by the Ministry of Health.

The chief instrument for the sustainable public funding for harm reduction was supposed to be the National Program for Prevention and Control of HIV/AIDS and STI 2017 – 2020. Due to the lack of political interest and support for HIV prevention policy and the rapid change of Bulgarian political governments in the period, the program adoption was significantly delayed, the money was significantly cut, and at the end it was adopted on 23 March 2017 with the Council of Ministers Decision № 163.

Program goals:
Goal 1: Reaching to minimum 60% coverage of the most-at-risk groups.
Goal 2: 75% Reduction of the new cases of HIV infection.
Goal 3: Elimination of mother-to-child ways of HIV transmission.
Goal 4: By year 2020 - 90% of the HIV-infected people should know their HIV status; 90% of these people should be on ART and 90% of those on treatment should be with non-detectable viral load.
Goal 5: By year 2020 95% of the pregnant women should be covered with syphilis testing and 90% with HIV testing.
Goal 6: By year 2020 - 90% reduction of the cases with inborn syphilis, Treponema pallidum infections and gonorrhea infections compared to 2015 level.
Goal 7: By year 2020 ensuring protection and "zero" level of discrimination for the people living with HIV and the members of the most-at-risk groups.

For the key vulnerable groups, the Program envisages the following strategic interventions:

A. The Injecting Drug Users (IDUs)

1. Strategic intervention 1: Reduction of HIV infection among IDUs:

Activity 1: Change in the HIV risky behavior by means of outreach work, use of mobile units and drop-in centers": exchange and distribution of needles and syringes as well as safe drug injecting paraphernalia, condoms distribution, testing for HIV, HCV, HBV and STIs. Offering available social and psychological consultation.

Activity 2: Keeping the work of the established 9 low threshold drop-in centers for IDUs for prevention services among IDU group.

2. Strategic intervention 2: Ensuring Opioid Substitution Treatment (OST) for opioid IDUs from especially risky and marginalized groups.

3. **Strategic intervention 3: Providing HIV, HCV, HBV and STI diagnostic among IDUs group** – ensuring maximal testing for the group through use of mobile units and low threshold drop-in centers.
4. **Strategic intervention 4: Case management for IDUs most-at-risk and HIV-positive.**

B. The Group of MSM

Strategic intervention 1: Institutional and implementation framework for delivering of effective and specific services targeting HIV prevention among MSM

Activity 1: Training of public health servants, NGO staff and MSM group members peer educators for delivering HIV prevention services through electronic media.
Activity 2: Reaching MSM group with HIV prevention messages though electronic media, social networks, etc.

Strategic intervention 2: Restricting HIV and STIs spread in the group of MSM by means of increasing the group coverage with full package of preventive interventions

Activity 1: Delivering HIV prevention services through the low-threshold drop-in centers – sustaining the existing 5 centers.
Activity 2: NGO Outreach work – delivering of package of HIV prevention services to the group.
Activity 3: Promotion and distribution of condoms and lubricants.

Strategic intervention 3: Testing and Consultation for HIV and STIs.

Activity 1: Delivering of anonymous and free testing and consultation for HIV – through mobile units, cabinets for anonymous and free consultation and testing.
Activity 2: Delivering low-threshold services for diagnosis of STIs – accessible medical services for the group.

Strategic intervention 4: Individual help for people most-at-risk

Activity 1: delivering individual support to the people most-at-risk by means of case management – preventive services but also especially for people living with HIV/AIDS.

Strategic intervention 5: Development of a favourable social environment for the implementation of effective HIV prevention activities among MSM.

Activity 1: Implementation of seminars for key institutions members – Commission for discrimination protection and public health institutions on stigma and discrimination of MSM issues.
Activity 2: Campaign implementation and active involvement of private sector in fundraising.

Even the brief analysis of the Program shows that it has very ambitious goals and plans to sustain and even to upgrade and develop the already accomplished during the GF funded phase.

The budget analysis of the financial shows that the total sum for the National Program for 2017 is 2 808 160 leva (1 Euro = 1.95583 leva). The total budget for HIV prevention services among the most at risk groups for the same year is 886 039 leva (IDUs group – 281 610 leva (200 000 leva – 2018), MSM group – 212 534 leva (160 000 leva – 2018), Sex workers – 156 895 leva (170 000 leva - 2018, etc.). The other key intervention areas have financing as follows: 1) HIV testing politic – 1 151 513 leva, 2) the STIs testing and treatment politic – 193 325 leva, 3) Treatment, care and support for people living with AIDS – 189 397 leva, 4) Epidemiologic surveillance, monitoring and evaluation – 0 leva, and 5) Supportive environment for sustainable national response for HIV and STIs in Bulgaria – 387 866 leva.

Main conclusions based on the context analysis

The first important note is that ***the general sum of money for the most-at-risk groups is much less than the provided by the Global Fund (for 2015 year, the NGOs working with risk groups*** effectively utilized 907 588 Euro – (figure provided by the financial staff of the Program) ***and this points that the ambitious goals and indicators cannot be reached and delivered***. Also, the sum of money for the groups of MSM and IDUs are decreased for the second year and then kept at that lower level for the rest of the Program period. Another alarming point with regards the IDUs group is that we can't be sure what part of the total sum is proposed for the different strategic interventions in the group – for example, the exact money for outreach work vs opioid substitution therapy vs providing HIV, HCV, HBV and STI testing for IDUs. So, this may result in fact that the actual money available for NGOs working with IDUs to be even much less.

Also, it is important to point out that ***the adoption of a National Program with a year by year budget in Bulgarian state practice does not provide a mandatory framework for the government to follow***. On the contrary, the exact money for any program and their distribution is a subject of a year by year planning and the political will and decision of Ministry of Finance and the Minister of Heath in our case. This makes the sustainability of the funding for NGOs working with most-at-risk groups even more problematic and fragile.

A good methodological step forward was the development and adoption of Methodological Guidance for standardization of the HIV/AIDS services among vulnerable groups deliver by NGOs enforced with Order № RD-01-211/02.10.2015 by the Minister of Health.

OST treatment may be financed using the Methodic for subsidizing treatment institutions, which is adopted every year by means of an Order of the Minister of Health. The Order RD – 01-12/ 13.01.2017 states that the state subsidy for a person on methadone treatment for a month is 56 leva. It can be delivered only in state or municipal hospitals or state or municipal mental health centers, which effectively excludes CSOs from the list of these recipients[6].

Another basic problem that we will have in the sustainable contracting of CSOs to provide services for prevention, treatment and reduction of HIV/AIDS funded by the public state budget, is related to the mechanism for service procurement. The existing mechanism for the implementation of CSO contracting is developed only because of the donor (the Global Fund) will and strict condition for providing the money. Actually there are no legal basis and adopted legal documents that may allow Ministry of Health to continue the existing mechanism. Therefore, the state money for CSOs providing services for IDUs, MSM, etc. should be distributed through other already existing mechanisms such as public tender or other. All that will be related to slower and more problematic procedures for CSO involvement in the provision of services for HIV/AIDS among the key target groups.

As a whole, ***Bulgaria does not have a developed and politically supported Transition plan how to move from the Global fund support to sustainable national financing of the services for prevention, treatment and reduction of HIV/AIDS that may be provided by CSO***. Despite the adoption of the National Program for Prevention and Control of HIV/AIDS and STI 2017 – 2020 in March 2017, which is a major positive step, there are still significant problems: 1) the total sum of money for the key target groups are less than provided by the

[6] http://www.mh.government.bg/media/filer_public/2017/01/13/doc001.pdf/

GF and decreasing with years, 2) there is no prioritizing of funding for the most-at-risk groups – IDUs and MSM, and 3) there is no legal mechanism for using the same favourable for CSOs grant procedure under GF.

This all poses a risk that the effective services to most-at-risk groups provided by NGOs will be significantly reduced because of the available money and hindered by the alternative not so friendly mechanisms for procurement of these services by the Ministry of Health. As a result, we may witness an increase of the number of HIV cases among most-at-risk groups of IDUs and MSM, which will lead to much higher need for a costly ART.

III. CONTRACTING OUT PUBLIC SERVICES IN BULGARIA: LEGAL MECHANISMS AND TRENDS

1. European guidelines

There is no clear statement on the question to what extend the social and healthcare services and mainly the applicable contracting mechanisms, are part of the legislation of the European Union (EU) that is binding member states to develop related framework. Formally, the delivery of social and health care services is not covered by the issues of common interest[7], so they are not considered to be under the rules of the EU treaties.

In most of the documents of the European Commission (EC) the terminology *"service of general interest"* (SGI) and *"service of general economic interest"* is used and it includes social and healthcare services[8]. In the recent years the EC issued different documents that are trying to set a common frame for ensuring good quality of life in all regions of the EU. One of the most important documents in this area is the Framework for the Quality of the Services of General Interest which defines the social, educational and healthcare services for children and adults as the basis for social protection of citizens that enhances the social cohesion[9]. The framework requires that services shall achieve good quality in an effective and efficient way. These services increase the demand to be synchronized and to be more constrained[10] (Universal Service Directive). Social services as part of SGI are outlined as tools for achieving specific aims for supporting and increasing the quality of life. They should address personal needs, support the person to have an independent and inclusive living[11] and in this way - to ensure that everyone is included.

[7] For which there is a clear EU binding regulation.

[8] Services of general *economic* interest (SGEI) are economic activities which deliver outcomes in the overall public good that would not be supplied (or would be supplied under different conditions in terms of quality, safety, affordability, equal treatment or universal access) by the market without public intervention. The public service obligation is imposed on the provider by way of an entrustment and on the basis of a general interest criterion which ensures that the service is provided under conditions allowing it to fulfill its mission.

[9] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, "A Quality Framework for Services of General Interest in Europe", COM(2011) 900 final.

[10] http://ec.europa.eu/energy/gas_electricity/forum_citizen_energy_en.htm [26] SEC(2010) 1407 final of 11 November 2010. [27] Directive 2002/22/EC of the European Parliament and of the Council of 7 March 2002, on universal service and users' rights relating to electronic communications networks and services.

[11] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, "A Quality Framework for Services of General Interest in Europe", COM(2011) 900 final.

The Framework for quality of services of general interest[12] underlines that the *public and private sector shall work together,* all together with the users, social partners and CSOs. The synergy should be on various levels – policy making, needs' assessment and service planning, provision and monitoring. The existence of such strategic partnership is perceived as a milestone for the social sector development. The clarification of the roles, responsibilities and interaction between the stakeholders involved in the process of planning, development, funding, monitoring and assessment is envisaged as quality criteria for good governance.

Specific questions - public procurement rules

Having in mind that SGI are public services, the question on how they can be contracted out interrelates with the public procurement rules as these rules are the main mechanism for that. There is a particular piece of EU legislation related to public procurement that allows the countries to stipulate different procedures for contracting out social services of public interest in compliance with the principles of publicity, transparency and equality. The Public Procurement Directive (2014/24/EU repealing Directive 2004/18/EC) allows each member state to have different procedures for commissioning the services mentioned in Articles 74[13], only if the requirements of Article 75[14] and 76[15] are met. This means that if a member state does want to apply this option, it has to develop a certain piece of national legislation in order to ensure that these requirements are met. Such mechanisms will exclude the requirement in the Directive to use procurement procedures for services that fall within the SGI[16].

This exception is allowed because of the imperfections (when we consider the desired outcomes from SGI) of the two criteria for evaluation of the potential candidates' offers regulated by the Public Procurement Directive: *"the lowest price"* and *"the most economically advantageous tender"*. "*The lowest price"* criterion takes into account only the price, offered by the potential candidates. However, regarding the public services like social and healthcare *"the lowest price"* is not a guarantee for provision of quality services. In most of the cases the financial standards for these services is a fixed amount (from the state perspective). Often the state is obliged to use the budgeted public funding for social services only for such activities and is not allowed to redirect the money to the fulfillment of any other public duty. The second criterion *"the most economically advantageous tender"* is more flexible. It takes into account the price, but also makes it possible for the contracting authority to determine indicators for complex assessment with their relative weighting. Nevertheless, this criterion is also not suitable for assessing the potential candidates in the process of contracting out social and healthcare services because, as far as we talk about economically advantageous tender, the price is important, even in the cases where it is not a leading indicator. In the case of

[12] Communication from the commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, A Quality Framework for Services of General Interest in Europe, Brussels, 20.12.2011, COM(2011), http://ec.europa.eu/services_general_interest/docs/comm_quality_framework_en.pdf.

[13] Social and other specific services listed in Annex XIV of the Public Procurement Directive 2014/24/EU.

[14] It requires member states to announce their intention to award contracts within such special procedures through a contract notice or through a prior information notice.

[15] Principles of transparency and equal treatment of economic operators; procedures may also take into account the need to ensure quality, continuity, accessibility, affordability, availability and comprehensiveness of the services, the specific needs of different categories of users, including disadvantaged and vulnerable groups, the involvement and empowerment of users and innovation; the procedures may also provide that the choice of the service provider shall be made on the basis of the tender presenting the best price-quality ratio, taking into account quality and sustainability criteria for social services.

[16] For example, in Bulgaria such special procedure is the social contracting, regulated by the Social Assistance Act and the Regulations for Application of the Social Assistance Act.

healthcare and social services the price is predetermined and other criteria for their delivery are important - quality, accessibility, coverage, etc.

Most recent trends

During the last 5-6 years even though that there is no special EU competence over SGI regulation, there are several trends within the policy process on formulating the priorities of the EU funding mechanisms:

- ✓ **Decentralization of service planning, funding and delivery.** The decentralization of the planning and funding of the services is commonly promoted and can be achieved through administrative and legal reforms that ensure transfer of competences from the central administration to the local authorities. The concept of decentralization is the basis of policies enhanced by different EU authorities. In various member states the contracting mechanisms are used as a tool to decentralize the process of service delivery through opening the market to private providers;
- ✓ **Deinstitutionalization of care:** in the last 5 years social policies emphasize on guarantying equality, social inclusion and antidiscrimination of vulnerable groups, which undoubtedly means investing more resources in building up a deinstitutionalization policy that ensures variety of community based social services (special documents were issued - *Guidelines on the Transition from Institutional to Community-based Care and Toolkit on the Use of European Union Funds for the Transition from Institutional to Community-based Care);*[17]
- ✓ **Trends to find long-term solutions for social inclusion:** for example upgrading the impact of the social support through social entrepreneurship.

2. General concept

There are different approaches to regulate service provision in the social and healthcare spheres. Relaying on partnerships and the potential that private providers can contribute to achieving specific social goals, is widely recognized as a successful practice in many developed systems. The following main funding approaches exist:

- ✓ Funding the provision of social services through **subsidies** for certain social service providers (i.e. Red Cross organizations, umbrella disability organizations, etc.). Subsidies are provided without competition, in the form of institutional support and the obligation to provide the service might even be part of a mandatory task defined by law[18]. This approach can be found in countries, where the social system is still evolving and has not reached the stage at which the "regulated" market of social services possesses the capacity and the resources to meet all special social needs.
- ✓ Funding the provision of social services through **grants.** Grants are usually provided by a competition procedure. In most of the cases this mechanism is used when the authority defines specific goals and results to be achieved and provides the freedom to the applicants to decide the exact activities and approaches that will be used in order to do so. In this way the authority has the opportunity to choose among different ideas and thus this approach is commonly used to fund innovations in the social area.

[17] The decentralization of social services provision in Bulgaria played an important role in activating policies and processes on various levels that foster another major social reform - the deinstitutionalization. The social contracting encouraged various community based and innovative services to develop during the years and thus had empowered the process of deinstitutionalization.

[18] This chapter is based on the Handbook on Non-State Social Service Delivery Models - A guide for policy makers and practitioners in the CIS region. ECNL and UNDP, 2012.

- ✓ Funding through **contracting out** social services. This approach is used when the state is commissioning the service provision to private providers and ensures the funding for their provision. The state or the local authority knows exactly what type of service it wants to receive. The role of the state is limited to the supervision and the funding of the service which is carried out by non-state actors, including CSOs, businesses and individuals.

Grants and contracting

The difference between the grant and the contract payment for provision of services is the degree of concretization of the assigned task, as well as who will use the production/service with funds provided. The contracting allows public authorities to be very specific when defining the assigned tasks and setting up the indicators for measuring the results that are expected to be achieved. The contracting authority knows the parameters of the service - for example, to provide specific social service for a specific target group defined by number, age and so on (i.e. to be provided the service Daily care center for children with disabilities, with capacity of 20 people and the framework of interventions is known). When using the project funding approach the contracting authority has goals that wants to achieve and certain financial resources, but do not want to "instruct" the applicant how to do it, rather than expects from them to find the appropriate way (i.e. to improve access to education for children from marginalized communities is using grant schemes). In these cases the ownership of the manufactured products, materials, analyzes and other remains for the recipient of the funding (specific beneficiary).

3. Existing procedures

Below is a list of the existing mechanisms that allow the involvement of CSOs in the provision of public services. Some of them are very well developed in the national Bulgarian legislation, some are just mentioned in some policy documents and others are never adopted or discussed.

- ✓ ***Tender procedure:*** this is the commonly used mechanism of contracting public[19] services. The contracting authority invites more than one provider, sometimes through open bids, for provision of a service. This procedure is strictly regulated by certain rules and in the end the candidate who provides the most advantageous offer (in the main case based on price offer) is selected to deliver the service. The tender procedure is usually initiated by the respective authority responsible for the delivery of the service. In Bulgaria the main instrument for that is the Public Procurement Act (as it was described above in this area there is a strict EU legislation that has to be followed). If the authorities want to conduct a tender which is not based on public procurement rules they have to create a mechanism which shall be described in a separate normative act (only in this way the general public procurement rules can be excluded but at the same time the requirements for transparency and publicity can be guaranteed);
- ✓ ***Direct contracting:*** this model is used in cases where only one potential candidate is identified. According to the Bulgarian legislation in the social area there are some cases where such model could be applied (i.e. the provision of the services of Personal assistant, Social assistant). Such model is applied also in the cases where a general social contracting tender is opened for a specific social service but only one candidate

[19] The special focus for public services here is given to the social, healthcare and educational services, or for very close area services.

applies and proceeds with the negotiations. This mechanism is not used very often because it would mean that the contracting party delivers a unique or very particular service. Only for that reason the competition rules can be avoided.

- ✓ **Grant funding:** it is a mechanism that is used in the Bulgarian framework i.e.
  - Grant schemes managed by Ministry of Justice for services against home violence (under the Domestic Violence Protection Act);
  - Grant schemes by Social Protection Fund to support innovations in the social area managed by Ministry of Labour and Social Policy (under Social Support Act);
  - Grant schemes by Fund "Culture", managed by Ministry of Culture (under the Culture Reservation Act),

These are funding mechanisms in specific areas where the state had adopted a particular piece of legislation regulating the use of procedures that are different from the public procurement and the social contracting. The main focus of the grant procedures is not to secure the provision of services but *to select ideas and different methods* in trying to overcome particular problem.

There are two other types of funding private providers to deliver services, which are not regulated explicitly in Bulgaria. Those are: ***a) the partnership agreement (public-private partnership/commissioning)*** - the government and the provider share the burden of financing the service. It may be co-financed by both parties, or one of the parties may be entitled to provide the facilities and the other - an appropriate funding for the service provision[20]; b) ***third party payment:*** the user of the service is entitled to choose a provider from a list with previously approved service providers. This mechanism is predominantly used for provision of services to people with disabilities. It may have different variations: vouchers, personalized budgets, individual services fund, etc.

4. Social contracting in Bulgaria

Impact

The social contracting is among the very well developed mechanisms for contracting out public services in Bulgaria. It is not based on the price offer but on the proposed program for developing the services. Since the reforms in the social sphere in 2002/2003 it has become evident that the social contracting has enormous potential to meet the requirements and the established quality criteria, as well as to convert into key mechanism for consistent implementation of modern and innovative policies in the field of social care. Like any other form of public-private partnership, the social contracting also may compensate the deficits of the public sector in the process of providing social services. According to data from the Ministry of Labor and Social Policy in 2012 (after not more than 10 years of social contracting) more than 20% of the social services are contracted out and these numbers are increasing[21].

The most important contribution of the social contracting could be found in the division between defining the social services and their provision. This separation establishes preconditions for more adequate control over the quality of services, contributes to the avoidance of conflicts of interest, stimulates the providers to develop their services and, in the end, leads to higher quality of the social services. Also, this division reflects the understanding that authorities are better at designing the policies for social services rather

[20] It is possible only on local/municipal level with local budgets but there are additional requirements, i.e. the partnership agreement has to be voted by the local council, etc.

[21] More than 20 000 000 leva per year for the contracted services.

than their direct delivery, while the private providers are working much better *"on the ground"*.

Providers

At present, social services can be provided by three categories of providers. These are as follows:

- **The state;**
- **Municipalities;**
- **Private providers:**

- Individuals, registered under the Commerce Act, respectively carrying out commercial activity in a Member State of the EU or EEA;
- Legal entities, registered under Bulgarian legislation (including CSOs), respectively – according to the legislation of a Member State of the EU or EEA.

Types of social services and requirements

The social contracting mechanism in Bulgaria was adopted in 2002/2003[22]. It is regulated in two normative acts:

- **Social Assistance Act;**
- **The Regulations for Application of the Social Assistance Act.**

Besides them, there are a number of additional normative and other acts that regulate various areas of the procedure – e. g. the annual state budget acts, the Child Protection Act, methodologies issued by the Social Assistance Agency on the parameters that each social service should have, etc. According to the new amendments adopted in January 2016 social services are *"activities in support of persons for their social inclusion and independent living based on social work and are provided in the community and in specialized institutions"*. Depending on the method of financing, the social services are three types – 1) **social services delegated by the state[23]** - those that are listed in the Regulations for Application the Social Assistance Act and are financed from the state budget if their provision is planned to be secured in a specific community; 2) **local activities** – when social services are financed from the municipal budgets, and 3) **activities**, **financed from other sources**. Regarding the facilities the social services in Bulgaria are categorized in two main groups: 1) **community-based social services[24],** and 2) **social services provided in specialized institutions[25]**.

The law allows the development of additional services besides those listed in the Regulations for Application the Social Assistance Act. When it is necessary new types of services can be initiated, taking into account the specific needs of the local community of each municipality. It is essential to note that in practice the state provides funding only for those activities which are listed as delegated state activities in the Regulations. Thus the financing of additional

[22] Significant changes in the legislation were made in 2016 regarding the conditions for placing a person in residential care.

[23] According to paragraph 1, p. 11 of the Public Finances Act: "Activities delegated by the state are the activities on providing state public services to which the population should have ensured equal access in accordance with the actual legislation and which activities are wholly and partially financed from the state budget through the municipal budgets".

[24] Community-based social services are: personal assistant; social assistant; home assistant; home social patronage; daycare center; center for social rehabilitation and integration; social service – residential care (center for family-type accommodation, center for temporary accommodation; crisis center; transitory housing; sheltered home; supervised housing; shelter); social educational-professional center; "Mother and baby" unit; center for community support; center for work with street children; foster care; public canteens).

[25] Specialized institutions for providing social services are: children`s homes (home for children deprived of parental care; home for children with physical disabilities; home for children mental retardation); homes for adults with disabilities (home for adults with intellectual retardation; home for adults with mental disorders; home for adults with sensory disorders; home for adults with dementia); retirement homes.

services is provided either from the local budgets through donor programs or on a contractual basis with the consumers themselves (through collecting fees).

The social contracting regulation is distinguished from the public procurement of services in order to ensure efficiency in spending public funds. The tender procedure could be used for contracting social services that are explicitly listed as funded through the state budget or services that are identified by local authorities as necessary to meet local communities' needs and are funded solely by the municipal own resources.

The mayors of the municipalities, who act on behalf of the local authorities, manage the social services in the relevant municipality as delegated by the state activities. They may decide to open new social services as local activities financed by the municipality budgets. The mayors of municipalities are also responsible for compliance with the criteria and standards for provision of social services.

The private providers of social services which want to participate in a competition for contracting out the management of social services should have been entered in the Register of private providers of social services, respectively to be licensed by the Chairperson of the State Agency for Child Protection when the services are provided to children. Except the legally determined criteria, at the discretion of the mayor, the candidates in the competition may be required to meet additional criteria as ensuring the necessary material basis. According to the amendments in the Law adopted in 2016 the mayor may set a requirement for the services provider to apply with an appropriate facility where the services shall be delivered. The private providers are also entrusted to open and manage social services financed by alternative financial resource (they can do it with grant funding or with fees collected from the users).

Tender procedure

The mayors have the autonomy to take independent decision when announcing competition for contracting out the provision of social services under the Social Assistance Act (for those services that are listed as delegated by the state or those that are announced as local activities). Undertaking steps for contracting out services to private providers is just an option but not an obligation for the mayors. Their only motivation is to seek better quality of the services for the citizens living on the territory of their municipalities.

The mayor shall issue an order for announcing competition for selection of social service provider. This is an administrative act which marks the beginning of the procedure. Its content is legally defined. The indication of the requisites is not exhaustive, but sets minimum obligatory content – e. g. conditions of participation and requirements to the candidates; characteristics and specificities of the social services provided; financing and way of providing funds; application documents; date, hour and method of carrying out the competition deadline and place for submission the documents; method of assessment and others.

According to the law the announcement for the competition must be published at least in one national and one local daily newspaper minimum 45 days before the date of competition. If this provision is not respected then the whole procedure is considered to be infringed. If there is no local newspaper the logically legal solution can be the establishment of a national register where all the announcements could be published.

The mayor should appoint a Commission on carrying out the competition and it has the power to assess the proposals received.

The assessment of the submitted proposals and ranking the finalists has to be done by Commission in 14-day period, documenting its work in a protocol and taking decision in accordance with criteria such as: correspondence of the candidate to the announced terms; experience in the social services provision and commercial reputation; working capacity; financial stability; providing a program for development of the social services and others. The assessment should be focused on the mentioned program for development, thus in cases of two competing candidates most likely to be chosen is the one who has more capacity, experience and vision for the service.

After issuing the order for ranking the candidates, the final phase of the competition procedure ends with signing a contract between the municipality and the winner and specifying the content of the agreement for fulfillment the service itself. The contract should include: subject, price (the amount and the type of financing), guarantees for the use of the budget funds, rights and obligations of the parties, term and sanctions if the obligations are not fulfilled.

Except the competition procedure the law also allows the so-called "*direct contracting",* but only in the case when a single candidate applies. However, in practice this is almost impossible because in order to be found that there is a single candidate, it is required to hold a competition anyway.

Except its obligations under the contract signed with the municipality the provider is obliged to follow all criteria and standards for quality of the service, assessment of the users and additional requirements etc. And whether the contract refers to the legal requirements, the municipality has reason to terminate the contract if the provider does not follow them.

Calculation of the cost of services

- *State funding per capita (or the so-called "unified normative standard")*

This approach is used for social services delegated by the state. The amount of state funding is defined in the annual state budget and is calculated as per capita depending on the planned number of users that a certain service should cover for the whole year throughout the country. This approach is used for both types of services – residential and daily/consultative services. It is supposed to provide the flexibility for the service provider to decide what kind of expenses the funding will be used for in order to achieve the desired results. The particular amount of the costs is decided every year by a working group from Ministry of Finance, Ministry of Labor and Social Policy and the National Association of Municipalities in Bulgaria, and their proposal is adopted by the Council of Ministers.

Besides the state funding received by private providers selected after a contracting procedure for provision of state-delegated services or local activities, there are legal provisions that regulate the amount of the fees that are collected from the users of these services. There are several approaches for defining the amount of the fees:

1) **Defining the amount in a normative act stipulated by the state** (a tariff approved by the Council of Ministers) – this approach is used for the*"delegated by the state services"*. The fee is usually calculated based on the income and property owned by the user. These fees are collected by the mayor or appointed officials of the municipal

administration and submitted to a bank budget account of the Ministry of Labor and Social Policy. The social services for children that are delegated by the state are free of charge except when the payment is regulated by law;

2) **Defining the amount through special provisions in the Local Taxes and Fees Act** - this approach is used for social services that are financed from the municipal budget (the so called local activities).

- *Free market pricing*

The providers which do not receive public funding but provide social services with own private resources are allowed to offer the amount of the fees on a free market base. The fee in these cases is defined upon **agreement between the user and the provider** on a solely market-based approach. This approach could be used for any type of social services.

Important lesson learned for social contracting is that one of its biggest added values is that it provides clear division between the role of funding and the role of provision and through this ensures better and transparent quality control. In the most developed social systems in Europe the social contracting is a base line for building not only the partnership, but the quality provision of services and increasing the resources for that in a sustainable way. It is a key example of public-private partnership where the model compensates the deficiency of public provision of services, creates enabling environment for social innovation and last but not least – solves the most important issue – effectively supports people in need and achieves social inclusion.

- *Funding of social services through grant schemes*

According to the Bulgarian legislation, there are several mechanisms for funding social services and initiatives through "grant" schemes (on a project basis). One example is the program for providing services and training under the Protection from Domestic Violence Act. The grant scheme is managed by the Ministry of Justice. The supported programs for provision assistance to persons who are victims of domestic violence include:

- ✓ Social, psychological and legal counseling by professionals;
- ✓ Referral to other specialists and interdisciplinary consultations, as well as to crisis centers for victims of domestic violence;
- ✓ Training of persons carrying out protection under the law;
- ✓ Specialized programs for people who have experienced domestic violence, and which include social and psychological counseling.

Another mechanism is the "Social protection" Fund. It is a legal entity within the Ministry of Labor and Social Affairs. The Fund allows alternative social services to be financed. Main characteristics of this grant scheme are:

- ✓ A wide range of individuals can apply, as in this way the competition is greater;
- ✓ Possibility of financing alternative social services that are not listed as state-delegated services;
- ✓ Short-term funding – the approved projects should last up to 1 year.

In fact, this is relatively uncomplicated procedure for application with clear criteria and assessment methodology.

Financing social services through funds under Operational programs, mainly Operational Program "Development of Human Resources", is another example. The municipalities are dominating project beneficiaries for opening new or expanding already existing social services.

There are also a lot of examples on municipal level for establishing funds that are supporting CSOs (not directly social service provision in its "narrow" understanding but more general service support and provision)[26].

IV. CONTRACTING HEALTHCARE SERVICES

Definition

There is no specific legal definition in the Bulgarian legislation for *"healthcare services".* Different terms can be met: *"medical services", "healthcare activities", "treatment activities", "healthcare services".* The content of these services can be defined by the activities that are performed by the healthcare (treatment) providers or healthcare facilities. In this sense, the healthcare services include activities for diagnostic, treatment and rehabilitation of patients, medical observation, prophylactic of diseases and early diagnostic of diseases, and measures for supporting and protecting the health[27].

Providers of healthcare services

According to the Bulgarian legislation healthcare services can be provided only by *healthcare providers.* The providers of healthcare services can be established by the state, municipalities or can be private entities (both legal entities and physical persons). In order to acquire the status of provider of healthcare services the entity should follow specific registration procedure regulated by the law. There is one third group – specific treatment facilities, i.e. emergency centers, centers for mental health, hospices, etc. It has to be underlined that a healthcare provider can be established ONLY as a commercial entity (within the Commercial Act) or cooperative (under Cooperative Act)[28]. The healthcare providers perform medical services and in some cases – integrated services (see below).

For the provision of some of the healthcare services listed in law it is enough for the provider to have a specific registration (within the regional healthcare centers)[29], and for other healthcare services it is necessary to have additional accreditation (as a hospital, mental health center[30], etc.). Some healthcare services can be provided only by the state[31] (in this case they are established as legal entities owed by the state).

[26] Small grants for projects of CSOs in the social sphere, including the provision of social services (e.g. Varna Municipality and its competition "Social inclusion of disadvantaged people by stimulating CSO initiatives from Varna Municipality"); Providing new social service with limited territorial scope - "Assistant for Independent Living" Program on the territory of Sofia Municipality).
[27] Article 2, par.. 1 Healthcare Insurance Act.
[28] Article 2 and the following from the Healthcare act.
[29] Article 41, par. 1 Healthcare Insurance Act.
[30] Article 46 Healthcare act.
[31] Article 5, Healthcare Insurance Act. .

Mechanism for providing funding to private providers of healthcare services[32]

- ✓ Services which shall be accessible for all Bulgarian citizens, nevertheless their health insurance status.

The funding of these services is secured and provided by the National Health Insurance Fund (NHIF). These services are: medical emergency treatment, gynecological prophylactic of women, hospital mental treatment, disability assessment, etc.[33]. The provision of those services is ensured by the state or municipal healthcare providers. Despite the emergency services, the other listed services can be provided by private providers and in these cases they can receive public funding for the delivery, but only if a) they have a contract under the implementation of the National Framework Agreement (NFA) and after that they will receive the funding from the NHIF[34], and b) the services are provided to health insured patient.

- ✓ Healthcare services, which are free of charge and are paid by the NHIF[35].

Generally these services are included in the mainstream pack for medical and dental support (detailed listed in the Ordinance 40), in reliance with the particular rules from the NFA for the particular year. Every healthcare insured person can receive these services. Providers can be the established healthcare providers who have contracts under the NFA. The payment is made by the NHIF within the established healthcare packages and procedures. If the providers do not have contracts with the NHIF the clients have to pay on their own the free established prices by the provider.

- ✓ Healthcare services for which the clients have to pay on their own nevertheless their insurance status.

These services are not included in the list of services funded by the NHIF. The clients can receive them on a free market base.

- ✓ Funding for special programs according to article 106 from Healthcare Act (HA)

For developing special programs the state or the local authorities can provide additional funding to the healthcare providers for particular healthcare activities which are not included in the package of services ensured by the NHIF. Additional contract is necessary to be stipulated between the state or local authority and the healthcare provider.

Additionally, the state can provide subsidies for some particular hospitals and facilities which are established by the local authorities and are in rural and hard to reach areas.

As a conclusion, the general rule for public funding of healthcare services can be made to private healthcare providers only if they a) are established as commercial companies and had passed the registration procedure for a healthcare provider, and b) they have an annual contract within the framework of the NFA and only for the listed medical services that are covered for the healthcare insured citizens. This mechanism is inapplicable to CSOs because they are not allowed to be registered as healthcare providers.

V. PUBLIC HEALTH APPROACH TO HIV AND INTEGRATED HEALTHCARE AND SOCIAL SUPPORT

1. PUBLIC HEALTH APPROACH TO HIV – the HIV prevention activities in Bulgaria for many years are seen as part of the health promotion and public health domain. The introduction of the newly adopted National Program for Prevention and Control of HIV/AIDS and STI 2017 – 2020 clearly points that the program is in line with the requirements and

[32] Private providers: not established by the state or municipalities or without their influence in the governance.
[33] Art. 82 Healthcare Act.
[34] Throughout the so called mechanism for ensuring "medical paths".
[35] Art. 45 Healthcare Insurance Act.

obligation that Bulgaria as a state had adopted in implementation of a number of international political documents such as UN Sustainable Development Goals, Declaration for HIV engagement, The Action Plan for European Strategy to fight HIV/AIDS, the 3rd Program for Union action in the field of health (2014 – 2020) , etc. All these documents clearly state the public health and health promotion nature of the activities for HIV prevention and call for the inclusion of the "civil society" in the planning and implementation of these efforts. By definition, civil society organizations (CSOs) include a wide array of organizations, such as community groups, nongovernmental organizations (NGOs), labour unions, indigenous groups, charitable organizations, faith-based organizations, professional associations and foundations.

However, the analysis of Bulgarian laws show that this long-term effective evidence-based practice in HIV prevention in Bulgaria actually is not related to an adequate representation of this philosophy in Bulgarian law system. The Bulgarian Health Act in art. 3 states that state health policy is managed and implemented by the Council of Ministers, which after the proposition by the Minister of Health is adopting national health programs that are financed as differentiated spending from the budget of Ministry of Health. These programs may be supported also by other sources. In Art. 5 of HA is stated that the Minister of Health is leading the national healthcare system. The National health policy on regional level is organized and implemented by the Regional Health Inspections, situated in the regional administrative centers. These inspections are budget supported organizations at the Minister of Health and among others they have clear mandate to perform activities aimed at: 1) health promotion and integrated disease prevention and specifically prevention and control of infectious diseases; 2) development and implementation of regional health programs and projects; 3) coordination and implementation of national and international health programs and projects, etc. The Chapter 4 of the same act is stipulating the existence of health organizations and among them the national centers on different public health problems. These National Centers among other functions have obligations for: 1) prevention, resctriction and eradication of infectious diseases' epidemics, 2) laboratory testing and expertizes; 3) health promotion and integrated diseases prevention. Examples of such national centers are: National Center for Infectious and Parasitic Diseases, National Center for Public Health and Analysis, National Center for Addictions, etc.

It is important to note that in the whole Health Act, HIV/AIDS is directly mentioned only in the Chapter V "Surveillance of Infectious Diseases" of Part II of the act and only in regard of an ordinance about the HIV infected cases testing, reporting and registering. There is no other reference to HIV, nothing to give legal basis for the public health approach and absolutely no mentioning of Civil society and CSOs as an integrated and fundamental part of the HIV prevention activities.

This differs considerably compared to other areas such as mental health and prevention of smoking, use of alcohol and other narcotic drugs.

The Chapter V "Mental Health" clearly states in Art. 145 that the mental health services should be organized and provided by the state, municipalities and CSOs, including those that provide community based social support. It is declared that ensuring such services is an obligation of the local authorities, including by providing the necessary financial support. The hospital treatment of people with mental health problems is envisaged to be ensured by the special hospitals and centers that can be only state owed entities.

There is a separate chapter for activities that are considered as risky factors for the health - smoking, alcohol and drug use. It is clearly stated that the Ministry of Health with other competent authorities and CSOs are creating condition for reduction of those risky factors

(within the national program for reduction of those factors). It is stated that the Ministry shall issue numerous sub normative acts that prescribe measures for reduction of the harm from these factors, the control mechanisms, the prophylactics, etc. Also, it is stated that the municipal authorities must adopt and implement regional programs for prevention of smoking, use of alcohol and other narcotic drugs and more importantly in the same article it is stated that 1% of the annual alcohol and tobacco products taxes should be used for financing these national prevention programs.

A somewhat better legal basis for the involvement of CSOs in the HIV prevention activities is provided for the key risk group of IDUs due to the provision of the Drug and Precursors Control Act (1999). In Chapter VII "Prevention of the use of narcotic drugs, treatment and rehabilitation of people who are abusing or dependent on narcotic drugs" in art. 84 it is stated that in the implementation of the prevention, treatment, rehabilitation and harm reduction programs both on national and regional/municipal level may be involved also legal entities with non-economic status. Several ordinances are developed and implemented following the act's stipulations.

Ordinance 2 from 2012 for the conditions and the rules for implementing programs for treatment of persons addicted to opioids with opioid agonists and agonist-antagonists states the activities can be performed only by healthcare providers that are either specialized psychiatric treatment facilities or treatment institutions that have medical doctors who are psychiatric specialists. Those healthcare providers can apply for a special permission to operate such programs to the Ministry of Health. As discussed elsewhere in this document, this requirement is excluding CSOs from running such OST programs as all healthcare/treatment institutions must be registered as commercial companies.

Only the healthcare providers owned by the state or municipalities that have valid permission for OST program implementation can receive funding from the state under article 106 (with separate contract). The patients are not paying for the treatment. The other providers can apply to receive the medicine (methadone hydrochloride) free of charge from the Ministry of Health, but in this case the patients have to pay for the treatment services (nor more than 1/3 from the minimum labor salary regulated for the state for the particular financial year). In all other cases (private provider who is delivering service/program without state provided methadone), the treatment is paid with a price, determined by the provider. The list of the OST programs with valid permission is preserved at the National Center for Addictions.

Ordinance 8 from 2011 is clearly saying that the psycho-social rehabilitation of people with drug addiction includes system of activities provided in the community and in the healthcare facilities, and it can be developed by providers delivering social services in the community or by health care providers. The services provided in the community have to follow the requirements of Social Assistance Act, and those provided in the healthcare facilities – the medical standard "Psychiatry" approved by the Minister of Health (Ordinance 24 from 2004). The programs can be developed by social services providers or by the providers under article 89 from the Drug and Precursors Control Act. The candidate institutions (that may include CSOs) are filing application with the program project to the National Center for Addictions (NCA) and in one-month period the Director of NCA should give or refuse to give consent for the program with the relevant argumentation. The list of rehabilitation programs with valid positive consents is preserved at the NCA.

Ordinance 7 from 2011 is about the conditions and rules for implementing harm reduction programs related to the narcotic drugs use. The ordinance provides definitions for the harm

reduction activities and re-states the position of the art. 84 from the Drug and Precursors Control Act that these activities may be performed by state institutions, healthcare institutions and legal entities with non-economic status (including CSOs). The candidate institutions (that may include CSOs) are filing application with the program project to the National Center for Addictions and in one-month period the Director of NCA should give or refuse to give consent for the program with the relevant argumentation. The team of the approved program should undergo special training according to a program approved by the Director of NCA. The list of harm reduction programs with valid positive consents is preserved at the NCA.

2. THE INTEGRATED HEALTHCARE – SOCIAL SERVICES. The integrated services and support is something that is very much promoted by different policy documents, but still there is no comprehensive regulation that can ensure efficiency and effectiveness of the process of delivering those services.

According to the Health Act the integrated healthcare-social services are activities, in which medical specialists and social service professionals deliver both healthcare and medical observation in parallel with social work, including in home settings, for different vulnerable[36] groups. These services can be performed by the municipalities, healthcare providers and social service providers (including CSOs who are registered as social service providers). If the last group of providers wants to perform those services they have to inform the Regional Healthcare Inspection offices. If the healthcare providers want to provide the social services they have to go through the registration for social services providers within the Social Assistance Act and the licensing procedure in case the social services are for children.

It is envisaged that the integrated services can be performed for a fee paid by the vulnerable groups that use the services. If there is a national public funding available, it has to be determined with an ordinance by the Council of Ministers (but till now there is no clear regulation on how such public funding will be transferred to the providers). Council of Ministers should also issue a particular ordinance for regulating the precise quality criteria for the integrated services.

It can be summarized that in some of the cases – like the integrated services and the other mentioned above, it is stated that CSOs shall be involved, but there is no particular mechanism how to ensure public funding for the services they will deliver.

VI. CSO SECTOR IN BULGARIA

There are more than 44 000 registered nongovernmental organizations in Bulgaria. Many of those officially registered are not active. Out of the registered organizations, roughly 12 000 have submitted reports to the National Statistical Office in 2014 (such report is mandatory by law for all registered CSOs). The key areas in which CSOs operate are education, social services, culture, youth issues according to the NGO Information Portal (www.ngobg.info).

The USAID CSO Sustainability Index for 2015 gives an overall score of 3.3 for Bulgaria meaning that sustainability is still evolving. Moreover, there is no improvement in the country's score during the last 3 years. The worst scores are within the areas of Financial Sustainability (4.3) and Organizational Capacity (4.1).

[36] Article 125b, vulnerable groups are defined as children, pregnant women, people with disabilities, people with chronic diseases and elderly people.

The registration process of civil society organizations is not too burdensome and expensive. It is expected that from 1 of January 2018 it will be organized by the Registry Agency.

CSOs play a key role in the provision of social services and are a key stakeholder within the contracting out mechanisms. They appear as the group of private providers that is the most dedicated to achieving the social service goals. In most areas CSOs are the main provider on the market of social services. This trend comes from some specifics that these organizations have:

- ✓ They are more flexible and can easily adapt to the particular needs and variety of possibilities for support;
- ✓ They are less bureaucratic and can be more autonomous;
- ✓ They are mission driven, stay very close to the users, very often they are representing the vulnerable groups themselves and because of that they have very high requirements for the quality of the support;
- ✓ They are sensitive to the local needs and context, and have great ability to contextualize;
- ✓ Because they are motivated to develop and constantly upgrade, they often find and invest in the provision of the services additional resources to the public funding they receive. This increases the quality and the outreach of the services.

Contracting out the provision of certain government tasks to private providers does not mean that the government is relieved from any further responsibilities. It remains responsible to ensure that the services are provided in a good quality. This is why the monitoring of service provision is an important part of the contracting process.

VII. CONCLUSIONS AND RECOMMENDATIONS

Lessons learned on social contracting model

The model of contracting out the services to private providers complies with the model of public-private provision of public (social) services[37]. The last is a hybrid between two other models – the traditional centralized model in which the public authorities are playing the roles of service providers, funders and supervisors and the market-based private model – where the private providers are the only providers and they fund the services by themselves.

The division of the roles between the public and private actors in the process of funding and provision of services has a crucial importance for determination of the model on guaranteeing the protection of vulnerable groups. In the case of social contracting the roles are divided as follows:

- ✓ The public authority concentrates on its essential function to develop policies, to provide funding and to control, instead of direct provision of services;
- ✓ The private providers are engaged with social service delivery and they are motivated to enhance their innovation potential, flexibility and ability to up-grade the quality of the services.

The advantage of contracting is that it allows the authority:

- ✓ to take care for the diversity of social needs and problems;
- ✓ to establish different relationships between the provider and the user in comparison with the most traditional provision of services and goods;

[37] Public-Private Partnerships in the Social Sector - Models of Services Delivery. Marc Mitchell

- ✓ to ensure dynamic provision of the services because it follows the everyday life problems and their complexity;
- ✓ to take into account the contexts specifics when striving for efficiency.

The potential of partnerships between the public sector and CSOs to foster the development and enrichment of different services for vulnerable groups is giving more opportunities – from combining resources to ensuring better quality and sustainability. CSOs can attract resources, involve people and receive a greater degree of public support, which undoubtedly affects the efficiency of the process of providing services - faster and better achievement of the objectives and desired outcomes on individual level and policy level. The availability of additional resources also affects the efficiency of the process and the total cost of the common public investments.

Outcomes from the analysis and general recommendations

Though a large proportion of the HIV prevention services provided by the CSOs are a mixture of public health, health promotion, healthcare/treatment and social ones, according to the Health Act the Ministry of Health has the mandate and obligation to be the key player on the government side for the organization, implementation and financial provision for the HIV prevention services. The Ministry of Health is running the National Program for Prevention and Control of HIV/AIDS and STI 2017 – 2020 adopted in March 2017 as the major form of financial provision of HIV prevention services as well as the Strategic Goals 4 – "Improvement of the access for harm reduction services for the individuals and the society" in the National Anti-Drug Strategy 2014 – 2018, where there is a provision of financial resource for the outreach activities among the key risk group of IDUs, which may serve as an additional financial source.

A serious gap in the area is that despite of the long-term effective evidence-based practice in HIV prevention in Bulgaria under the financially supported by GF national program, actually there is no adequate representation of the related public health philosophy and the need for CSO involvement in Bulgarian law system (especially in the Health Act). This may be seen as the fundamental obstacle for sustainable development and financial provision for the HIV prevention activities in Bulgaria.

Along with that, non-adequate involvement of other ministries (Ministry of Labor and Social Affairs, Ministry of Education, Ministry of Youth and Sports, Ministry of Justice) as well as the non-sufficient involvement of the municipalities creates other serious problems for the sustainable provision of public funding for the CSO HIV prevention services.

The analysis of the context however also shows that the organizational level of preparedness of the Ministry of Health at the moment for contracting out the HIV prevention services to the CSOs through the well-known mechanisms of GF is low. Despite the well-developed system of social contracting in Bulgaria related to other fields such as in social assistance, etc. actually the Ministry of Health has no experience of use of such approach and mechanisms in contracting CSO services. Therefore, the basic mechanism for contracting HIV prevention services provided to CSOs by the Ministry of Health will be the basic public tender mechanism according the Public Procurement Act with all the related difficulties.

Another important outcome is that if the main task is to ensure long-term sustainability, it is important to establish a system for partnership that can be easily interacted with similar fields, which are important for developing cross-sectoral interventions and holistic approaches.

The general recommendations with regard to the above mentioned outcomes include:

1. There is a fundamental need for provision of legal basis for the public health and health promotion HIV services and the need for CSO involvement in their implementation (in the Health Act).
2. If the research question is how to ensure partnership in delivering public health, health promotion, healthcare and social services for HIV/AIDS prevention and reduction, it is important to take into account the existing positive experience so far in the social area, as well as the public health and healthcare/treatment system specifics.
3. There is a need further to produce and improve a comprehensive list of HIV prevention services and interventions and to take steps for their financial cost estimation.
4. It is necessary to have clear definition of the social interventions and services among the total package of HIV prevention activities in order to successfully involve the existing system of social contracting both on central and on municipal levels.
5. A part of the process of developing an integrative system for contracting services is to legally regulate the requirements that the providers should follow. It is essential not to regulate new types of social or healthcare providers, but to ensure that the existing ones can provide both groups of services, especially in an integrated manner.
6. In order to ensure efficiency and successful partnership, relevant criteria and quality standards have to be developed that will allow to assess and monitor the impact of the HIV prevention services over the quality of life of its users. This will encourage providers to continuously increase their professional capacity to search and implement innovations.
7. The introduction of social contracting mechanism in HIV prevention activities is related to the need to invest in capacity building initiatives among all involved stakeholders. The Ministry of Health on the one hand has to have the leading role but also the Ministry of Labor and Social Policy and municipalities should also be stimulated to take part in the process.
8. Last but not least, CSOs should be included in the process of policy planning on national and local level. The network of organizations supported till now that provide services for prevention of HIV/AIDS are those that can share experience gathered for more than 10 years. They should be recognized by the relevant state institutions as partners in the process of elaboration and consultation of strategic measures that will ensure the future provision of the mentioned services.

Specific recommendations

The list of recommendations below take into account the above outcomes and general recommendations and focus on the necessary actions that should be taken in order to ensure the continuation of the CSOs sustainable involvement in the delivery of HIV prevention services for the most-at-risk groups (MSM and IDUs) after the cease of the GF financial support. The proposed actions should be organized in several time frames in order to address in the best possible way the identified issues in the area.

The formula for a comprehensive reform shall include a combination of the following approaches:

1.1. **Urgent actions** – these are the steps that should be taken within the current year 2017 in order to fill in the gap that is emerging immediately after the deadline of GF funding on May 31, 2017. The urgent actions should minimum include:

1.1.1. The provision of the funding necessary to cover the costs of the services *by the state* because it has the obligation to secure those who are in need. That could be achieved in the following ways:

a) Use of the last remaining money from the GF – 364 000 EUR for a last no-cost extension that may use the already existing GF contracting mechanism for CSOs and therefore help to sustain the existing CSOs HIV prevention services especially among the key groups of MSM and IDUs. Unfortunately, according to Dr. Varleva and her team during the interview meeting with experts this money is not available for financing of HIV prevention activities.

b) Use of the available financial resources from the National Program for Prevention and Control of HIV/AIDS and STI 2017 – 2020 and the National Anti-Drug Strategy 2014 – 2018 (for the IDUs group) utilizing the already existing public procurement mechanism by the Ministry of Health and the National Center for Addictions respectively. The key moment in that process is to strictly apply and make use of the selecting criteria used under GF funded program (to have capacity for outreach work, to have stable contact with the target groups, enough experience, etc.);

1.1.2. Starting the process of developing legal basis for the financing of HIV prevention activities:

a) Developing and adopting a legal framework for a specific grant mechanism (similar to the grant schemes for protection against domestic violence, etc.) that could be applied by the Ministry of Health and that should exclude the Public Procurement mechanisms. For that, there will be a need for change in the respective article of the Healthcare Act with a corresponding development of relevant ordinance and other legal documents with specific regulations for the implementation of that grant mechanism. After a certain period - to develop a more comprehensive contracting model (separate from social contracting – see 2.1.2). This could be a good starting point for developing experienced and professional providers, quality criteria, practices, etc. In order to regulate a new grant scheme in which the selection is not based on price criteria, a separate part of legislation has to be developed (possibly in Healthcare Act). This is a way for the exclusion of the Public Procurement mechanism.

b) Another approach is to set up particular social services for the target group, and ensure public funding for it. This will make it possible to use the traditional social contracting mechanism that is currently regulated in the social area and is applied by the Ministry of Labor and Social Policies and the municipalities. A challenge in this case however has to be considered: the willingness of the mayors to open and contract such services. In order to use this approach, there is no need to change the law, but to make changes in the annual decisions of the Ministry of labor and Social Policy, the Ministry of Finance and the National Association of Municipalities of Bulgaria in order to ensure funding for those services.

c) Exploring the possibilities for CSO involvement in the provision of the healthcare services in the HIV prevention package.

1.2. **Mid-term actions** – these are steps that should be taken within the period 2018 – 2020. They will secure the long-term sustainability of the delivery of the HIV prevention services with the participation of CSOs. The mid-term actions should minimum include:

1.2.1. Application of a grant scheme for public financing of CSO provided for prevention services among the key risk groups;

1.2.2. Development and pilot testing of more comprehensive contracting mechanism (similar to but separate from the existing social contracting) in several Bulgarian municipalities. Development and adoption of the necessary legal basis for the introduction and functioning of the system that will allow better and more adequate involvement of municipalities in the process of procurement and delivery of HIV prevention services by CSO. Also, this will help to the important integration of the services for the vulnerable groups on the local basis;

1.2.3. Undertake measures that aim at the development of the capacity of partnership between the actors and train them how to use the model in the most effective way. This culture has to be stimulated not only by giving the possibility within the law but also by training the parties how to collaborate. The measures should also aim at the involvement of CSO sector in the monitoring and evaluation process of HIV prevention services procurement and delivery, which will be accomplished by:

a) sustainable development of a "watch dog" NGOs that are not involved in the practical service delivery;
b) foster the formation and functioning of an active and viable association of the CSOs working in the field of HIV prevention among vulnerable groups.

1.3. **Long-term actions** that should be completed by the year 2021. These actions should target:

1.3.1. Establishment of a comprehensive contracting model, involving the municipalities that is fully functional by the year 2021. With regard to that, besides the general recommendations above, the following specific aspects should be taken into account:

a) It is crucial for the model, in order to work well and achieve its goal, to distinguish clearly the roles of the parties involved in the service delivery. The state keeps the role of 1) drafting the policy, 2) taking the decisions to define what is a service and which activities should be funded by the state (so that it will fulfill its obligation to provide social care to vulnerable groups), 3) providing the funding and setting up the specific rules, and 4) monitoring the service provision in terms of funding and quality. The local authorities should be involved in 1) needs assessment, 2) organization of contracting procedures or providing facilities. The private provider should 1) have the obligation to provide the services in a good quality, and 2) ensure the effective use of the funding.
b) Having in mind that most of the services for HIV prevention are integrated services (a combination between social, healthcare and educational interventions), a contracting mechanism can be developed only if the possibility for contracting out public services in these areas exists. The coordination comes when the provider has the possibility under the law to manage different professionals (the doctor, the teacher, the social worker) in a way so that they follow one case management and make a common plan, agree about it, and the provider can pay their intervention from funding sources (budgets) that belong to the respective systems (the payment to the doctor from the healthcare system, the payment to the social workers from the social system, etc.). The existing option for provision of integrated services within the Healthcare Providers Act will allow such services to be provided only 1) by providers who are commercial entities, but not CSOs (because currently they are not allowed to perform healthcare services), and 2) if the state ensures public funding for the services within both systems (social and healthcare) .

1.3.2. Development and adoption of the new National Program for Prevention and Control of HIV/AIDS and STI 2021 – 2025 – it should include measures that will create an enabling environment that will foster the use of the contracting model in the area. Such measures should secure the capacity of all stakeholders to participate and fulfil their role - government institutions (mainly Ministry of Health), CSOs and municipalities;

1.3.3. In all state financing mechanisms, including contracting, it is of key importance to establish transparent decision-making. Adopting standard regulation on the rules of publicity and conflict of interest can facilitate transparency and clear expectations towards the contracting parties.

ANNEX: Summary of interviews

Summary from interviews with Initiative for Health NGO, 31 May 2017, BCNL office and with Health without borders NGO, 5 June 2017, BCNL office

Presentation of Initiative for health NGO: one of the organizations actively working under project funded from both components of the GF. The services they had provided have healthcare-social character and include: a) dissemination of medical consummative (syrengies, etc.) and medical testing, and b) active social work with people tested HIV + (support to acquire ID card, social housing, psychological consultation, etc.) in order to be motivated to follow the treatment. The NGO plays the role as a connecting point between the target groups and the available social services. The NGO focuses its work mainly on the healthcare part while the target groups are redirected towards other social providers in order to receive long-term everyday social support.

Presentation of Health without borders NGO: one of the organizations actively working under projects funded by the GF. The services they had provided are in the area of HIV/AIDS prevention; treatment of sexually transmitted diseases and health education. They were funded in the period 2004 – 2011 by the GF for the establishment of a center for testing of HIV (the only one existing till now). They have experience with all types of target groups, especially with the group of men having sex with men.

Main conclusions from both interview (both organizations shared similar comments and concerns, so the conclusions are valid for both interviews):

As most suitable mechanisms for public funding of the services, supported by the GF, the following approaches and main conclusions were pointed out:

- The service providers need the state funding in order to access the target groups. Till now the state supports a network of medical cabinets where every person can go and receive the services. The target groups that are a priority of the NGO (roma community, drug addicts, people with risky sexual behavior, men having sex with men) however do not use this opportunity or they are not provided with it because of the discriminatory attitudes towards them or because they had not been integrated into the society. For these target groups special types of services need to be available (for example in Ordinance 7 these services are pointed but they are only for the drug addicts, not for the other target groups).
- In the beginning the most suitable mechanisms for provision of state funding for such services would be the grant mechanism (with annual contracts for grant funding) because of the experience gathered by now. In the Ministry of Health there is a structure that has already some capacity in the area of monitoring of projects funded by the GF. It is advisable to keep this structure and to upgrade its capacity. Such grant mechanism could be used in the pilot phase during the next 3-4 years until the deadline of the existing National healthcare strategy. Within this pilot period legislative amendments can be elaborated and planned so that in the end of the pilot

period a contracting mechanism for this type of services is introduced in order to secure the stable long-term funding for these services.

- The municipalities should be involved in the process of planning and contracting of this special type of services, however some risk should be taken into account within the advocacy (see below). Also there are municipal strategies on HIV prevention and it could be researched whether a financial support cannot be distributed through these documents.
- If a contracting mechanism is elaborated, it is necessary to be guaranteed equal participation for all types of providers (NGOs and healthcare entities).

Main risks if the funding is organized as a grant mechanism are pointed as follows:

- the risk that the Ministry of Health will authorize the Regional healthcare departments (monitoring and licensing structures of the Ministry) to provide the services to the target groups;
- the risk municipalities (if they are involved) will contract their own structures (municipal hospitals and medical centers), rather than to use the network of NGO providers that had worked with the target groups till now;
- the mechanism for pricing of the services – currently there are guidelines from the Ministry of Health that describe these services but do not regulate their pricing. It is possible to think about using the methodology for budgeting the projects supported by the GF as a basis to formulate the pricing in the future. The pricing should be made in a way so that the providers are stimulated to involve more and more people from the target groups as well as to take into account the fact that the number of the people in these target groups is constantly changing.

Stakeholders that should be part of the planning, contracting and monitoring of these services:

- **Ministry of Labor and Social Policy and the Ministry of Health** - the services are aiming to achieve healthcare objectives as a final effect, but using mainly social approaches and instruments to do so. The secondary aims of the services are of entirely social character and not medical. Because of the above it is obligatory to involve the Ministry of Labor and Social Policy and the Ministry of Health. Both ministries should have leading role in the process of planning.
- **NGOs that had been supported in the provision of the services by the GF -** these NGOs should be provided with the opportunity to continue their work and be supported through planned state funding.
- **Municipalities** – they may provide infrastructure where the services can be delivered (buildings and properties).
- **Ministry of Justice –** it may also play specific role in the process of contracting of these services for those people from the target groups who are inprisoned.
- **Ministry of Finance –** it should be involved because it will be responsible for the mechanism for pricing the services and for national budget sharing.

- **Regional Healthcare Inspections and the National Center for Addictions** - they could be involved in the process of monitoring together with the special structure within the Ministry of Health.
- **Healthcare mediators** – they are already trained for these services but they can also play the role of a key partner to the service provider and could be used as an additional resource.

The role of NGOs in the process of planning, contracting and monitoring

Currently there is a National council on prevention of sexually transmitted diseases where NGOs are participating. The Council is chaired by the Minister of Health. The council could be used as a mechanism to involve NGOs in the process of decision-making related to these services. This council currently approves the contracts with NGOs that receive funding from the GF.

Besides the role of a services provider a challenge that needs to be addressed is the lack of a watchdog organization that will monitor the transparency of the future policy and funding process related to these services.

Meeting with Dr. Tonka Varleva, Director of HIV/AIDS Prevention and Control Programme of the Ministry of Health, and her team at the HIV Prevention Program Meeting room at the National Center of Infectious and Parasitic Diseases, 26 June, 2017.

The involvement of CSO in the implementation of HIV prevention activities among the most at risk groups is seen as big priority and all efforts at the moment are aimed at ensuring that there will be no gap in the financial support for their work.

According to Dr. Varleva and her team, the good news is that the new political leadership in the Ministry of Health and especially the responsible Deputy Minister of Health – Mrs. Yordanova are very supportive for the role of CSO in HIV prevention actitivies.

The adoption of the National Program for Prevention and Control of HIV/AIDS and STI 2017 – 2020 on 23 March 2017 with Council of Ministers Decision № 163 is seen as a major positive step in that direction. Even more, currently on April 25, it is approved the planning for budget spending for year 2017 at total of 500 000 leva.

The desire of Dr. Varleva and her team is to use the already existing Global Fund procedure for contracting CSOs to perform prevention activities. At the same time, they are aware that under the law it is mandatory to use the public tender procedures of the Public Procurement Act and that there may be significant sanctions in case of non-compliance with the law. Therefore, a question was sent to the Public Tender Agency whether they may use the already existing GF procedure or not. If the answer is “no” then there is readiness to continue with the standard public tender procedure.

This procedure is considered to have the possibility to effectively support the CSOs with the crucial condition of successfully implementing the GF criteria in the competition process (to be NGO, to have capacity for outreach work, to have stable contact with the target groups, enough experience, etc.).

The general sum for the financial coverage of the CSOs HIV prevention services for the target groups provided by the National Program is clearly smaller compared to the financial aid from the GF. Therefore, there is a plan to integrate the coverage of the services for the different target groups – so, in one city only CSO may get financing for implementing HIV prevention services for all local key target groups (for example, IDUs+MSM+Roma, etc.). On the other hand, this may result in fewer CSOs getting funding.

In the longer time period, the important task is seen to find and introduce legal basis for the use of grant and competition mechanisms that may go around the Public Tender procedures and use the proven its efficacy GF model.

Another way of enhancing the CSO involvement is the improvement and further development of the functioning of the National AIDS Council. For that, the ex-minister of Labor and Social Affairs - Hristina Hristova, is recruited as a consultant, she is currently advisor to the Vice-Premier Valeri Simeonov.

A different possibility for an additional financial source for the HIV prevention activities for the key risk groups is in the preparation of the new Social Assistance Act, its project is currently under consideration on the web page of the Ministry of Labor and Social Affairs.

Another ambitious goal is the development of local HIV situation analysis on municipal level and the further preparation of municipal HIV strategies and action plans.

As a more distant goal was mentioned the idea for creation and function of HIV Prevention Fund at the Ministry of Health, which may play the role as a financial resource and the municipalities may apply for funding to it.

Dr. Varleva and her team were clear that there is a big need for the development of the legal basis for HIV prevention activities in Bulgaria. Also, they all admitted the lack of such professional legal capacity inside the Ministry of Health and expressed the need for an external professional legal capacity and help for achieving that goal.

In relation to that, Dr. Varleva proposed the idea of organizing a working meeting with the responsible Deputy Minister Mrs. Yordanova for discussion of the possible directions for further legal development in the field of HIV prevention.

List of abbreviations

AIDS - Acquired Immune Deficiency Syndrome
ART – antiretroviral treatment
BCNL – Bulgarian Center for Not-for-Profit Law
CHP – Center for Humane Policy
CSO – civil society organization
EC –European Commission
EEA – European Economic Area
EU – European Union
GF – the Global Fund to Fight AIDS, Tuberculosis and Malaria
HA – Healthcare Act
HBV – Hepatitis B Virus
HCV – Hepatitis C Virus
HIV – Human Immunodeficiency Virus
IDU – injection drug user
MSM – men having sex with men
NCA – National Center for Addictions
NFA – National Framework Agreement
NGO – non-governmental organization
NHIF – National Health Insurance Fund
OST – opioid susbtitution treatment
SGI – service of general interest
STI – sexually transmitted infection
UN – United Nations
USAID – United States Agency for International Development