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Legal and Documentation Gaps in the Organization of Urgent Medical Care in Bulgaria

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ABSTRACT

Urgent medical care in Bulgaria occupies a gray area between emergency response and routine outpatient treatment. This article examines the normative and institutional shortcomings that hinder the quality and accessibility of urgent care services. Key regulatory documents some outdated fail to define urgent care clearly or enforce consistent documentation and oversight. Data collection mechanisms have been relaxed, staff employment often relies on informal contracts, and patient-provider continuity is disrupted. We propose targeted reforms: modernizing legislation, reintroducing accountability procedures, and ensuring integration between providers. These improvements are essential to promote equity and effectiveness in urgent care across Bulgaria.

Keywords:

Urgent and emergency care, Legal regulation, Documentation.

Introduction

The health care reform and the establishment of the National Health Insurance Fund (NHIF) were key steps toward improving the deteriorating health status of the Bulgarian population in the late 1990s. Strategic goals at the time emphasized better access, equity, sustainability, transparency, and effectiveness. Urgent (non-emergency) medical care, although not often in the spotlight, is a critical component of the primary care system, especially outside regular working hours. However, its organization in Bulgaria is marred by legal ambiguity, insufficient funding, lack of oversight, and serious human resource shortages.

This paper aims to critically review the legal framework regulating urgent care in Bulgaria, identify the gaps in documentation and implementation, and propose improvements for more effective and equitable urgent care delivery.

Discussion

Legal framework and practical challenges

The Constitution of the Republic of Bulgaria (Article 52) guarantees access to free health care under terms set by law. Despite this, patients frequently face out-of-pocket payments, undermining the principle of universal access. According toArticle 103 of the Health Act, the state is obliged to organize and finance a system for providing medical care in emergency situations, aiming to prevent death, severe morphological or functional disabilities, and complications during childbirth [1,2].

Apart from emergency care, urgent medical care exists, whose legal framework is fragmented and dates back to Ordinance No. 10 of 1994, which defines the organization and accountability of urgent care units in healthcare facilities [3,4].

According to this Ordinance:

"Urgent medical care is medical activity for providing timely assistance to sick and injured persons whose life is not directly threatened but who require medical help within a short time to prevent worsening of their condition." [3]

Urgent medical care is defined legally, and obligations are outlined in various regulations, including Ordinance No. 10/1994 and Ordinance No. 40/2004, which detail the responsibilities of general practitioners (GPs) in providing care outside regular hours [5,6].

However, urgent care is inconsistently implemented. While GPs are required to ensure 24-hour care through on-call arrangements, delegated practices, or consultation hotlines this often leads to service gaps. Many practices contract external facilities that may not be closely integrated into the patients' ongoing care, disrupting continuity and efficiency [1]. Some key legal documents, the date of the establishment and the focus to healthcare services are presented in Table 1:

The legal definitions of "emergency" and "urgent" care are often conflated in practice. Emergency care addresses life-threatening conditions and is publicly funded through the Ministry of Health. Urgent care, conversely, covers conditions that require medical attention within a short time frame but are not life-threatening. Despite the different funding sources (urgent care is financed via NHIF), lack of clarity in regulation leads to misuse of emergency services for non-emergent cases, burdening emergency departments and delaying care for true

Table 1: Key legal documents and focus to healthcare services.

Key Legal Documents	Focus	Year
Ordinance No. 10	Urgent medical care regulations	1994
Ordinance No. 40	NHIF-covered health services	2004
Ordinance No. 25	Emergency medical care framework	1999

emergencies [3,7].

Ordinance No. 25/1999 outlines the scope of emergency medical care and responsibilities of various institutions. However, there is no equivalent updated standard for urgent care. Ordinance No. 10/1994 still governs the latter, and although amended, it reflects outdated institutional arrangements and fails to ensure modern standards of documentation and oversight [1,8].

A further problem lies in the disconnection between GPs and urgent care providers. GPs often outsource this function, and urgent care teams frequently operate without access to patients' full medical histories. This lack of integration reduces the quality and safety of care, particularly when diagnostics or follow-up are needed [9,10].

Documentation and oversight deficiencies

Urgent care providers are obliged to report service delivery to the NHIF monthly, supported by electronic reports, patient lists, and invoices. However, changes introduced in 2016 removed the requirement to submit monthly duty schedules. Instead, practices declare once which facility covers their urgent care, after which no regular updates or monitoring occur. This leads to the absence of real-time oversight or accountability [7,11]. Data are presented in Table 2:

Table 2: Some gaps in labor protection and performance tracking.

Documentation Element	Before 2016	After 2016
Monthly duty schedules	Mandatory submission	No longer required
Oversight of schedules	NHIF/Ministry involvement	Declared once, no monitoring
Provider–patient integration	Limited	Often disconnected

Compounding the problem is the frequent employment of medical staff under non-standard contracts (civil or informal arrangements), leading to gaps in labor protection and performance tracking. Moreover, no dedicated directorate within the Ministry of Health monitors urgent care. As a result, services are left to function in a legal and regulatory vacuum, increasing variability in quality and availability [2,12].

In smaller municipalities, urgent care is sometimes better integrated due to the proximity and accessibility of GPs. In contrast, urban residents often interact with unfamiliar providers in rotating shifts, weakening continuity and patient–physician relationships [8,13].

A (Lack of clear regulation) --> B (Inconsistent provider roles);

B --> C (Fragmented patient records);

C --> D (Low care quality and safety);

A schematic flowchart could show how lack of monitoring leads to poor service coordination, which reduces care quality and increases patient dissatisfaction.

Table 3: Emergency vs. urgent medical care in bulgaria.

Criterion	Emergency Care	Urgent Care
Financing	Republican budget (via Ministry of Health)	NHIF (for health-insured individuals)
Provided by	Centers for Emergency Medical Services, hospitals	General Practitioners, duty offices, private/ municipal structures
Accessibility	For all citizens regardless of insurance status	Only for health-insured patients
Standard	Yes – Ordinance No. 45/2010	No – no official medical standard
Legal Definition	Ordinance No. 25/1999	Ordinance No. 10/1994
Role of Emergency Units	Primary – transport and primary resuscitation	Limited – receive and redirect signal if necessary

The lack of a medical standard for emergency care further worsens the conditions for implementing quality activities and makes it difficult for control bodies. The obligations of GPs are presented for better visualization in Table 4:

Table 4: Options for providing urgent care by GPs

Option	Description
1. Group Practice	Through a duty office within the group practice
2. Contract with another medical facility	Located within 35 km of the GP's practice location
3. Individual Practice	Telephone consultation or home visits
4. Shared GP Schedule (in sparsely populated areas)	Rotating shifts 8:00–20:00 + minimum 6 hours on holidays/weekends
Legal Definition	Ordinance No. 25/1999
Role of Emergency Units	Primary – transport and primary resuscitation

The legal requirement for general practitioners (GPs) in Bulgaria to ensure 24-hour access to urgent medical care reflects an important public health commitment but is fraught with practical and regulatory challenges. Although the legislative framework (e.g., Ordinance No. 40/2004) provides several mechanisms through which GPs may fulfill this obligation including on-call services, contractual partnerships, and regional duty rotations implementation remains inconsistent.

A major concern lies in the outsourcing model, where GPs contract private medical centers to fulfill urgent care responsibilities. While legal, this practice often lacks adequate oversight, raising questions about the quality, continuity, and

clinical responsibility for care delivered under such agreements. In many cases, patients are unaware of the arrangements or encounter fragmented services, especially during nights or weekends.

The financial remuneration of 0.26 BGN per insured person per month is grossly insufficient and does not incentivize GPs or third-party providers to invest in sustainable, high-quality on-call care. This underfunding contributes to systemic inefficiencies, including overuse of hospital emergency departments for non-emergency cases, longer waiting times, and dissatisfaction among both patients and providers.

Additionally, the lack of standardized protocols for urgent care provision in general practice means that the level and quality of care can vary significantly across regions. This variability undermines equity in access to healthcare and highlights the need for national standards, monitoring systems, and possibly a rethinking of the financing model.

Recommendations

- Introduce minimum standards and quality indicators for urgent care services provided by or on behalf of GPs.
- Strengthen the contractual and accountability mechanisms for outsourced services, including regular audits.
- Consider increasing the funding rate to reflect the true cost of maintaining round-the-clock availability.
- Promote regional collaboration models in underserved or rural areas, supported by centralized coordination.
- Improve patient communication and transparency regarding how and where they can access urgent care.

Conclusion

Urgent medical care in Bulgaria remains under-regulated and under-monitored, despite its essential role in the healthcare continuum. The lack of a modern, clearly defined legal framework and the absence of consistent oversight mechanisms hinder effective planning and resource allocation. Reform should begin with updating Ordinance No. 10/1994 to reflect contemporary health system organization, introducing binding documentation standards, and restoring monthly duty reporting. Establishing a dedicated supervisory unit within the Ministry of Health would further enhance accountability.

These steps are vital to ensuring quality, equity, and continuity in urgent care services, thereby supporting the broader goals of the Bulgarian healthcare system.

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