

Urgent Medical Care in Bulgaria: Importance, Challenges, and Organization

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ABSTRACT

The reform of emergency medical services was the first stage in modernizing the National healthcare system in Bulgaria. Preceding in time the reform of other outpatient and inpatient care structures, it has played and continues to play the role of a safeguard buffer in the process of building a modern healthcare system in the country. Ensuring uninterrupted access to emergency medical care for the population is a primary concern and responsibility of the state. In this regard, urgent care has remained in the background. Growing disparities between social groups are evident, as legally regulated access to urgent care is reserved for individuals with uninterrupted health insurance rights. Before, during, and after the healthcare reform in the period 1997–2001, the role of urgent care has gained increasing significance; however, it remains underfunded, with limited resources and virtually no legal regulation.

Keywords:

National Health Insurance Fund (NHIF), General Practitioner (GP), Urgent care, Current realities.

Introduction

Between 1997 and 2001, Bulgaria underwent a reform in its healthcare system. The most significant change was the transition from a state-budget-funded model to one funded by a Health Insurance Fund [1,2]. The law stipulates that both emergency and urgent medical care are free of charge for every citizen of the country [3].

Following this change, the role of urgent care in preserving the population's health has gained more importance. On the other hand, it remained underfunded, with limited resources and minimal legal regulation [4]. According to the medical standard, an emergency condition is one that has the potential to cause severe or irreversible morphological or functional damage to vital organs and systems or death including critical dysfunction of vital functions, loss of organ or body part function, and temporary or permanent disability if immediate medical action is not taken [5]. Unlike emergency medical care, which is financed by the National budget, urgent care falls within the scope of medical assistance covered by mandatory health insurance [1,2].

Exposition

During the study, numerous information sources regarding the health insurance systems of EU member states, as well as the USA, were reviewed and analyzed. Legislative acts and reports on the activities of structures analogous to the NHIF were examined, along with comparative data and studies from the WHO and the European Commission, as well as analyses by the National Statistical Institute on healthcare in Bulgaria [1,2,6,7].

The legal framework is detailed in Ordinance No. 10/1994 on urgent medical care. According to it, urgent medical care is defined as “*medical activities for providing timely care to ill or injured individuals whose lives are not directly threatened,*

but who require medical assistance within a short timeframe to prevent the further development and complication of their condition [4]”.

Urgent medical care is directly financed by the Health Insurance Fund, and therefore only insured Bulgarian citizens are entitled to it [1,2].

As of December 31, 2023, the number of physicians in Bulgaria was 29,599. The highest population coverage is by general practitioners - 6.0 per 10,000 people. They are followed by cardiologists (2.9), obstetricians-gynecologists (2.7), anesthesiology and intensive care specialists (2.7), surgeons (2.3), pediatricians and neurologists (2.2 each), and emergency medicine physicians (1.9 per 10,000 people). The total number of doctors per 10,000 people is 45.9. The regions with above-average physician coverage include Pleven, Sofia (capital), Plovdiv and Varna [6,8].

Only four Emergency and Urgent Care Centers (EMUCs) serve the capital, with recent years seeing the implementation of the idea for air emergency medical services [9,10].

Patients in need of urgent care require a rapid, though not immediate, response from medical professionals to diagnose the acute condition and relieve accompanying symptoms or syndromes, such as nausea, vomiting, headaches, abdominal or chest pain, among others. This care includes follow-up treatment, therapy optimization, or the initiation of new treatment. An urgent condition requires timely intervention within 2 to 4 hours of the onset of symptoms for clarification, diagnosis, and appropriate therapeutic action [11,12].

Comparative analysis of emergency and urgent medical care in Bulgaria: significance, challenges, and organization

The importance of urgent care within the healthcare system is increasing, primarily because during a significant part of the day on weekdays and entirely during weekends and public holidays, patients rely on it [2,6].

Before the reform in June 2000, urgent care was considered a supplementary form of healthcare, serving as an additional

support pillar within every municipal/state healthcare facility to manage less critical emergency cases. In essence, it represents emergency care that allows for some delay, with the urgency of the condition assessed by the physician [13,14].

A comparative analysis of emergency and urgent care was conducted to better visualize the challenges. Table 1 outlines the definitions, organization, and future prospects of both sectors:

Table 1: Comparative analysis of emergency and urgent care.

Criterion	Emergency Care	Urgent Care
Definition	Life-threatening conditions requiring immediate intervention in or outside hospitals	Medical care for conditions that, while not immediately life-threatening, cannot wait for a routine GP appointment because the condition may deteriorate and become life-threatening
Care providers	Emergency Medical Centers (EMC), ambulance teams with doctors, hospital emergency departments	GPs, with emphasis on after-hours duty offices and shifts
Access and entry	Via 112 (ambulances) or direct visit to an emergency department; EMCs operate on-site	Visit or call to personal GP, after-hours groups on evenings/weekends
Level of equipment	Well-equipped ambulances, teams with physicians; hospital shock rooms and observation areas	Basic diagnostic capabilities; no intensive equipment
Problems and challenges	Overload, low coordination, unequal distribution of staff and equipment	Overuse for minor cases, burdening EMCs and hospital emergency departments
Reforms and directions	Introduction of triage standards, training, financial reforms, and infrastructure upgrades (2014–2020)	International inspiration from community urgent care/walk-in centers
Response time	Urban areas: up to 30 min; Rural: often over 30 min	Usually faster for minor needs, but no specific Bulgarian data
Patient experience and satisfaction	Partial improvement post-pandemic; long wait times still reported	Models in Bulgaria not yet widely implemented; GP duty system still evolving

At the start of the reform, post-June 2000, there was an unsuccessful attempt to transfer the responsibility for urgent care to General Practitioners (GPs). Initially, GPs were confused and hesitant about the new obligation to provide 24-hour care for their patients. To comply, they began organizing rosters, each taking one night shift per month to collectively cover the full month [15-17].

It soon became clear that this system of shared duty rosters among GPs would not be sustainable for several reasons. Not only due to the lack of financial incentives for GPs to provide such services, but also because of the emergence of private medical centers in major cities, primarily Sofia and Plovdiv - that took over the responsibility for urgent care from GPs [13,14]. These private centers assumed the function of providing urgent care in exchange for the payments due from the NHIF to the GPs for this activity—either receiving the payments directly from the NHIF or indirectly through agreements with the GPs [11,14].

In other regional centers outside Sofia and Plovdiv, municipal and state hospitals were compelled to establish medical centers with urgent care offices due to the GPs' lack of interest in distributing overnight, weekend, and holiday shifts among themselves.

Although the regulations do not prohibit GPs from volunteering to provide duty shifts in urgent care offices attached to external healthcare facilities, such instances are rare. GPs are relieved of this obligation in exchange for transferring the monthly fee of BGN 0.26 per patient, which they receive from the NHIF for

ensuring 24-hour care. On the one hand, this frees up time for GPs, but on the other, it drastically reduces their direct contact with patients from the intended 24 hours, it realistically drops to about 5 hours per day [14,18,19].

During the remaining hours, patient care is handled by urgent care centers—hence the growing role of urgent care in safeguarding public health.

A widely publicized case emerged in a small town where the urgent care office within the municipal hospital was forced to close due to a lack of staff and funding. A local MP attempted to address the issue but instead escalated the public tension. In a televised interview, he implied that the obligation for GPs to provide 24-hour care to their patients still formally exists. He stated that the outsourcing of urgent care to an external medical center had failed, leaving a town of 33,000 people without such services. The prevailing public sentiment became that GPs should take on this responsibility and organize duty shifts themselves [14].

Public data revealed that some GPs in the town were earning up to BGN 15,000 per month while working only 4–5 hours a day on weekdays. At the same time, doctors working in the outsourced urgent care office earned 30 times less only BGN 500–600 per month on civil contracts. These physicians were responsible for providing care during the remaining 19–20 hours of each weekday and full 24-hour coverage on weekends and holidays [7,20].

The GP's remarks were strongly criticized by the medical

community. GPs maintained that they were only responsible for the 4–5 weekday hours and that what happens with their patients during the remaining 19–20 hours and on weekends and holidays is not their concern or responsibility. According to them, a return to the originally envisioned 24-hour care model is unthinkable [12,13,21]. This time-based division of responsibilities between GPs and urgent care approximately in a 5 to 19-hour ratio has led to depersonalization of healthcare

and the breakdown of the GP patient relationship, which was a core concept of the 2000 healthcare reform [3,6,13,22]. Table 2 presents a more up-to-date situation regarding the criteria for assessing the importance of emergency and urgent care. These include triage protocols, training and resources, shifts, integration with other services, patient flow load, air services and, last but not least, staffing shortages [23,24].

Table 2: Extended comparative analysis of emergency and urgent care in bulgaria (Post-2022).

Criterion	Emergency Care	Urgent care/GP shifts
Triage protocols	National standards with color codes (red ≤ 8 min, yellow ≤ 20 min, green ≤ 120 min); includes phone and priority triage	Basic telephone screening; GP duty shifts redirect some patients, but no effectiveness analysis
Training and resources (PULSS)	Over 6,900 people trained via PULSS project (2017–2023): doctors, paramedics, drivers; simulation-based practical sessions	GP shifts operate with general medical instructions; no specific “urgent care” training
Equipment and technology	358 new ambulances (types B, C, and 4 × 4) delivered by March 2024; high-clearance vehicles for 5 EMCs	Usually basic equipment; no centralized tele-triage or GPS/112 integration
GP duty shifts	–	Expanded since 2022 in regional cities, but no national regulation or statistics
Integration with other services	Full connectivity with 112, Mol, and emergency departments via unified information system	Mostly operates independently; no direct contact mechanism with EMC or 112
Patient flow and load	Around 30% of patients in EDs arrive on their own, increasing emergency department overload	Often handles minor cases like cough or sore throat; no national data collection
HEMS (Air ambulance services)	Pilot flights started; expansion planned for 2025–2026 – still in early phase	–
Staff shortage	Estimated 40–60% shortage in EMC staffing; GP shifts rely on available doctors without emergency specialization	GP duty shifts compensate for other gaps, but lack long-term strategy

A fundamental, still unanswered question remains: What happens to patients during the remaining 19–20 hours of the day and during weekends and holidays?

Key Takeaways from Table 2:

- Emergency care has made progress through standardized triage protocols, training under the PULSS project, and updated technical infrastructure ambulances, simulators, and HEMS (Helicopter Emergency Medical Services) pilots [2,6,7,10]
- Urgent care, on the other hand, has evolved in a fragmented way through GP duty shifts and private urgent care clinics. However, it currently lacks a regulatory framework and consistent effectiveness analysis [10,13,14].
- A significant gap in the system is the lack of integration and statistical monitoring for GP shifts: Who is seen? What diagnoses are made? What referrals are issued? There is no clear framework or national oversight [10].

In Sofia and Plovdiv, private medical centers have been created, to which GPs have transferred the urgent care function. Patient care outside GPs’ working hours is essentially delegated. Since the NHIF reimbursement of BGN 0.26 per patient per month is insufficient, these centers—being registered as commercial entities seek to increase their revenue by charging patients for each service. This practice contradicts Article 52(1) of

the Constitution of the Republic of Bulgaria, which states that:“*Citizens have the right to health insurance guaranteeing them access to medical care and free use of healthcare services under conditions and procedures established by law*” [25].

Moreover, although not every specific activity is listed in the National Framework Agreement (NFA), GPs receive bundled payments for comprehensive care for their patients. Therefore, interpreting any unlisted activity as one requiring additional patient payment is incorrect and illegal [1,2,26].

In Sofia, urgent care offices generally maintain patient fees in line with regular GP visits. However, in Plovdiv, prices are higher and every billable activity is charged. This may be because the two main urgent care centers are owned by non-medical investors whose main goal is profit. They argue that since many services are not covered by the NFA, patients must pay. Examples from their pricing lists (not exhaustive):

- Charging mileage fees several times higher than taxi services for home visits (in violation of Art. 8 of Ordinance No. 10/1994, which states such visits must be free for the patient);
- Charging inflated prices (3 × pharmacy retail price) for any injectable medications administered during visits—contrary to the Health Establishments Act, which grants dispensing rights only to licensed pharmacists.

- Requiring payment for death certificates at extremely high rates, with close relatives forced to pay to proceed with burial formalities. In some cases, these visits are accompanied by funeral agents—raising potential conflict of interest concerns. (By contrast, GPs do not charge for death certificates, but since they work only ~5 hours/day, patients are much more likely to encounter the urgent care team.)
- In other regional cities, urgent care offices are established within municipal or state hospitals and mostly function as auxiliary units acting as a filter for hospital emergency departments (e.g., in Burgas and Varna) [11,13,14]. There are also instances where urgent care offices exist only formally (with no patients during entire shifts), while the nearby emergency department handles all cases. The rationale is that the urgent care office cannot order any tests, whereas the emergency department just ten meters away can, and patients there are exempt from the BGN 2.90 copayment (e.g., in Pernik) [13].

As previously mentioned, during approximately 19–20 hours of each weekday and 100% of weekends and holidays, the responsibility for public healthcare lies with urgent care services. This illustrates their critical importance to public health. In reality, patients are served by urgent care during 85%

of the time. GPs work only about 15% of the month:

$$5 \text{ hours/day} \times 22 \text{ work days} \div (24 \text{ hours} \times 30 \text{ days}) \approx 15\%$$

At the same time, urgent care remains underfunded, with limited resources and minimal legal regulation [2,6,22,26].

In many urgent care offices, there is high staff turnover, and although doctors are officially appointed, paramedics (feldshers) often work there—even though by law they are not permitted to examine patients independently [5].

Modern healthcare structures allow newly graduated doctors, most of whom are still residents, to work second and third jobs to earn higher incomes. As a result, they are often fatigued, while the challenges in urgent care are considerable. The range of conditions they face is diverse and requires a high level of professionalism and the ability to quickly switch between specialties. It is not uncommon for a shift to include patients with a purulent carbuncle, acute psychiatric crisis, and hypertensive emergency in sequence. Physicians must stay highly focused, as patients with acute myocardial infarction also frequently appear often due to patient preference for urgent care offices over hospital emergency departments, or simply because of a lack of understanding of the healthcare structure [17,21,26].

Table 3 presents a more up-to-date situation regarding the criteria for assessing the importance of emergency and urgent care:

Table 3: Extended Comparative Analysis of Emergency and Urgent Care in Bulgaria (2022–2024 Data).

Criterion	Emergency Care	Urgent Care/GP Shifts
Call handling	24% of 112 calls in 2021 were not responded to; pressure due to service scope limitations [mediapool.bg]	–
Staff shortage	Approx. 500–6,545 vacant positions in EMCs (up to 60%) in 2024; GP shifts filled with available non-specialist doctors	–
Training and qualification (PULSS)	Over 7,000 trained by 2023–24 (68–71% rated practical utility as “very good”); €7 million project; includes simulators, algorithms, standards, telelearning	No specific programs. Uses general GP guidelines – not prepared for urgent care
Equipment	400+ ambulances delivered (types B, B4×4, C), updated diagnostic/mechanical equipment, and 9 high-clearance models by Feb 2024	Basic equipment; no telemedicine or GPS/112 integration
Integration and system approach	Enhanced linkage with 112 and Mol; NextGen 112 platform implemented; HEMS system launched (6 helicopters by 2026)	GP shifts operate in isolation, with no direct connection to EMCs or 112
Patient load/flow	30% self-referred patients; since 2019, ~24% of calls to emergency teams remain unfulfilled	Frequent visits for mild conditions (e.g., cough, pain); no official statistics on GP shifts
HEMS and infrastructure	First training flights in 2024; national program plans 6 helicopters and 6 bases by 2026 (coverage radius ~250 km)	–

Despite the high professional demands, there is no quality control mechanism for the medical services provided in urgent care offices.

In many cases, physicians are hired without even verifying their diplomas. In the best-case scenario, they work on civil contracts, but in over 50% of cases, they have no contracts at all i.e., they work illegally [14].

In most cases, neither the GP (who outsourced their patients’ care) nor the manager of the medical center is interested in the doctor’s knowledge or qualifications. The only goal is to “cover the shift” to ensure “there is someone in the office.” This is likely due to high turnover and the general lack of interest in working

under such conditions, largely due to inadequate funding [20,24,27].

Even highly qualified urgent care doctors are severely limited in diagnostic and therapeutic capabilities [6,14,21]. They are not allowed to issue referrals to specialists, nor to order lab tests, imaging, or instrumental diagnostics. They rely solely on a stethoscope and an ECG machine [7,12,13].

These examinations also leave no trace in the patient’s health records. The only documentation is a handwritten entry in the ambulatory journal, which includes only the patient’s name, age, and working diagnosis. According to a flawed ordinance, this record must be archived every three years [10,23,26].

From all the above, it becomes clear that during 85% of the month, health-insured patients are served by an underfunded, diagnostically limited, and almost entirely unregulated medical structure, staffed by underqualified, overworked, and often uncontracted personnel, with no medical documentation of their work [2,6,13].

A subject for future studies is whether and how these circumstances impact morbidity and mortality in the country.

Conclusion

In recent years, the emergency medical care system in Bulgaria has demonstrated significant progress in the standardization of triage protocols, through the introduction of color-coded categories and the implementation of national guidelines for prioritized treatment. This includes extensive training under the PULSS project, with over 7,000 healthcare professionals trained, using simulation-based practical exercises.

Additionally, more than 400 new ambulances of types B, B-4x4, and C were successfully procured and equipped with diagnostic and support technology, improving emergency preparedness.

Despite these achievements, chronic staff shortages remain a critical issue, with up to 60% of positions in Emergency Medical Centers (EMCs) remaining unfilled. This leads to over 20% of emergency calls through 112 going unanswered and causes delays in emergency care delivery. Another pressing challenge is the integration of new technologies such as telemedicine and GPS tracking, whose large-scale impact has yet to be fully assessed.

Urgent care (GP duty shifts and clinics) in Bulgaria is still in its early developmental phase, spreading mainly in regional cities without a clear national regulatory framework or systematic data collection on patient flow and efficiency. The lack of specialized training and equipment in "urgent care" settings limits their ability to properly triage patients and reduce the burden on emergency departments.

Looking ahead, the expansion of HEMS (Helicopter Emergency Medical Services) with six helicopters planned by 2026, as well as the thorough evaluation of tele-triage solutions, could improve response times and provide more equitable access to emergency and urgent care services. To achieve lasting results, sustainable investment, a national framework for GP duty shifts, and the creation of a unified information platform covering all levels of emergency care are essential.

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