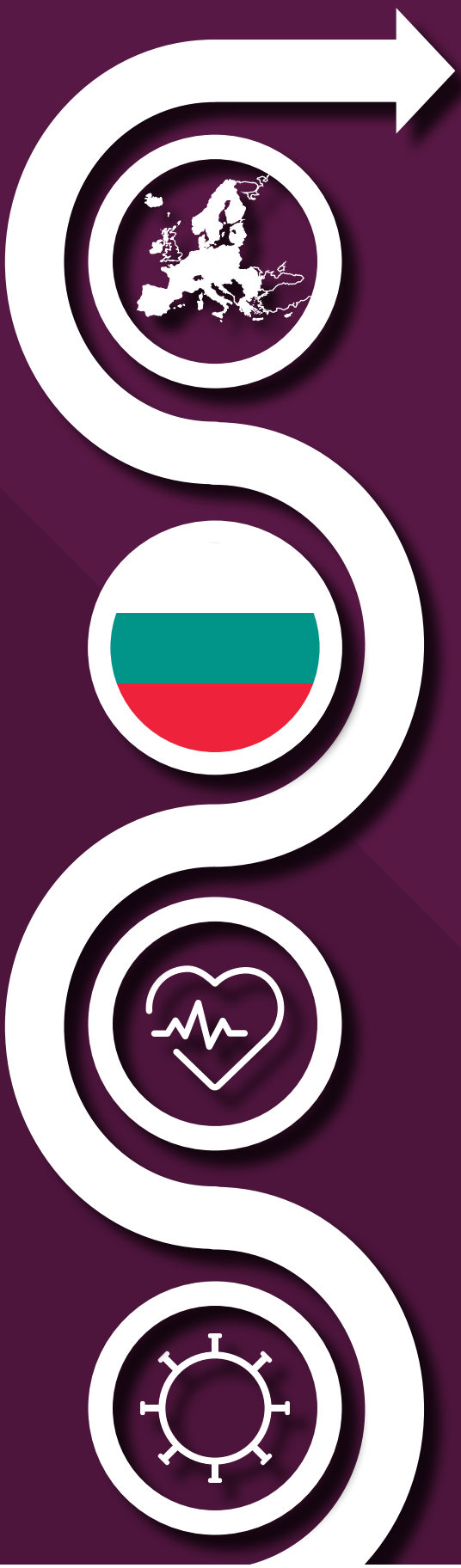


State of Health in the EU

BULGARIA

Country Health Profile 2025

European Commission

OECD
BETTER POLICIES FOR BETTER LIVES

European Observatory on Health Systems and Policies
a partnership hosted by WHO

The Country Health Profiles series

The *State of Health in the EU*'s Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policy makers and influencers with a means for mutual learning and knowledge transfer. The 2025 edition of the Country Health Profiles includes a special section dedicated to pharmaceutical policy.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Observatory's Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

Contents

Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys, the Survey of Health, Ageing and Retirement in Europe (SHARE), the European Cancer Information System (ECIS) and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was finalised in September 2025, based on data that was accessible as of the first half of September 2025.

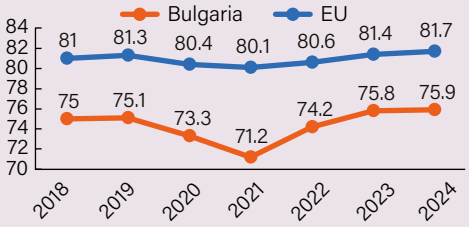
Demographic and socioeconomic context in BULGARIA, 2024

Demographic factors	Bulgaria	EU
Population size	6 445 481	449 306 184
Share of population over age 65	24 %	22 %
Fertility rate 2023[1]	1.8	1.4
Socioeconomic factors		
GDP per capita (EUR PPP)[2]	26 265	39 675
At risk of poverty or social exclusion rate[3]	30.3 %	20.9 %

1. Number of children born per woman aged 15-49.
2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.
3. At risk of poverty or social exclusion (AROPE) is the percentage of people who are either at risk of poverty, severely materially and socially deprived, or living in a household with very low work intensity.

Source: Eurostat Database.

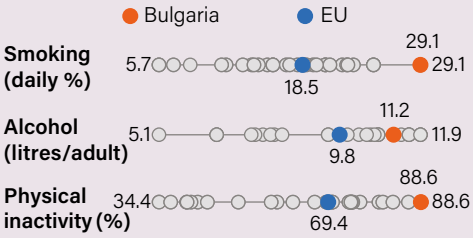
1 Highlights



Life expectancy at birth

Health Status

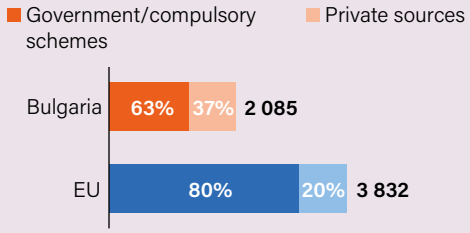
Bulgaria's life expectancy remains the EU's lowest despite its post-pandemic recovery. After sharp losses in 2020–21, it rebounded in 2022 to reach 75.9 years in 2024, surpassing its pre-pandemic level, yet still almost six years below the EU average. A wide 7.4-year gender gap reflects higher male exposure to behavioural risks, alongside persistently high cardiovascular mortality.



Adults, 2022 (or nearest year)

Risk Factors

The proportion of adults in Bulgaria who smoke daily is the highest in the EU, without any reduction over the past decade. Alcohol consumption has not declined either and remains over 10 % higher than the EU average. While obesity rates among adults are low, only 11 % of adults reported doing physical activity at least three times per week, the smallest share in the EU.



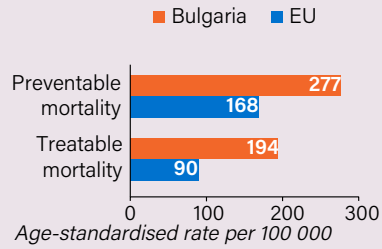
Health spending per capita (EUR PPP), 2023

The Health System

Health expenditure per capita in Bulgaria in 2023 was only about half the EU average (after adjusting for differences in cost of living). As a share of GDP, Bulgaria devoted 7.9 % of its GDP to health, well below the EU average of 10.0 %. Public funding covered 63 % of health expenditure, a much lower proportion than the EU average of 80 %, with nearly all of the remaining costs being paid out-of-pocket.

Health System Performance

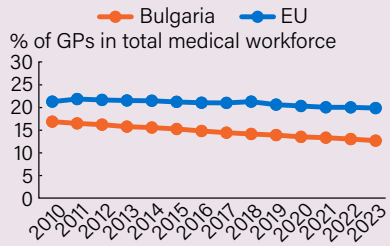
Effectiveness



Age-standardised rate per 100 000 population, 2022

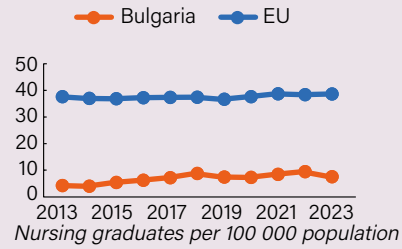
Bulgaria records one of the EU's highest avoidable-mortality rates. Preventable mortality rose in 2019-22, due to COVID-19, while treatable mortality has scarcely improved in a decade and remains more than twice the EU average. Since stroke and ischaemic heart disease dominate both categories, policy responses prioritised zero-copay cardiovascular drugs and new stroke centres.

Accessibility



Bulgaria faces a low and decade-long declining supply of GPs, compounded by stark regional imbalances that restrict access and shift care toward hospitals. A 2021 move to allow independent practices for nurses, midwives, and rehabilitation therapists has had limited effect without NHIF reimbursement, prompting NRRP-backed incentives and a 2027 national strategy to rebalance primary care.

Resilience



Nursing graduates per 100 000 population

Bulgaria's persistent nursing shortfall is driven by a very low graduate output, compounding already low nurse density and straining service delivery. Structural factors include limited training places, poor working conditions and low pay, which depress recruitment and retention. Recent reforms designate nursing and midwifery as priority fields and make programmes tuition-free.

Spotlight: pharmaceuticals

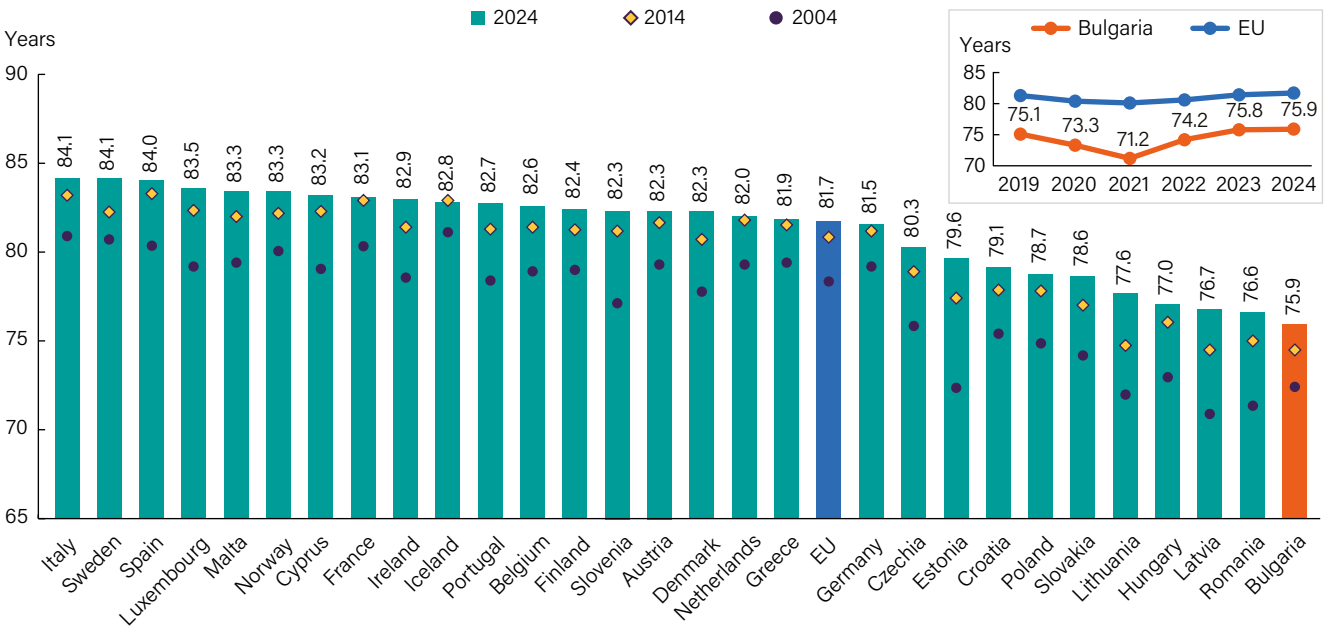
Bulgaria devotes the largest share of its health spending in the EU to pharmaceuticals, yet public coverage for retail medicines is the EU's lowest, reflecting low overall health spending and shallow outpatient drug coverage. This creates a high out-of-pocket spending burden, with households financing over 75 % of these costs. While policies to ease the financial strain on citizens are being introduced, rules preventing pharmacy-level substitution constrain savings from lower-cost generics, and while eventual coverage for new medicines is broad, patients face some of the longest reimbursement delays in the EU. On a positive note, a national digital tracking system has proven effective in mitigating medicine shortages.

2 Health in Bulgaria

Bulgaria's life expectancy at birth is the lowest in the EU

Life expectancy in Bulgaria has historically ranked among the lowest in the EU. Following a sharp decline during the first two years of the COVID-19 pandemic in 2020 and 2021, life expectancy began to rebound in 2022 and reached 75.9 years in 2024, exceeding its pre-pandemic level. Despite this recovery, Bulgaria continues to trail significantly: its life expectancy remains the lowest in the EU, almost six years below the EU average (Figure 1). The persistent gap reflects both aggregate mortality patterns and substantial internal inequalities: the life expectancy gender gap in Bulgaria is particularly pronounced at 7.4 years, substantially larger than the EU average gap of 5.2. While this gender gap has narrowed incrementally since 2010, the persistent disparity is largely driven by higher exposure among men to behavioural risk factors, particularly smoking and excessive alcohol consumption.

Figure 1. Life expectancy at birth in Bulgaria was almost 6 years below the EU average in 2024



Notes: The EU average is weighted. Data for Ireland pertains to 2023.
Source : Eurostat (demo_mlexpec)

Cardiovascular diseases are responsible for nearly two thirds of all deaths

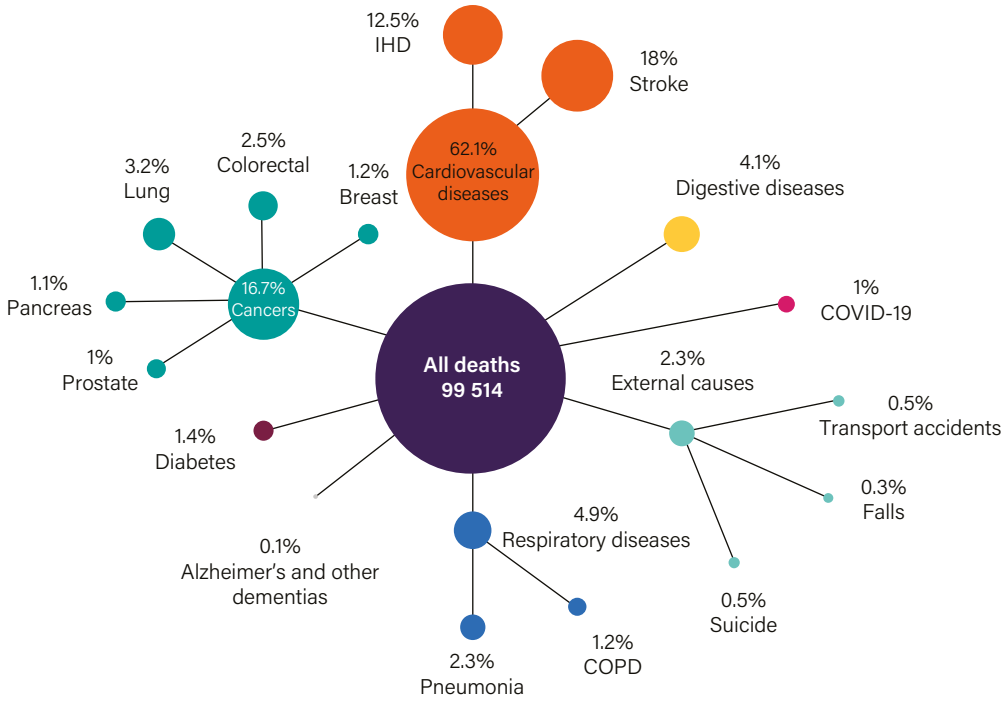
Bulgaria faces a severe and persistent cardiovascular disease (CVD) mortality burden, which has shown the slowest decline in the EU over the past decade. Between 2012 and 2022, CVD mortality fell by only 8 %, compared to an average reduction of over 20 % across the EU.

This long-standing challenge continues to dominate the country's health outcomes. In 2023, CVDs were the leading cause of death by a wide margin, accounting for over 60 % of all mortality, nearly double the EU average of 33 % (Figure 2). This burden compresses the relative contribution of other causes: cancer was the second leading cause at 17 % compared with an EU average of 23 %, while respiratory and digestive diseases each accounted for nearly 5 %. By contrast, deaths attributed to Alzheimer's disease and other dementias were negligible, consistent with a competing-risk pattern and possible differences in diagnosis and certification practices. In response to persistent prevention and treatment gaps, the government introduced a landmark pharmaceutical reform in April 2024. The policy provides 100 % reimbursement for 56 essential cardiovascular medicines and heavily subsidises over 300 others. Early results are promising: nine months after implementation, the National Health Insurance Fund (NHIF) reported that an additional 30 000 people were effectively managing their conditions, with a corresponding decrease in hospitalisations for complications.

Most Bulgarians report being in good health, but gender and income disparities are large

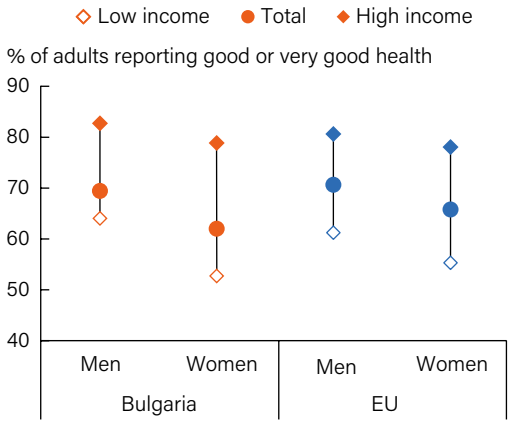
In 2024, 66 % of Bulgarians reported good health, slightly below the EU average of 68 %. As elsewhere in the EU, there is a sizeable gender gap in favour of men: 70 % of Bulgarian men reported good health compared with 62 % of women (Figure 3). Income-related differences are even larger, particularly among women: only 53 % of women in the lowest income quintile reported good health, compared with 80 % in the highest quintile. For both men and women, these income gaps in self-reported health are wider than the EU average.

Figure 2. Cardiovascular diseases and cancer accounted for over three-quarters of all deaths in Bulgaria in 2023



Notes: IHD = ischaemic heart diseases; COPD = chronic obstructive pulmonary disease.
Source: Eurostat (hlth_cd_aro); Data refer to 2023.

Figure 3. Income-based disparities in self-reported health are more pronounced in Bulgaria than the EU average



Note: Low income refers to adults in the bottom 20 % (lowest quintile) of the national equivalised disposable-income distribution, while high income refers to adults in the top 20 % (highest quintile).
Source: Eurostat based on EU-SILC (hlth_silc_10). Data refer to 2024.

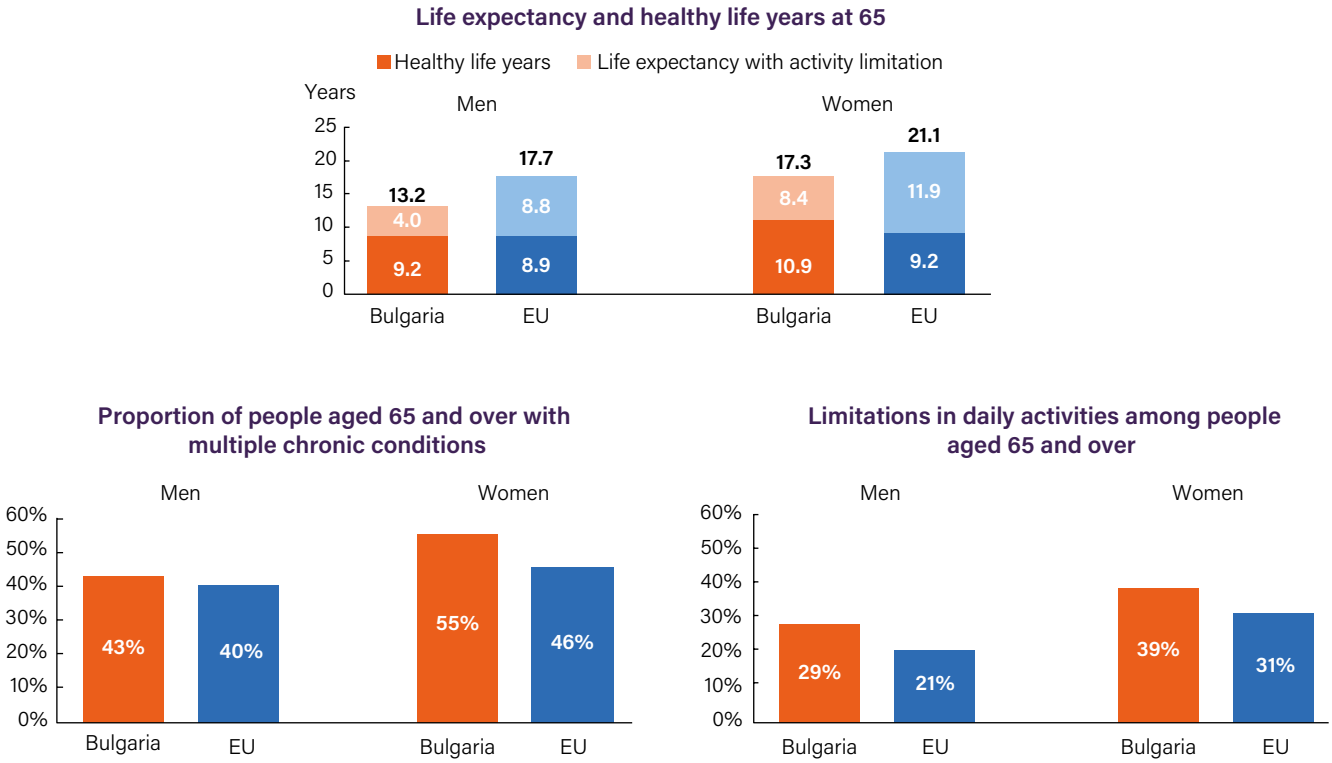
Bulgaria's ageing population faces a high burden of chronic illness

Bulgaria's population is among the oldest in the EU: the share of people aged 65 and over rose from 16 % in 2000 to 24 % in 2024 and is projected to reach about 31 % by 2050, broadly in line with the expected EU average. At age 65, life expectancy in 2022 stood at only 15.4 years compared with 19.5 years in the EU. By contrast, healthy life years (HLY) at age 65 were slightly higher than the EU average at just over 10 years compared with 9.1. This seemingly positive health statistic is, however, at odds with data on chronic illness: in 2022, 43 % of Bulgarian men and 55 % of women aged 65 and older reported multiple chronic illnesses, while 29 % of men and 39 % of women reported functional limitations, all figures above their respective EU averages (Figure 4). This complex picture suggests that while the period of disability at the very end of life in the Bulgarian population is relatively shorter, potentially reflecting high mortality from acute cardiovascular events, the burden of chronic morbidity among the surviving elderly population remains high.

The incidence of cardiovascular diseases is among the highest in Europe

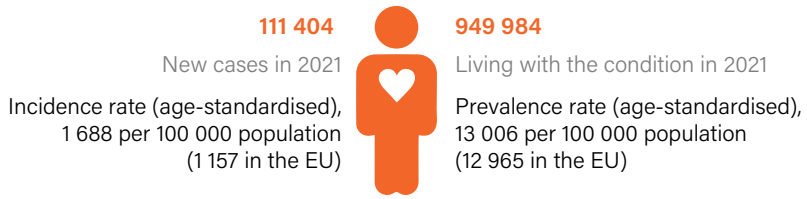
Consistent with Bulgaria's high cardiovascular mortality, the incidence of CVDs is among the highest in the EU. According to estimates from the Institute for Health Metrics and Evaluation (IHME), over 116 000 new cases of CVDs occurred in Bulgaria in 2021 and almost 950 000 people were living with a CVD. This corresponds to an age-standardised incidence rate of 1 688 per 100 000 population, almost 50 % above the EU average, while the prevalence rate was only slightly higher (Figure 5). This combination of higher incidence but only slightly higher prevalence points to lower survival after CVD events in Bulgaria than elsewhere in the EU. Ischaemic heart disease, also termed coronary artery disease - caused by narrowing of the coronary arteries, is the primary driver of this trend, accounting for half of all new CVD diagnoses with an estimated 58 000 new cases annually.

Figure 4. A large share of Bulgarians aged over 65 report multiple chronic conditions and limitations in daily activities



Source: Eurostat for healthy life years (tespm120, tespm130) and SHARE survey (for chronic diseases and limitations in daily activities). Data refer to 2022 and 2021-22, respectively.

Figure 5. Around one in seven people are living with a cardiovascular disease in Bulgaria

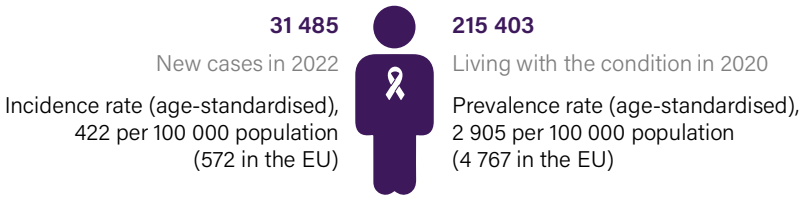


Source: IHME, Global Health Data Exchange (estimates refer to 2021).

High cardiovascular disease mortality suppresses observed cancer rates in Bulgaria

The profound mortality burden from CVDs in Bulgaria creates a significant competing-risks dynamic that fundamentally reshapes the epidemiological profile of other major non-communicable diseases, particularly cancer. This dynamic, whereby a substantial portion of the population succumbs to cardiovascular events before reaching advanced ages when cancer risk is highest, directly influences observed cancer patterns. Cancer ranks as the second leading cause of mortality in Bulgaria, yet according to estimates from the European Cancer Information System (ECIS), its incidence in 2022 was 26 % lower and prevalence in 2020 was 39 % lower than the EU average (Figure 6). Although these figures are consistent with the competing-risks effect combined with lower cancer survival rates, the data warrant cautious interpretation, as they likely also reflect deficiencies in diagnostic capacity, limited access to preventive screening programmes and issues with the completeness and quality of national cancer registries (OECD/European Commission, 2025).

Figure 6. Almost 31 500 new cancer cases in Bulgaria were estimated for 2022



Source: European Cancer Information System (estimates refer to 2022 for incidence data and 2020 for prevalence).
Notes: These are estimates that may differ from national data. Cancer data includes all cancer sites except non-melanoma skin cancer.

3 Risk factors

Behavioural and environmental risk factors account for 36 % of all deaths

A substantial proportion of mortality in Bulgaria is attributable to preventable risk factors, with the overall burden considerably exceeding the EU average. Estimates from the Institute for Health Metrics and Evaluation (IHME) indicate that in 2021, approximately 50 000 deaths in Bulgaria were linked to behavioural factors such as dietary risks, tobacco smoking, alcohol consumption and low physical activity. Among these, poor diet and high smoking rates are the most significant contributors to this burden. Furthermore, environmental factors pose a significant threat to public health. In the same year, an estimated 11 000 deaths were attributable to air pollution, specifically exposure to fine particulate matter ($PM_{2.5}$) and ozone. Taken together, these risk factors accounted for 36 % of all deaths in Bulgaria in 2021, a share markedly higher than the EU average of 29 %.

Persistently high tobacco and alcohol use, especially among youth, demands stronger prevention

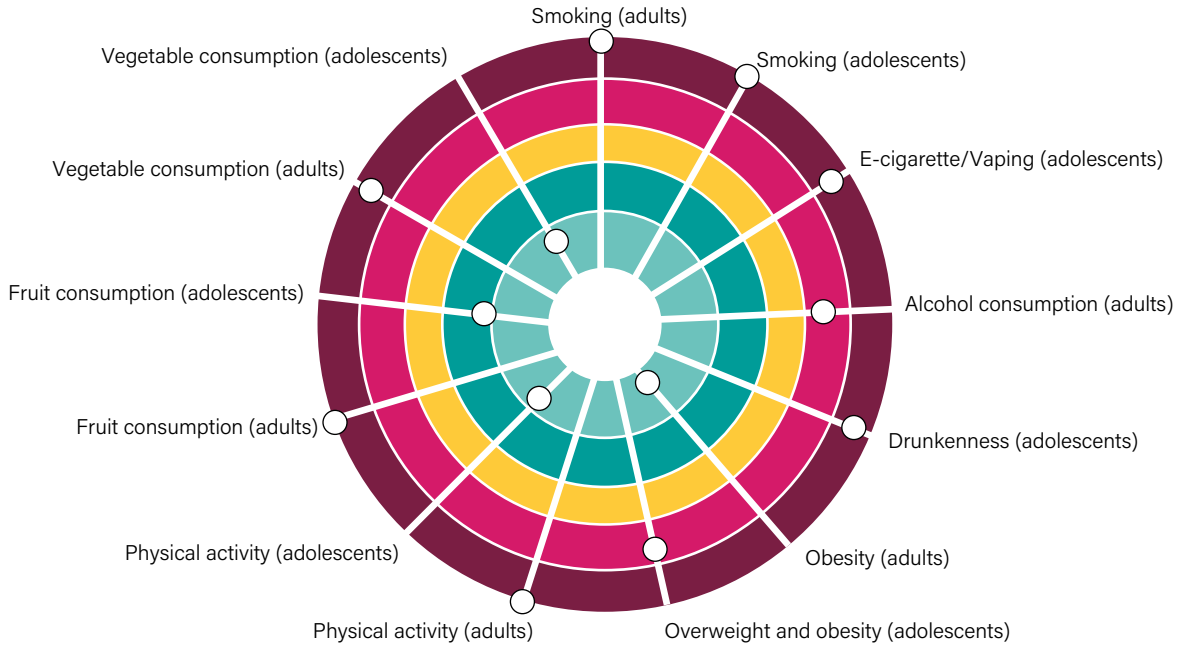
Adult smoking rates in Bulgaria are the highest in the EU: 29 % of adults smoked daily in 2019 and, unlike in most other EU countries, rates have not declined over the past decade. The burden is uneven by gender, with men nearly twice as likely to smoke as women, reflecting differential social exposures and gendered patterns of tobacco use. Rates among adolescents are equally alarming: in 2022, 32 % of 15-year-olds reported smoking cigarettes in the past month and nearly a third reported using e-cigarettes. These figures are among the highest in the EU, highlighting substantial obstacles to preventing tobacco and nicotine initiation among youth. In response, Bulgaria has recently increased excise taxes on tobacco products, with further rises planned to align with the updated EU minimum excise duty requirements for 2025.

Alcohol use follows a similar pattern: In 2022, 36 % of 15-year-olds reported having been drunk more than once - nearly one and a half times the EU average of 23 %. Among adults, per-capita alcohol consumption was 11.2 litres, about 14 % above the EU average of 9.8 litres. The persistence of high tobacco and alcohol use indicates entrenched behaviours and points to the inadequacy of current prevention strategies.

Rising adolescent obesity threatens Bulgaria's favourable adult obesity rate

While Bulgaria's adult obesity rate was the third lowest in the EU in 2022 at 12 %, this positive outcome is contrasted by widespread behavioural risk factors. An above-average share of adults report poor nutritional habits, with only 34 % consuming fruit daily and 43 % consuming vegetables daily. Moreover, levels of physical activity are a significant concern: at just 11 %, the proportion of adults engaging in some form of physical activity at least three times per week is the lowest

Figure 7. Bulgaria scores worse than most EU countries on most behavioural risk factors for health



Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country reaches the white target area, indicating that all countries have room for improvement in all areas.
Sources: OECD calculations based on HBSC survey 2022 for adolescents indicators; and Eurostat based on EU-SILC 2022 and OECD Data Explorer for adult indicators (2022 or nearest year), except for smoking (EHIS 2019).

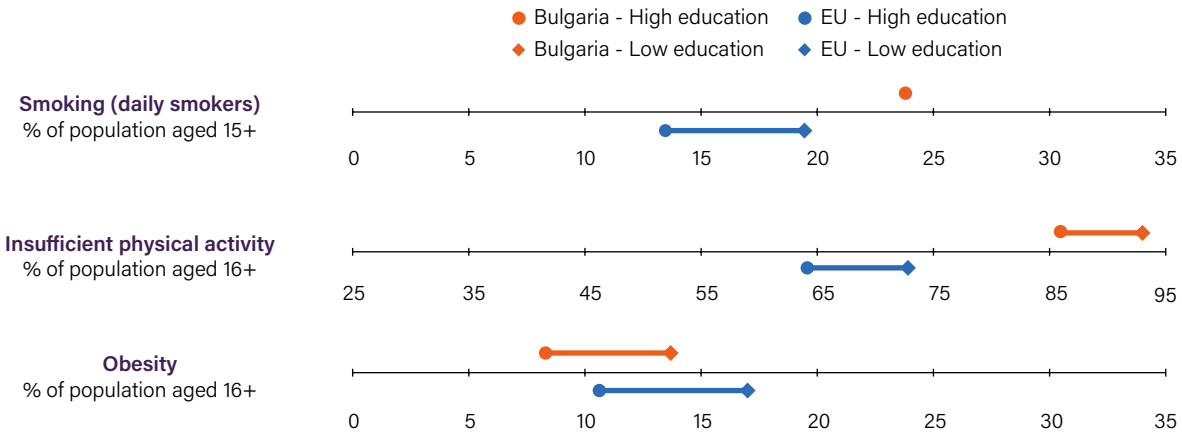
in the EU (Figure 7). The most pressing challenge is among adolescents, where the risk of rising obesity undermines Bulgaria's relatively favourable adult statistics. In 2022, 24 % of 15-year-olds were overweight or obese, up from 20 % in 2014 and above the EU average of 21 %. The gender gap is large, with boys three times more likely than girls to be overweight or obese.

Adolescent behaviours present a mixed picture: in 2022, 18 % reported daily moderate physical activity, slightly above the EU average of 15 %, and daily fruit and vegetable consumption were also marginally higher than the EU average. These patterns suggest that recent policy measures, including restrictions on unhealthy foods in schools and mandated low-salt, low-fat options in nurseries and children's kitchens may be having an effect, though not yet sufficient to reverse the upward trend in adolescent obesity (World Cancer Research Fund International, 2023).

Most health risks in Bulgaria are concentrated among the less educated

With the exception of smoking, which is similarly prevalent among Bulgarians with the lowest and highest education levels, most behavioural risk factors in Bulgaria are more common among the least educated. The contrast is strongest for adult obesity: 14 % among those without upper secondary education compared to 8 % among individuals with tertiary education. By comparison, education-related gaps in physical activity are smaller, as low activity levels are widespread across all education groups (Figure 8).

Figure 8. With the exception of smoking, risk factors cluster among the least educated



Note: Low education is defined as the population with no more than lower secondary education (ISCED levels 0-2), whereas high education is the population with tertiary education (ISCED levels 5-8). Low physical activity is defined as people doing physical activity 3 times or less per week.
Source: Eurostat based on EHIS 2019 for smoking (hlth_ehis_sk1e) and EU-SILC 2022 for physical activity and obesity (ilc_hch07b, ilc_hch10).

4 The health system

Bulgaria runs a centralised SHI system with a single purchaser and primary care gatekeeping

Bulgaria operates a centralised health system under a compulsory social health insurance (SHI) model. The Ministry of Health (MoH) oversees system organisation and performance, defines the publicly funded benefits package and directly operates the national emergency care network, the 28 hygiene-epidemiological inspectorates and several national research and reference centres. The Executive Agency 'Medical Supervision' (*Meditsinski nadzor*) registers outpatient facilities, hospices and other establishments and coordinates transplantation activities.

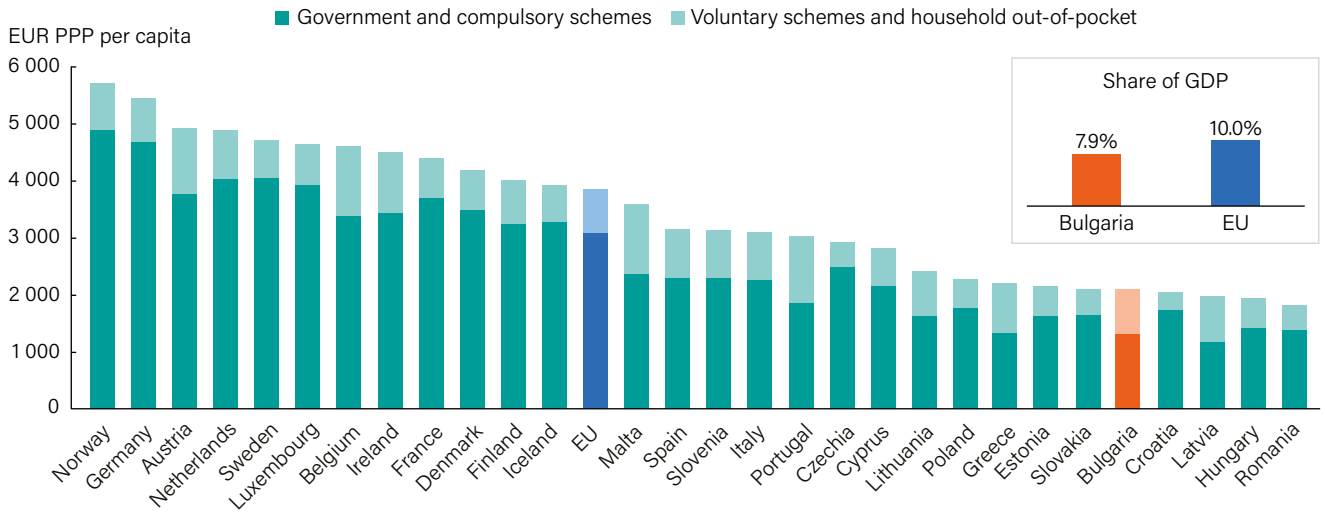
SHI is compulsory for all residents and is centrally managed by the NHIF, the single purchaser of services, with purchasing executed through 28 Regional Health Insurance Funds (RHIFs). At the district level, 28 Regional Health Inspectorates act as MoH branches for public health control and policy implementation. Municipalities contribute to governance through municipal health commissions and are important owners of providers.

Pharmaceutical governance is shared by the Bulgarian Drug Agency and the National Council on Prices and Reimbursement of Medicinal Products. Care is delivered by public and private hospitals, clinics and medical centres within the NHIF-contracted network, with free choice of provider. General practitioners act as gatekeepers to diagnostics, specialist outpatient care and hospital admission, and referral volumes are managed through quarterly quotas.

Low public funding drives the EU's highest rate of out-of-pocket health spending in Bulgaria

Health expenditure in Bulgaria is significantly lower than the EU average. In 2023, per capita spending was EUR 2 085 (adjusted for differences in purchasing power), just over half the EU average of EUR 3 832, while health spending as a share of GDP stood at 7.9 %, well below the EU average of 10.0 % (Figure 9). The structure of this funding also differs notably from the EU average: public sources financed only 63.0 % of current health expenditure, one of the lowest shares in the EU. As a direct consequence, the burden of financing falls more heavily on individuals: out-of-pocket (OOP) payments constituted 36.0 % of all health spending, the highest share in the EU and more than double the average of 16.0 %, with voluntary health insurance (VHI) playing only a marginal role. This high OOP spending share is driven by cost-sharing for most statutory services and direct payments for medicines and services outside the public benefits package (see Section 5.2).

Figure 9. Health spending per capita in Bulgaria is among the lowest in the EU



Note: The EU average is weighted (calculated by OECD).
Sources: OECD Data Explorer (DF_SHA); Eurostat Database (demo_gind). Data refer to 2023.

Hospital care and pharmaceuticals dominate Bulgaria's health spend, crowding out outpatient care

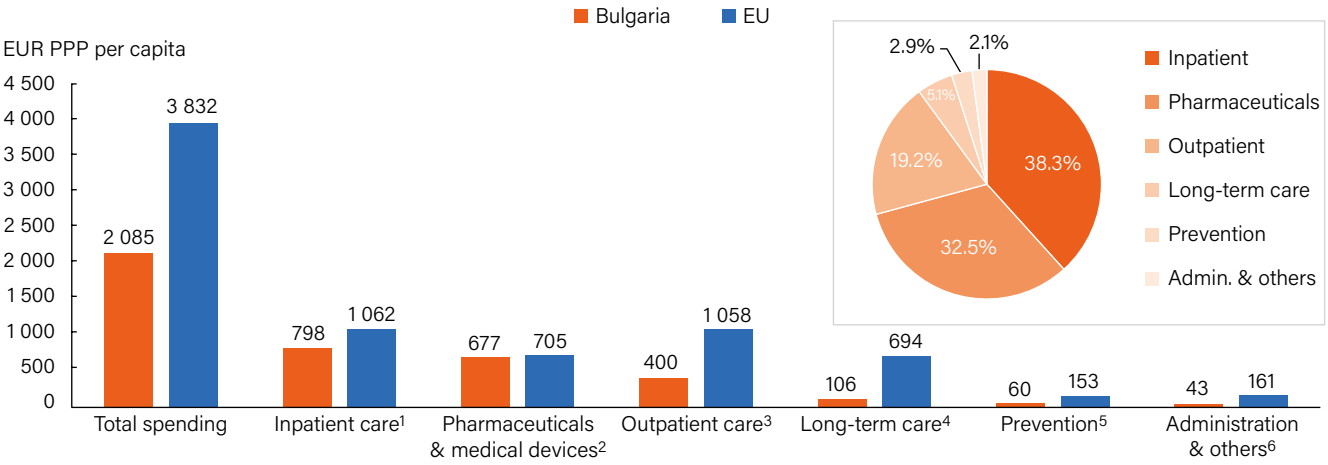
The allocation of health expenditure in Bulgaria is heavily skewed towards hospital-based and curative services. In 2023, inpatient hospital care accounted for 38 % of total health expenditure, well above the EU average of 28 %. Spending on pharmaceuticals and medical devices was also exceptionally high at 33 % of the total, the largest share in the EU (Figure 10). This high share for pharmaceuticals is particularly notable: despite Bulgaria's overall health spending per capita being 46 % lower than the EU average, its per-capita spending on pharmaceuticals was only 4 % lower. This does not imply unusually high volumes or prices - rather, reference-based pricing and the inelastic demand for many medicines mean per-capita outlays do not fall in proportion to the smaller spending base. This concentration of spending comes at the expense of other functions: spending on outpatient care was low at 19 % compared to an EU average of 28 %, while prevention absorbed only 3 %. Overall, this profile underscores the hospital-centric nature of Bulgaria's healthcare system.

Notwithstanding a high doctor density, a nurse shortage leaves Bulgaria's workforce out of balance

In 2023, Bulgaria reported 4.6 doctors per 1 000 population, a density above the EU average of 4.3. However, this headline figure masks a misaligned physician mix: general practitioners (GPs) account for only 13 % of doctors, compared with an EU average of 20 %, reflecting a decade-long decline that has eroded primary care capacity and shifted demand toward costlier specialist and hospital services.

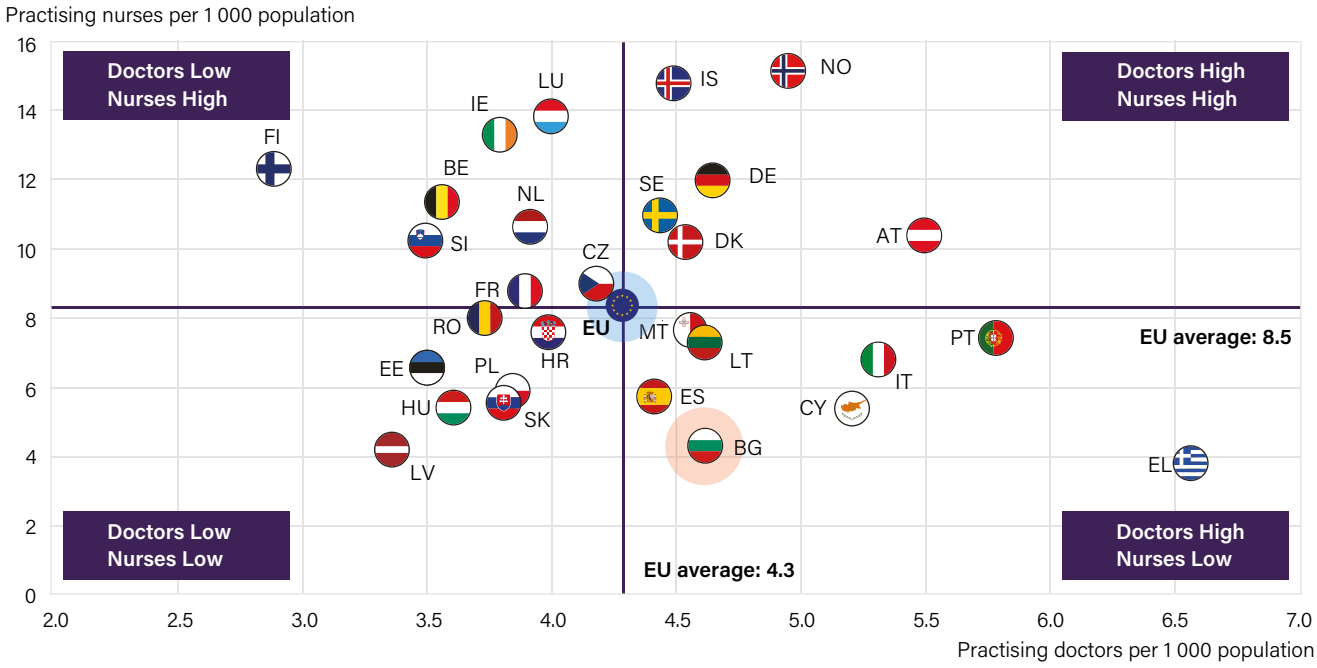
In contrast, Bulgaria has only 4.4 nurses per 1 000 population, roughly half the EU average of 8.5, with estimates indicating a functional shortfall of between 16 900 and 29 000 nurses for the healthcare system to operate effectively (Simeonova-Ganeva & Ganev, 2025). This shortage has resulted in a distorted workforce structure: Bulgaria's nurse-to-doctor ratio stands at about 1:1 compared with an EU average of 2:1, leaving insufficient nursing capacity to support physician-led care or manage rising chronic disease needs (Figure 11). Multiple factors drive this nursing deficit. Demographic pressures are acute: the average age of a Bulgarian nurse is 53, and 20 % of the workforce has reached retirement age. Simultaneously, poor remuneration and working conditions perpetuate high attrition. These conditions fuel high rates of emigration, with approximately one-third of nursing graduates leaving the country shortly after qualifying to seek better opportunities abroad (see Section 5.3).

Figure 10. Health spending is heavily oriented towards hospital inpatient care and pharmaceuticals



Notes: 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes only the outpatient market; 3. Includes home care and ancillary services (e.g. patient transportation); 4. Includes only the health component; 5. Includes only spending for organised prevention programmes; 6. Includes health system governance and administration and other spending. The EU average is weighted (calculated by the OECD).
Source: OECD Data Explorer (DF_SHA). Data refer to 2023.

Figure 11. Physician density is relatively high in Bulgaria, but the density of nurses is among the lowest



Note: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospital.
Source: OECD Data Explorer (DF_PHYS, DF_NURSE). Data refer to 2023 or nearest year.

5 Performance of the health system

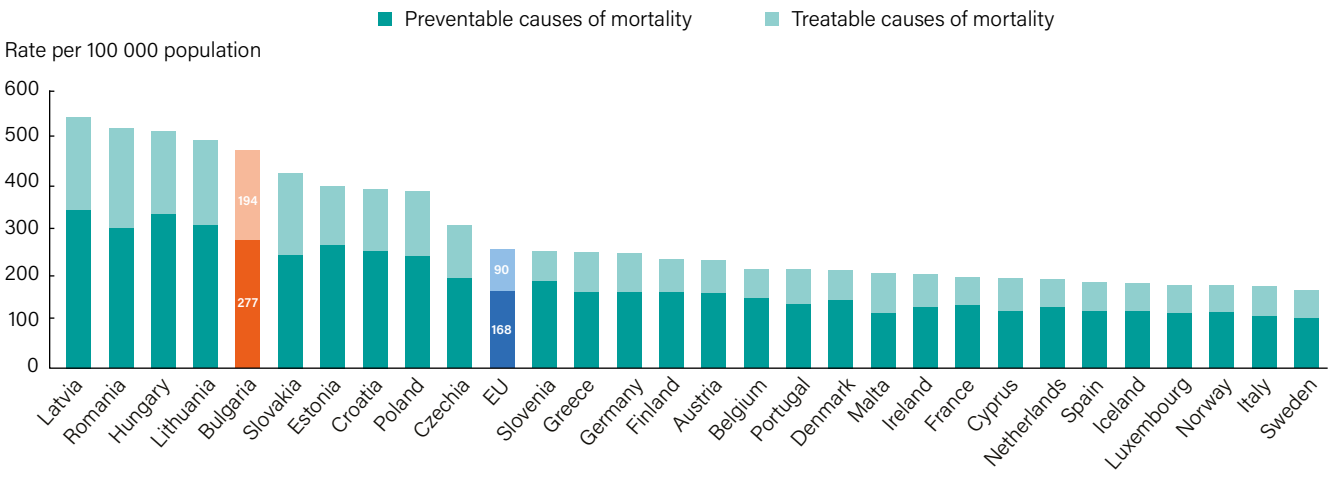
5.1 Effectiveness

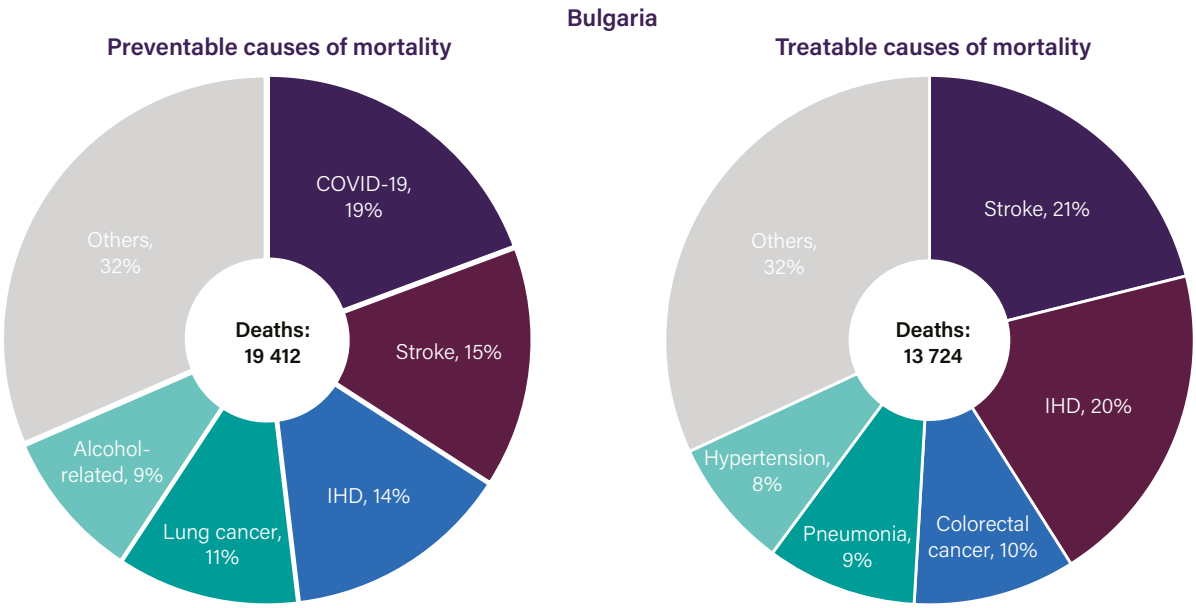
Persistent gaps in both prevention and healthcare drive Bulgaria's high rate of avoidable mortality

Bulgaria continues to have one of the highest rates of avoidable mortality in the EU, reflecting both healthcare gaps and broader public health challenges. Between 2019 and 2022, mortality from preventable causes increased, largely driven by COVID-19-related deaths, which have been classified as preventable through effective public health and prevention measures. By contrast, mortality from treatable causes was less affected by the pandemic but has shown little improvement over the past decade, diverging from

trends in most EU countries and leaving Bulgaria's treatable mortality more than twice the EU average (Figure 12). Beyond COVID-19, stroke and ischaemic heart disease were the leading contributors to both preventable and treatable mortality in 2022, reflecting their amenability to both primary prevention and timely, effective care.

Figure 12. Bulgaria has one of the highest avoidable mortality rates among EU countries





Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths for some diseases (e.g. ischaemic heart diseases, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death. COPD refers to chronic obstructive pulmonary disease.
Source: Eurostat (hlth_cd_apr) (data refer to 2022).

Bulgaria prioritises prevention and targeted investments in cardiovascular and stroke care

Bulgaria's 2030 National Health Strategy places a strong emphasis on investing in prevention and health promotion by encouraging healthy lifestyles, creating supportive environments, and implementing effective screening and prevention measures for chronic diseases. Recent reforms have focused on improving access to cardiovascular medicines by reducing out-of-pocket payments, as well as enhancing acute care through the establishment of new centres for interventional diagnostics and endovascular treatment of strokes, supported by the National Recovery and Resilience Plan (NRRP). Another commitment under the NRRP, the National Map of Long-Term Health Needs, adopted by the Council of Ministers in 2022, aims notably to strengthen the country's capacity to diagnose and treat strokes by expanding highly specialised stroke facilities nationwide within a broader scope of reorganising healthcare delivery across Bulgaria.

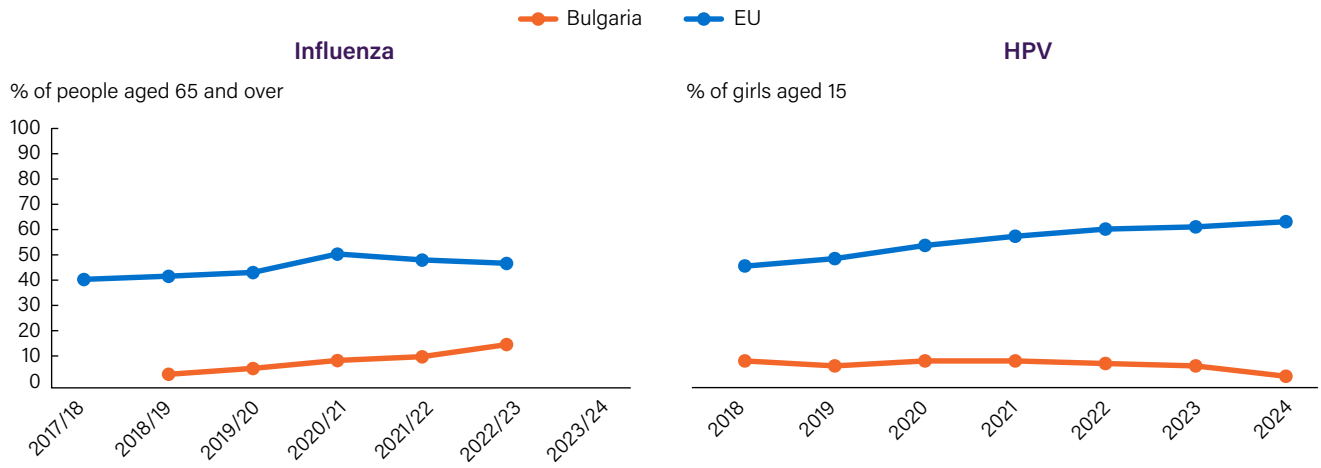
Vaccine uptake remains low, driven by hesitancy and low health literacy despite new initiatives

Low vaccine coverage in Bulgaria is driven by a confluence of factors, including low health literacy, widespread vaccine hesitancy and low institutional trust. This environment has been exacerbated by the spread of misinformation, particularly since the COVID-19 pandemic. Evidence indicates that 36 % of the population has a poor or unsatisfactory

level of health literacy, with older populations and those with lower socioeconomic status facing the greatest barriers to understanding health information.

The impact of these challenges is visible in the uneven performance of national vaccination programmes: on one hand, influenza vaccination for those aged 65 and over has shown progress, rising from 4 % in 2018/19 to 15 % in 2022/23, likely due to a national programme providing free vaccines and heightened awareness during the pandemic. However, even this improved rate remains far below the EU average of 47 %. In stark contrast, human papillomavirus (HPV) vaccination coverage is exceptionally low and declining, underscoring the profound effect of hesitancy and disinformation. Despite the vaccine being free for girls aged 10-13, uptake was only 2 % in this group, resulting in just 3 % of 15-year-old girls being vaccinated in 2024, the lowest rate in the EU and a fraction of the 63 % average (Figure 13). To address these deep-seated issues, the Ministry of Health launched the 'Plus me' initiative in 2022, an online platform designed to provide evidence-based information and counter false narratives. This is complemented by new programme-specific efforts, such as expanding free HPV vaccination to boys aged 10 to 13 and better integrating flu/pneumococcal immunisation into primary care.

Figure 13. Influenza and HPV immunisation rates are very low in Bulgaria



Notes: The EU average is weighted for influenza (calculated by Eurostat) and unweighted for HPV.
Sources: Eurostat (hlth_ps_immu) and WHO/UNICEF Joint Reporting Form on Immunization (JRF).

New population-based programmes aim to close Bulgaria's cancer screening gaps

Cancer screening coverage in Bulgaria remains among the lowest in the EU, a consequence of the historical reliance on opportunistic rather than population-based programmes (OECD/European Commission, 2025). This has resulted in significant coverage gaps: breast cancer screening among women aged 50-69 reached 36 % in 2019 compared with 66 % across the EU, cervical screening achieved 57 % against an EU average of 71 % and colorectal cancer screening participation stood at only 4 % among adults aged 50-74. Screening is nominally provided via annual preventive check-ups funded by the NHIF, but the absence of invitation and call-recall systems leaves participation dependent on individuals contacting their GP, reinforcing inequities and inconsistent follow-up.

Recognising these shortcomings, Bulgaria has initiated a fundamental shift towards systematic, population-based screening, guided by the National Plan for Combating Cancer 2027. In January 2025, the country launched its first population-based cervical cancer screening programme. With initial funding of EUR 4.5 million, it features universal eligibility regardless of insurance status and includes mobile units to improve access in remote areas. A nationwide colorectal cancer screening campaign in Spring 2024, which tested 50 000 adults, is serving as a precursor to a comprehensive national programme planned for 2025–2030. Complementing these efforts, the 2025 NHIF budget introduced full reimbursement for biomarker testing, aiming to enhance the precision of cancer diagnosis following a positive screening result (Republic of Bulgaria, 2025).

5.2 Accessibility

A significant share of the Bulgarian population remains uninsured

All residents who contribute to Bulgaria's compulsory SHI scheme are entitled to a core package of services financed by the NHIF. In 2024, around 94 % of the population was insured, implying about 6 % uninsured, although national sources estimate the uninsured share at 11–12 %, reflecting differences in measurement due to inclusion of residents abroad, lapses in contributions and registration status. The uninsured typically include citizens residing abroad, the long-term unemployed, and people who opt out or face documentation barriers. Beyond the persistently uninsured, temporary lapses are common: regional evidence suggests that over one fifth of residents had interrupted insurance rights in 2020-2022, rising to about one third among working-age adults, underscoring the instability of coverage (Kostadinov et al., 2023). Recent measures, such as NHIF-funded obstetric care for uninsured

women and actions under the National Strategy for Roma Integration, seek to narrow these gaps.

Bulgaria has expanded access to state-funded health insurance by raising income thresholds and replacing the outdated minimum income benchmark

Bulgaria's Law on Health Insurance mandates that recipients of monthly social assistance are automatically covered by state-funded health insurance. Previously, eligibility for this support was determined by the Guaranteed Minimum Income (GMI), a static threshold set significantly below the national poverty line (frozen at BGN 75), leaving several low-income individuals without access to social benefits and state health coverage.

Amendments to the Social Assistance Act that took effect on 1 June 2023 abolished the GMI and introduced a more dynamic Monthly Social Assistance Base, set at 30 % of the official poverty line. Together with a 22 % increase in the poverty line (from BGN 413 in 2022 to BGN 504 in 2023), this reform has considerably raised the income threshold for support.

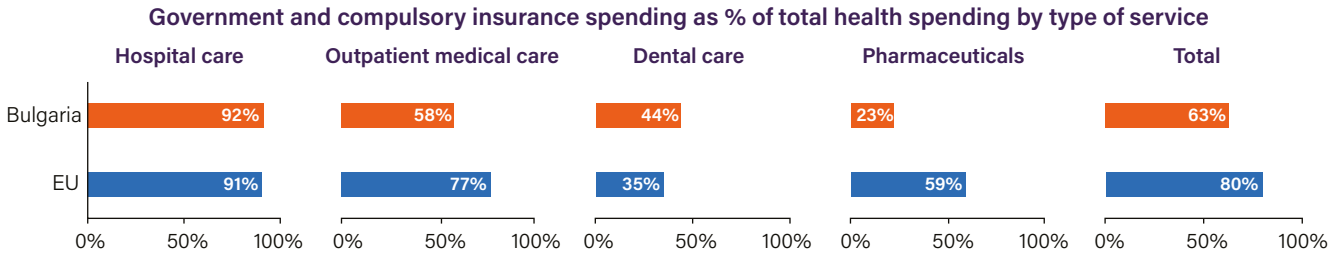
The end of hospital payment caps boost patient access but demand new cost controls

In 2024, Bulgaria's Constitutional Court and Supreme Administrative Court struck down provisions of the Health Insurance Act that barred the NHIF from reimbursing hospital care beyond pre-set monthly quotas, ruling that such limits infringed citizens' right to affordable and timely medical care. Under the old system, each diagnosis was paid at a fixed rate ('clinical pathway') and hospitals operated under strict volume/budget ceilings; once a ceiling was reached, further clinically indicated care was either unpaid by NHIF or shifted to patients, prompting delayed admissions, early discharge or out-of-pocket charges. Removing these ceilings means hospitals can provide indicated treatment and be reimbursed, reducing turn-aways and delays, especially for time-sensitive conditions where short waits raise mortality and disability risks. However, eliminating caps also removes a blunt cost-control tool, creating near-term budget pressures and making it essential to shift toward more sophisticated, quality-oriented purchasing and audit systems so that higher activity reflects appropriate care rather than supplier-induced demand (see Section 5.3).

Public health coverage in Bulgaria is comprehensive for hospitals but leaves sizeable gaps for pharmaceuticals and outpatient care

Bulgaria's public benefits package covers a core set of services for insured residents, but coverage depth varies substantially across service sectors. Inpatient care receives comprehensive public financing, with 92 % of costs covered, broadly in line with the EU average and reflecting the policy priority accorded to acute hospital care. By contrast, outpatient services require substantial co-payments: public financing accounts for only 58 % of outpatient spending compared with 77 % on average across the EU (Figure 14). Dental care is only partially covered, as in most EU countries, yet public sources still finance 44 % of dental costs, above the EU average of 35 %. Coverage for pharmaceuticals is instead much thinner: only 23 % of spending is publicly funded, far below the EU average of 59 %. Coverage is limited to medicines on a comparatively restrictive positive drug list meaning many essential or newer products carry high co-payments or are excluded entirely (see Section 6). Efforts to broaden coverage for pharmaceutical services have faced fiscal and implementation constraints, limiting progress toward more equitable financial protection across the healthcare system.

Figure 14. Public coverage rates for outpatient care and pharmaceuticals are low



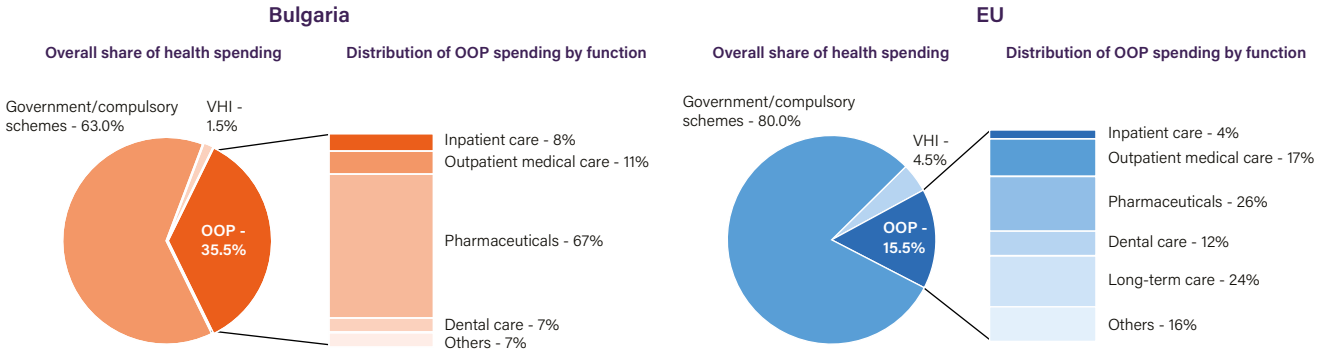
Notes: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA). The data pertain to 2023.

High out-of-pocket spending on medicines is the primary driver of financial hardship in Bulgaria

Bulgaria's OOP spending share has long been among the highest in the EU. From 2006 to 2017 it consistently exceeded 40 % of current health spending, peaking in 2017 before gradually declining to about 35 % in 2023. Despite this improvement, Bulgaria still records the highest OOP payments burden in the EU, more than double the EU average of 16 %. High OOP spending stems in large part from direct payments for non-covered services and goods, followed by co-payments for services within the benefits package. This high burden translates directly into severe financial hardship: in 2018 (latest year available), Bulgaria recorded the highest rate of catastrophic health spending in the EU, affecting 19 % of households, roughly three times the EU average. This burden is sharply regressive, falling disproportionately on the poorest households.

The primary driver of both high OOP and catastrophic spending is pharmaceuticals, with medicines accounting for over two-thirds of total OOP spending, reflecting a combination of a restrictive positive drug list, low public financing and a comparatively high VAT rate of 20 % on prescribed medicines (Figure 15). To alleviate this burden, recent reforms have expanded reimbursement in 2024 to cover 100 % of many cardiovascular medicines, which were previously only partially subsidised (see Section 2). Nevertheless, OOP spending on outpatient medicines remains a major source of financial hardship.

Figure 15. Spending on pharmaceuticals accounts for two thirds of out-of-pocket spending

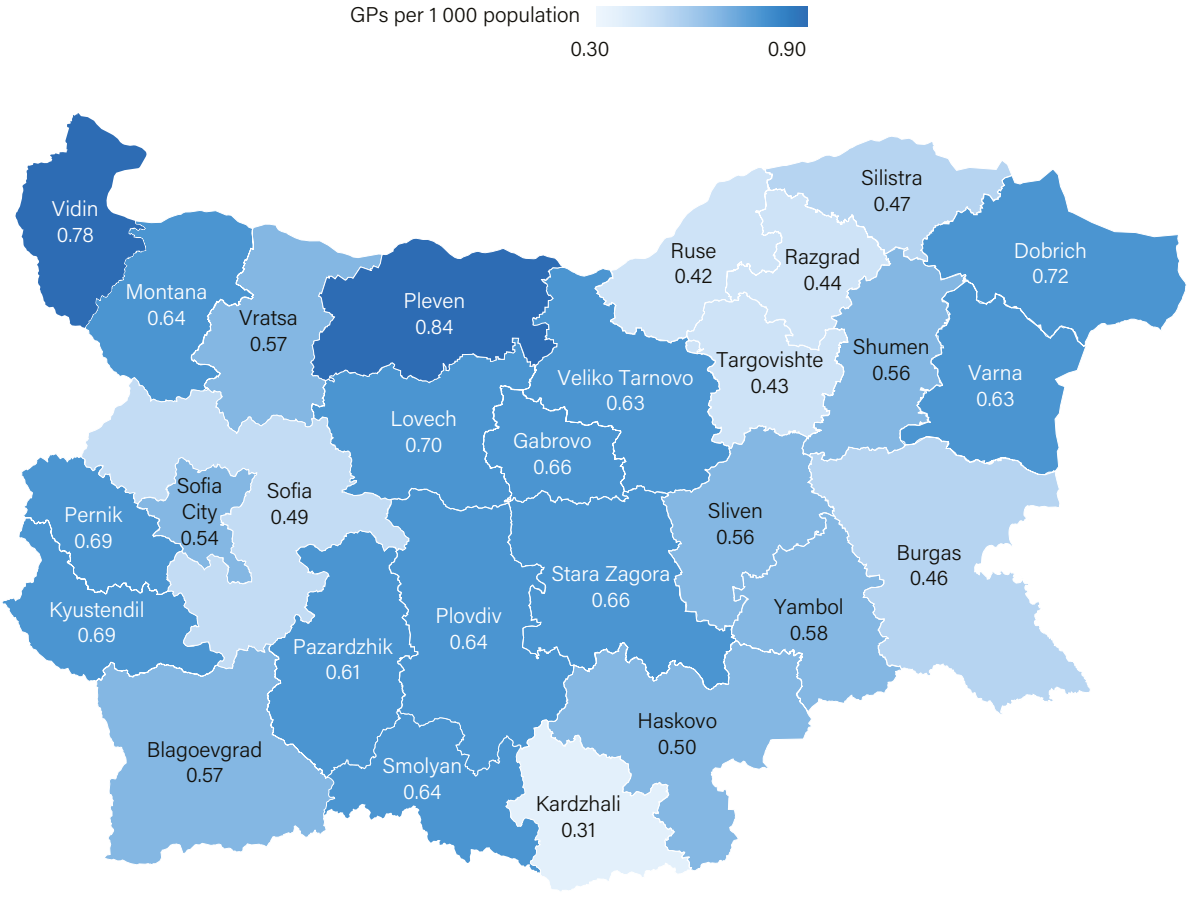


Note: VHI also includes other voluntary prepayment schemes. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023.

New incentives and a national strategy aim to correct severe health workforce imbalances

Severe geographic imbalances in Bulgaria's health workforce undermine access to care, particularly in rural areas. The distribution of GPs, for example, varies by more than two-fold across regions, from a low of 0.31 per 1,000 population in Kardzhali to a high of 0.84 in Pleven, driving uneven primary care access and downstream pressure on hospital services (Figure 16). An initial reform in 2021 sought to address this

Figure 16. The uneven distribution of GPs hampers access to primary care in some regions



Source: Ministry of Health, 2023.

Box 1. Recent providers' incentives led to an increased activity in targeted underserved areas as well as in preventative services

In 2023, Bulgaria introduced targeted measures to strengthen primary care, including increased capitation and fee-for-service rates for GPs, alongside performance-based payments for preventive service targets. The reforms also placed a strong emphasis on addressing regional inequities by introducing substantial financial incentives for practice in remote and underserved areas.

Recent NHIF data for 2024 indicate that these investments have successfully expanded service coverage. The most significant growth was recorded in dispensary surveillance for chronic conditions and annual preventive examinations for adults. Within the "Children's Health" programme, improvements were driven by higher rates of immunisation and preventive screenings for school-aged children. Notably, the targeted funding for remote and hard-to-reach areas saw a more than fourfold from BGN 2.2 million in 2023 to BGN 9.0 million in 2024.

allowing independent practices by physician assistants, nurses, and other health professionals to expand community-based services and make these careers more attractive. However, its impact has been limited because services delivered by these practices are not reimbursed by the NHIF and must be paid for out-of-pocket.

Recognising the need for publicly financed solutions, Bulgaria has since launched broader measures. Under the National Recovery and Resilience Plan, targeted recruitment and retention initiatives in underserved areas are underway (Box 1). These are being reinforced by a new national strategy for 2027, which aims to address shortages by investing in primary care facilities, offering incentives to attract young professionals, and implementing real-time monitoring to ensure a more balanced distribution of staff nationwide.

5.3 Resilience

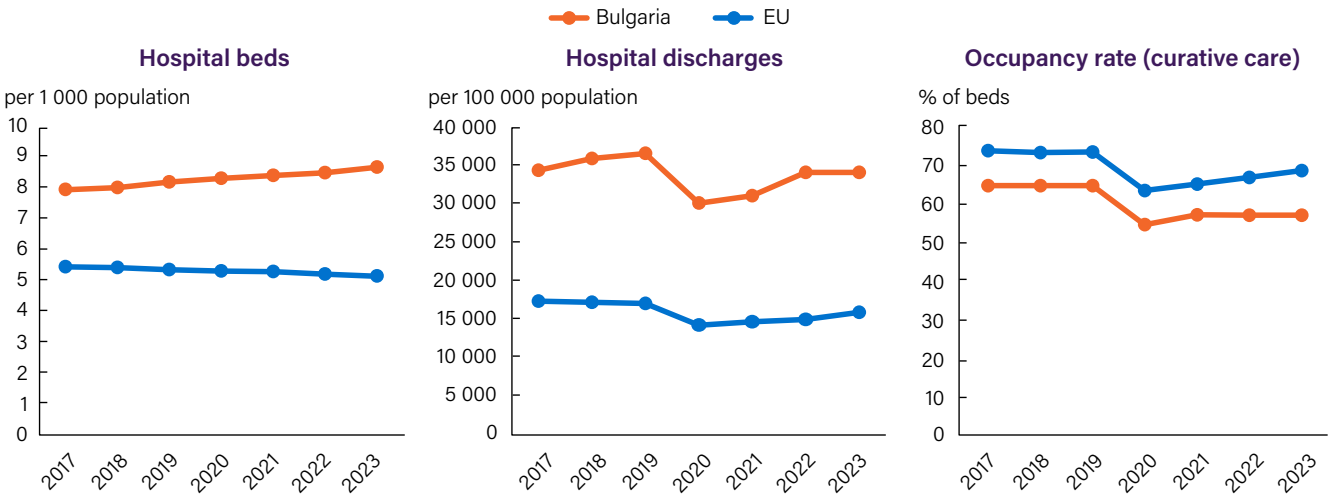
Health system resilience - the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks and structural changes - has become central to policy agendas. Key priorities include easing pressures on service delivery, strengthening health infrastructure and workforce capacity, adapting crisis preparedness strategies, supporting digital innovation, and safeguarding long-term sustainability.

Financial incentives and weak primary care sustain an oversized and inefficient hospital sector

Bulgaria's hospital-centric model is reflected in a high and rising bed supply. In 2023, there were 8.6 hospital beds per 1 000 population, over 50 % above the EU average, and, in stark contrast to EU trends, bed numbers have continued to rise in recent years (Figure 17). Utilisation patterns point to inefficiency: hospital discharge rates have been more than double the EU average over the past five years, yet bed occupancy stood at only 57 % in 2023, well below the EU average of 68 %. Combined with one of the shortest average lengths of stay in the EU, this signals a high-throughput, low-intensity model in which beds turn over quickly but capacity is under-utilised.

The drivers of this inefficient model are rooted in care organisation and financial incentives: primary care gatekeeping is weakened by quarterly referral quotas, which push patients to either wait, pay out-of-pocket or bypass the system by going directly to hospitals. Payment systems reinforce this pattern: hospitals are reimbursed on a case

Figure 17. Bulgaria's hospital bed supply is over 50 % larger than the EU average and rising



Note: The EU average is weighted.
Source: Eurostat (hlth_rs_bds1) and OECD Data Explorer (DF_KEY_INDIC).

basis with volume-linked physician bonuses, while under-resourced outpatient care operates on fee-for-service.

A court ruling against hospital payment caps has triggered significant fiscal pressure

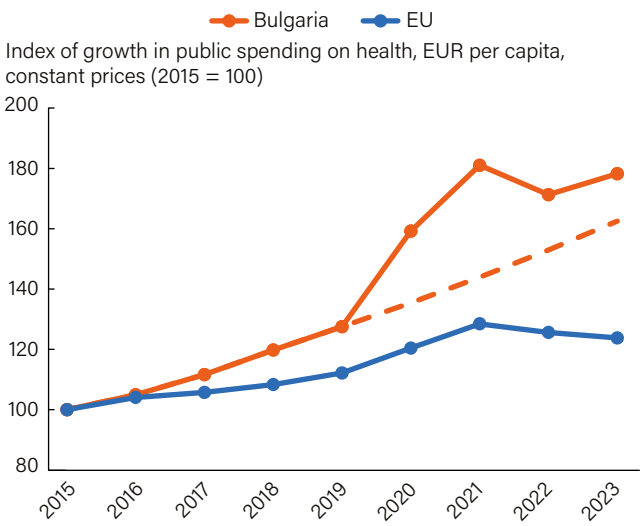
Bulgaria's health financing system has entered a volatile phase following the 2024 court rulings that annulled hospital payment ceilings (see Section 5.1). While removing payment ceilings improved alignment with clinical need, they also crystallised liabilities, pushing NHIF obligations above plan. By October 2024, hospital care costs were 6 % higher than budgeted, opening a EUR 150 million gap. This pressure hit a sector already burdened by over BGN 400 million in combined state and municipal hospital debt, much of it accumulated under the old ceiling regime. The NHIF posted a EUR 75 million deficit in 2024, with the 2025 shortfall projected around EUR 110 million for the first nine months of the year (NHIF, 2025).

Policy responses have stabilised cash flow but not the underlying imbalance. Although the Parliament raised the 2025 NHIF budget by 16 %, cumulative shortfalls - including EUR 212 million in 2024 arrears - already exceeded the Fund's reserve of BGN 141 million, leaving little buffers in a system where inpatient care absorbs already half of health spending (see Section 4). On the medicines side, the state budget was exhausted by September 2024, and EUR 412 million were back-filled via mandatory manufacturer rebates, an emergency measure rather than a structural fix. Meanwhile, verification and litigation timelines mean payment lags persist, keeping liquidity tight for indebted hospitals even as legal payment obligations have been clarified. A further complication arose in July 2025 when Parliament amended the Health Insurance Act to tie NHIF payments to contractually agreed limits and earmarked budgets, effectively seeking to reintroduce caps. As of September 2025, the legal and operational status remains uncertain, with potential for renewed constitutional scrutiny.

A trend of rapid expenditure growth accelerated by the pandemic underpins current budget pressures

Against this backdrop, longer-run trends help explain the high-pressure fiscal environment. In the five years before the pandemic, Bulgaria's public health spending rose by over 6 % per year in real terms, well above the EU average of 2.9 %. COVID-19 drove a further surge, with a 25 % real increase in 2020; after a small contraction in 2022, spending rose again in 2023. Overall, public health expenditure grew by roughly 80 % in real terms between 2015 and 2023, and post-2020 growth has remained above the trajectory implied by the pre-pandemic growth trend (Figure 18). The 2025 NHIF budget reflects these mounting pressures from uncapped inpatient activity and liabilities from past 'over-limit' care, alongside persistent wage and input-price inflation. The new funds are primarily allocated to address these pressures in inpatient care and pharmaceuticals, while also financing new policy commitments, such as expanded drug coverage for children and rare cancers, biomarker testing and support for pharmacies in remote areas (Republic of Bulgaria, 2025). These investments are further supported by various EU-funding programmes (Box 2).

Figure 18. Public expenditure on health has increased strongly both before and after the pandemic



Notes: The EU average is weighted, calculated by the OECD. The dashed line represents the projected trend based on pre-pandemic (2015-2019) data.
Source: OECD Data Explorer (DF_SHA).

Workforce reforms target the dual challenge of medical graduate emigration and severe nursing shortages

In 2023, Bulgaria had the EU's second-highest rate of new medical graduates per capita, approximately double the EU average (Figure 19). This high output is largely driven by international enrolment, with non-nationals comprising nearly 60 % of medical students in 2021/22. However, the net impact on the domestic workforce is limited, as most international graduates leave Bulgaria after qualifying for better career prospects elsewhere. This retention challenge is compounded by uneven postgraduate training distribution, leading to acute shortages in key specialties such as general practice, infectious diseases, anaesthesiology and emergency medicine.

In response, In June 2025 the government introduced a targeted policy to curb the growing trend of post-graduation emigration among medical students by linking state-funded medical education to mandatory service obligations. Specifically, 15 % of state-funded admission slots for medical programmes were designated as contingent upon students signing binding employment contracts with selected facilities. To address specialty shortages, the state funds general practice trainees at over two and a half times the national minimum wage, a policy that has contributed to the number of GP postgraduates nearly doubling between 2022 and 2024.

In stark contrast, Bulgaria faces a severe deficit in nursing graduates: nursing graduate output is more than five times below the EU average, consistent with the country's low overall nursing density (see Section 4). This shortage stems from limited university places, poor working conditions and low remuneration, which undermine both recruitment and

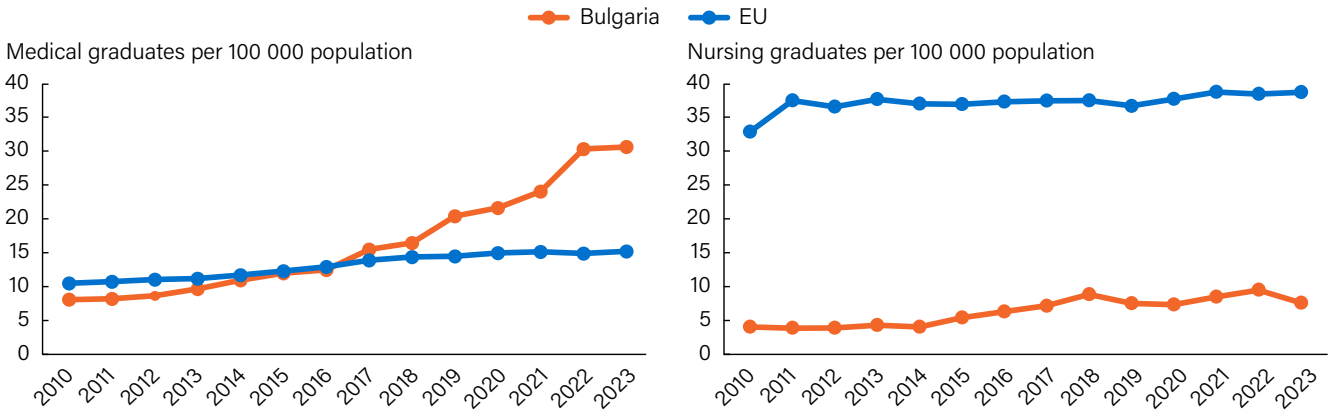
Box 2. EU programmes are supporting health system investments and resilience in Bulgaria

Bulgaria's health sector is supported by significant EU funding across multiple instruments. Under the Recovery and Resilience Plan (RRP), Bulgaria allocated EUR 287 million (about 5 % of its total RRP funds) to health. With this funding, Bulgaria aims to improve the provision and availability of health services across the country. This will be achieved through reforms and investments to modernise hospitals (including psychiatric care), set up outpatient units, as well as to establish an air ambulance system for remote regions. Some of the funding is also allocated to address health professional shortages and geographical imbalances, while other resources are allocated to enhance e-health by completing the National Health Information System and creating a medical diagnostics platform.

Aiming to modernise health facilities and enhance quality care across the country, about EUR 181 million from the European Regional Development Fund is envisaged for measures such as the construction of needed municipal health infrastructure and support to GPs, focusing on remote and hard-to-reach locations. An additional EUR 84 million is dedicated to improving the emergency medical care system.

Lastly, the *EU4Health* programme also supports Bulgaria's health sector by funding projects that strengthen health system resilience, improve access to high-quality care, and address public health challenges such as cancer prevention and pandemic preparedness. The programme backs initiatives to modernise healthcare infrastructure, promote digital health, and expand preventive services, including cancer screening and vaccination campaigns.

Figure 19. The number of medical graduates has increased greatly over the past decade, but the number of nursing graduates remains low



Note: The EU average is weighted (calculated by the OECD).
Source: OECD Data Explorer (DF_GRAD).

retention. Recent reforms have responded by classifying nursing and midwifery as priority specialties and making their university programmes tuition-free.

Low overall uptake and a wide digital divide hinder progress in digital health

Despite recent reforms that have significantly reshaped Bulgaria's digital health landscape (see Box 3), the use of digital health tools in the country remains relatively low compared to other EU countries. As of 2024, only around 40 % of individuals in Bulgaria have sought health information online, an increase from approximately 36 % in 2018-2021, but still well below the EU average of 58 %. Similarly, online medical appointment booking remains uncommon: about 18 % have ever booked a doctor's appointment online compared to an EU average of 40 %. Access to electronic health records (EHRs), though growing from 10 % in 2020 to 19 % in 2024, also lags behind the EU average of 28 %.

Against this backdrop, Bulgaria faces significant education-related disparities in the use of digital health services, with equity gaps that are often wider than the EU average. For instance, for basic activities like seeking health information online, the gap between the least and most educated in seeking online health information was 49 percentage points in 2024, substantially larger than the EU average of 32 points. For more interactive services, the picture is mixed. While the gap for booking online appointments matches the EU average, the disparity is most pronounced for accessing personal health data: only 5 % of Bulgarians with low educational attainment have accessed their EHRs compared to 36 % of those with high education, a wider gap than the EU average (Figure 20).

Mandatory e-prescribing spearheads efforts to curb high antibiotic consumption in Bulgaria

Reducing inappropriate antibiotic use is a central pillar of efforts to tackle antimicrobial resistance (AMR), a priority

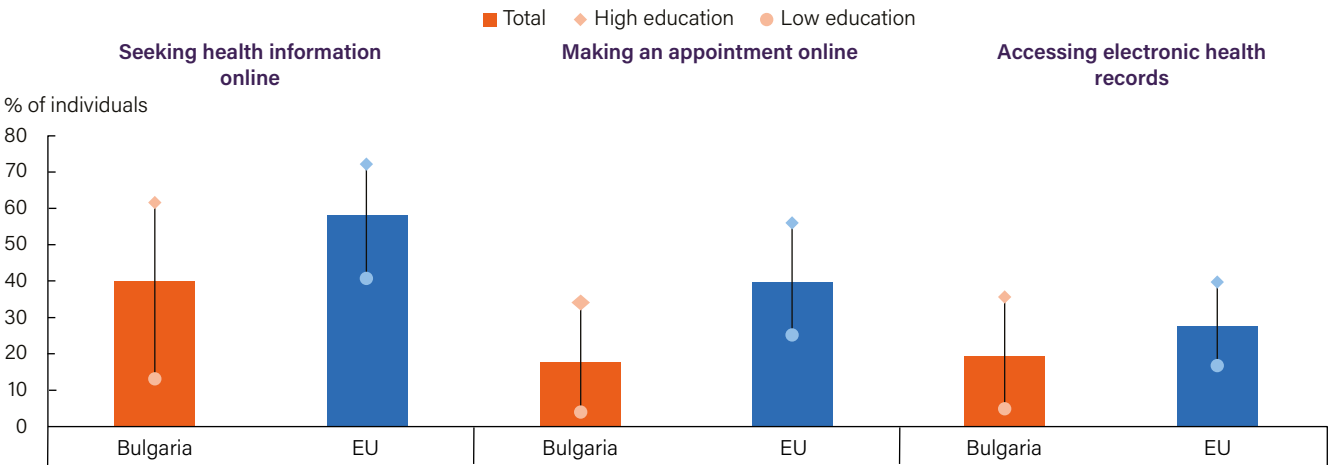
Box 3. Bulgaria is accelerating its digital health transformation with system-wide reforms

Bulgaria is accelerating its digital health transformation, pivoting from foundational pilots to a comprehensive, system-wide implementation. Recent policy shifts aim to embed digital tools into the core of healthcare delivery, backed by significant EU funding from the Recovery and Resilience Plan and Cohesion funds.

A landmark 2024 amendment to the Public Health Act made electronic health records (EHRs) mandatory for all medical activities across both public and private sectors, creating a unified digital health profile for every citizen. The legislation also formally regulates telemedicine, establishing standards for remote consultations and mandates a national online appointment system for public hospitals, extending a convenience previously common only in private clinics. These reforms build upon the expanding National Health Information System (NHIS), which already supports millions of e-prescriptions and e-referrals. The changes address critical system challenges: mandating EHRs reduces data fragmentation, improves care continuity and creates a robust foundation for evidence-based planning and quality oversight. A unified booking system can shorten waiting times and increase transparency for patients, while clear telemedicine rules are set to expand specialist access beyond major urban centres.

The central challenge is translating this legal and technical framework into broad and equitable use. Priorities for 2025 focus on implementation: supporting provider onboarding, enforcing interoperability standards for IT vendors and launching public awareness campaigns to drive uptake. A key focus is mitigating digital divides through assisted-access points (such as hospital kiosks) and targeted digital literacy initiatives. Key risks to monitor include uneven provider compliance, cybersecurity incidents and ensuring sustainable financing to maintain and upgrade digital systems once EU funds taper.

Figure 20. Education-related gaps in digital health tool use are wider in Bulgaria than in the EU



Note: Low education is defined as the population with no more than lower secondary education (ISCED levels 0-2), whereas high education is the population with tertiary education (ISCED levels 5-8).
Source: Eurostat database (isoc_ci_ac_i). Data pertain to 2024.

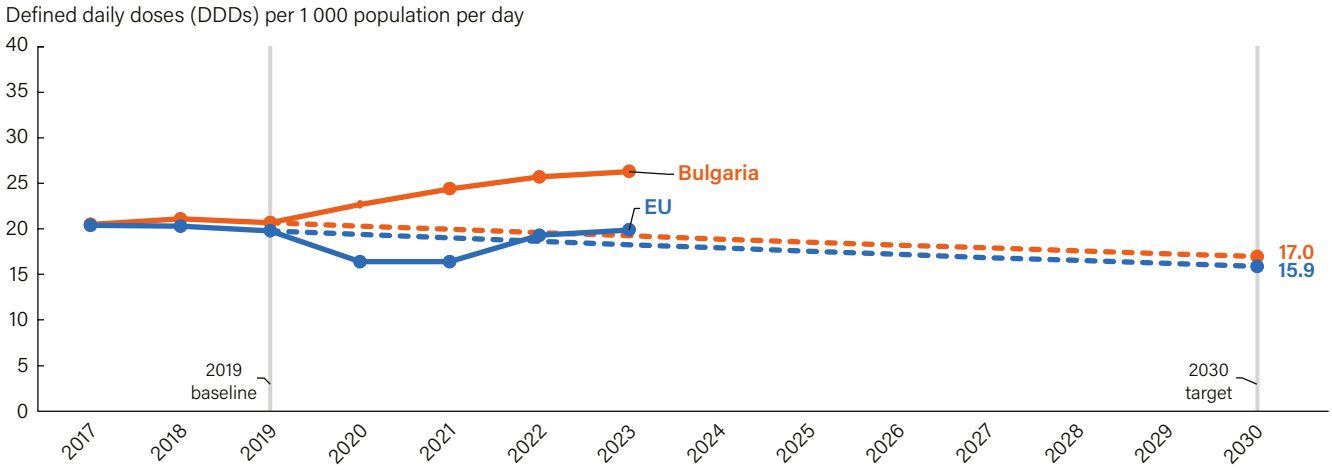
reinforced by the EU Council's 2030 consumption targets adopted in 2023.[1] Bulgaria faces a particularly acute challenge: its antibiotic consumption remains among the EU's highest and, unlike most EU countries, rose sharply during and after the pandemic, reaching 26.3 defined daily doses (DDDs) per 1 000 population per day in 2023, about 30 % above the EU average (Figure 21). The composition of use is also concerning, as only 42 % came from the WHO 'Access' group, which has lower potential to drive AMR, compared to an EU average of over 60 %. These figures place Bulgaria far from its 2030 targets, underscoring the urgency of effective intervention.

In response, Bulgaria has implemented mandatory e-prescribing for antibiotics as a foundational policy tool. After a difficult initial rollout that included a temporary suspension to resolve technical issues, the system was fully reinstated in April 2024 and is now operational, with over 7.1 million e-prescriptions issued by January 2025. Early signals on its effectiveness are cautiously positive, with preliminary data showing a decline in community antibiotic sales in 2024 for the first time since the pandemic. The government plans to build on this technical infrastructure by extending e-prescribing to all medicines under the National Healthcare Strategy 2030.

[1] Council Recommendation on stepping up EU actions to combat antimicrobial resistance in a One Health approach, 2023/C 220/01.

Bulgaria is now formalising a longer-term strategy through a National Plan against AMR for 2025-2028, currently pending adoption. The programme aims to increase public awareness, reduce multi-resistant infections and promote more prudent prescribing, especially of third-generation cephalosporins, while also setting objectives for the veterinary health sector. Combined with the technical enforcement provided by e-prescribing and reinforced by participation in initiatives like EU-JAMRAI-2, this national plan signifies a more systematic approach to tackling Bulgaria's AMR challenge.

Figure 21. Antibiotic consumption in Bulgaria has increased steadily since 2019



Note: The EU average is weighted. The chart shows antibiotic consumption in hospital and the community. The dashed line illustrates the policy target pathway to meet the 2030 reduction targets.
Source: ECDC ESAC-Net.

6 Spotlight on pharmaceuticals

Budget caps and clawbacks aim to curb high pharmaceutical spending

In 2023, retail pharmaceuticals accounted for 31 % of health expenditure in Bulgaria—the highest share in the EU and far above the EU average of 13 %. On a per-capita basis, retail pharmaceutical spending reached EUR 644 compared with an EU average of EUR 510 (Figure 22). This unusually high share reflects, in part, the relative price-inelasticity of medicines across the EU: where overall health spending and GDP are lower, pharmaceuticals absorb a larger proportion of the budget even when volumes or prices are not exceptionally high.

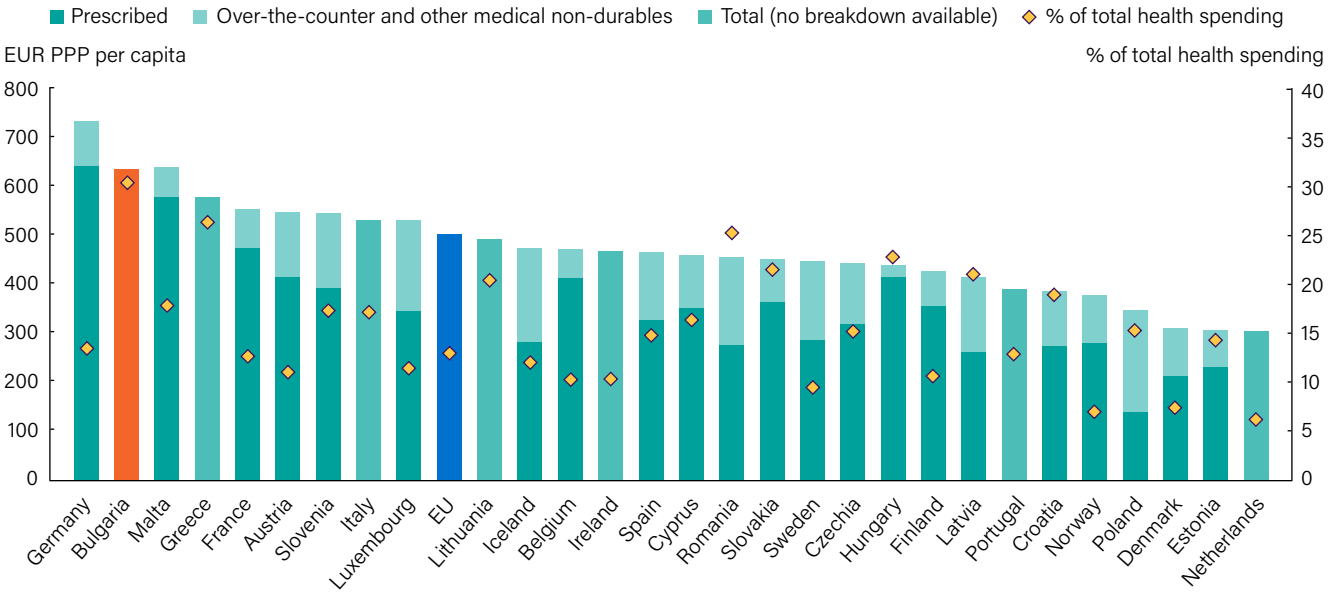
To improve predictability and contain expenditure growth, the NHIF applies a budget-cap and pay-back ("clawback") mechanism since 2018. Reimbursed outpatient medicines are grouped into three categories: Group A (high-cost outpatient drugs requiring prior approval by a specialist panel), Group B (all other reimbursed outpatient drugs), and Group C (oncology and other life-saving medicines). The NHIF negotiates annual (and quarterly revised) spending ceilings for each group. When actual expenditures exceed a cap, companies refund the excess proportionally to their market shares. The mechanism has increased transparency and accountability and generated substantial refunds - EUR 59 million in 2021, up from EUR 34 million in 2019 - but these have not fully offset overspending, leaving residual budget pressure with the NHIF (Mitkova et al., 2022).

Expenditure growth remains concentrated in Group C, with oncology medicines the primary driver and anti-diabetic therapies also contributing; cardiovascular and neurological drugs add further, albeit smaller, pressure. Preliminary indications for 2024 point to continued growth, with Group C expanding fastest. While the cap-and-clawback framework has strengthened budget discipline, it only partially absorbs shocks from inflation and the rapid entry of high-cost therapies.

Limited coverage leaves households paying most retail drug costs, though recent measures aim to ease OOP payments burden

The NHIF's coverage framework is set by Ministry of Health ordinance and operationalised by the NHIF Supervisory Board through the list of conditions for which medicines are covered and the 'positive drug list' (see Section 5.2). Within an overall cap on outpatient pharmaceutical outlays, the scheme provides 100 % reimbursement for selected specialty medicines, notably oncology treatments. On the other hand, public coverage of retail pharmaceuticals remains remarkably low: in 2023, social health insurance financed about 23 % of spending, the lowest share in the EU, leaving

Figure 22. Expenditure on retail pharmaceuticals per capita is one of the highest in the EU



Note: This figure represents pharmaceutical expenditures dispensed through retail pharmacies for outpatient use only. It excludes medications administered in hospitals, clinics or physician offices.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023, except for Norway (2022).

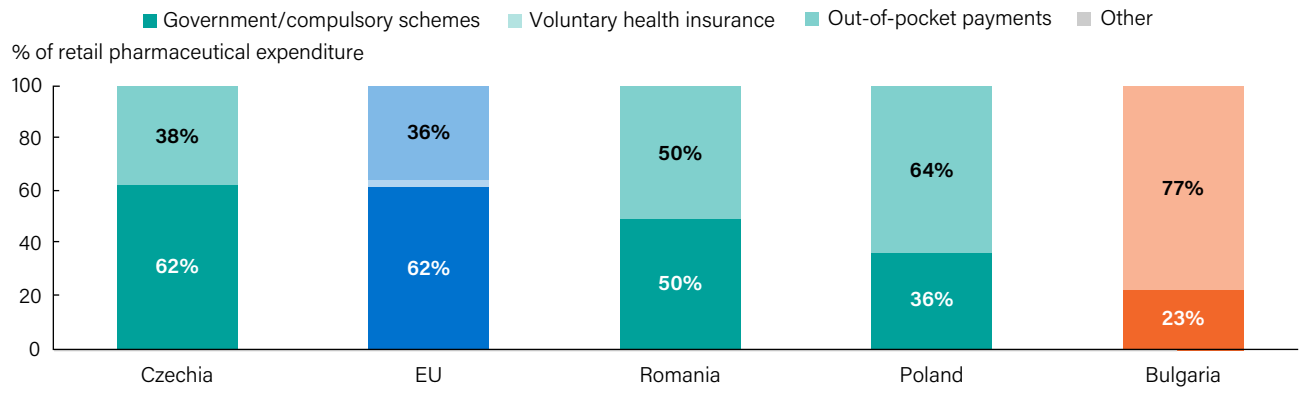
households to pay roughly 77 % out-of-pocket (Figure 23). This reflects a narrow benefits scope and percentage co-payments for many routine outpatient drugs, compounded by a non-trivial uninsured population and limited use of lower-priced generics.

Recent measures aim to strengthen financial protection: since 2024, for each of about 52 cardiovascular active ingredients (INNs), at least one product is fully reimbursed by the NHIF (see Section 2). The 2025 NHIF budget further introduces full reimbursement for antibiotics and antivirals prescribed to children under seven from 1 July 2025 (Republic of Bulgaria, 2025). These steps should lower OOP payments burden and support adherence, but their impact will depend on complementary policies to promote cost-effective prescribing, including wider generic prescribing and tighter alignment of health technology assessment (HTA), reference pricing and contracting.

Reimbursement rules delay access but ensure broad coverage for new medicines

Market entry and reimbursement of new medicines are governed by the Medicinal Products in Human Medicine Act, first adopted in 2007 and subsequently amended. For reimbursement, products must be listed on the positive drug list which covers prescription medicines deemed necessary to meet population health needs. The National Council on Prices and Reimbursement of Medicinal Products sets and registers maximum prices using external reference pricing and maintains a public price register. Since January 2025, Bulgaria also participates in EU-level joint clinical assessments under the HTA Regulation for oncology medicines and advanced therapy medicinal products. After EU marketing authorisation, innovative (non-generic) medicines undergo centralised negotiations with the NHIF on discounts, rebates and refund conditions; annual discount negotiations also apply to medicines included in national, regional and municipal

Figure 23. Less than one quarter of retail pharmaceutical spending is covered by SHI in Bulgaria



Note: The EU average is weighted.
Source: OECD Data Explorer (DF_SHA). Data pertain to 2023.

programmes. Beyond these standard steps, two structural features contribute to longer access times: a requirement that a medicine be reimbursed in at least 5 of 17 designated EU countries before the Bulgarian authorities will consider inclusion in the positive drug list, and an annual budgetary cycle whereby new listings generally take effect from 1 January following the decision.

Timeliness and breadth of access, as reported by EFPIA's Patients W.A.I.T. survey - indicative rather than definitive of meaningful access, place Bulgaria among the slower adopters by EU standards. For medicines approved by the EU in 2020-2023, the average time from authorisation to reimbursement was 768 days in Bulgaria compared with the EU average of 578 days. By January 2025, however, 53 % of these medicines were reimbursed nationally, above the EU average of 46 %, indicating that coverage is relatively broad but delayed (Newton et al., 2025).

A national digital tracking system aims to mitigate medicine shortages

To mitigate the risk of medicine shortages and improve the country's reactive capacity to manage supply disruptions, Bulgaria has implemented the Specialised Electronic Tracking and Analysis System (SETAS), operated by the Bulgarian Drug Agency. SETAS requires suppliers, wholesalers and pharmacies to report transactions and inventories for medicines on the positive drug list, providing near-real-time visibility of national stocks and automatically flagging products at risk. When a medicine is designated as critically short, authorities may temporarily restrict exports to stabilise domestic supply while replenishment is organised. These measures have strengthened early warning and coordination since 2022, reducing pharmacy "no-stock" events and knock-on pressures on primary care and hospitals. Nonetheless, tracking and export controls cannot resolve upstream manufacturing constraints or sudden demand surges, so intermittent shortages persist due to factors such as constrained manufacturer supply and demand surges. Further resilience gains will depend on better forecasting and procurement (including joint purchasing), closer EU-level coordination and linking SETAS more tightly with national e-health systems to align warehouse, pharmacy and clinical needs.

Rules constrain generic substitution and limit potential savings

In Bulgaria, the NHIF reimburses outpatient medicines at a reference price per defined daily dose (DDD), typically aligned with the lowest available equivalent; when a higher-priced brand or generic is prescribed, patients pay the difference out-of-pocket. Generics accounted for about 30 % of pharmaceutical sales by value in 2022, a low proportion by EU standards, despite high generic use by volume (EFPIA, 2024). A key constraint is that pharmacy-level substitution is not permitted: physicians prescribe a specific product, and pharmacists must dispense that (branded or designated generic) product if available. This prescribing pattern sustains use of higher-priced brands and elevates OOP spending. The roll-out of the National Health Information System (NHIS) with e-prescribing enables systematic monitoring of international non-proprietary name (INN) prescribing, generic uptake and biosimilar penetration, supporting more targeted stewardship of pharmaceutical outlays. However, data visibility alone is unlikely to shift behaviour at scale, with international experience suggesting that complementary levers are needed. Implemented alongside robust reference pricing and contracting, INN-first prescribing requirements with clinical override, enabling pharmacist substitution within reference groups, differential co-payments that favour lowest-priced options and prescriber benchmarking would help translate Bulgaria's high generic availability into greater savings and lower OOP payments burden.

A dynamic clinical trials sector contrasts with a limited R&D base

Bulgaria's pharmaceutical sector is relatively small but export-oriented, anchored in generic manufacturing and contract production by domestic players alongside multinational sites (e.g. Teva's Balkanpharma). In addition, Bulgaria serves as a key contract-manufacturing and export hub within Central and Eastern Europe, leveraging lower production costs and EU market access. This orientation, however, means the domestic industry is geared toward replication of existing products rather than originator R&D. Innovation inputs remain limited: business enterprise pharmaceutical R&D has hovered at about EUR 10 million annually in recent years, and international patenting by Bulgaria-based applicants is negligible.

In contrast, clinical research is comparatively dynamic: in 2024, Bulgaria recorded just over 21 clinical trials per million population, above the EU average, with trials predominantly industry-sponsored and about one-third in early phases, slightly below the EU average. This profile reflects cost-competitive trial operations and experienced sites, but a thin upstream science base and constrained venture finance. Policy support is largely general rather than sector-specific, centred on a low 10 % corporate income tax, investment promotion schemes and EU-funded innovation programmes, with targeted pharmaceutical R&D instruments and public grants used selectively for clinical infrastructure and technology upgrades.

7 Key findings

- Bulgaria's life expectancy remains the lowest in the EU at 75.9 years in 2024, nearly six years below the EU average, with a wide 7.4-year gender gap. Mortality is dominated by cardiovascular disease, responsible for more than 60 % of deaths, with high incidence and signs of poorer survival after events, although a 2024 reform that fully reimburses essential cardiovascular medicines is demonstrating early positive outcomes. Rapid ageing and high multimorbidity add pressure, while observed cancer rates are depressed by competing cardiovascular risks and possible underdiagnosis.
- Behavioural and environmental risks drive a high mortality burden in Bulgaria, accounting for 36 % of deaths compared with 29 % in the EU. Adult smoking remains the highest in the EU and adolescent tobacco and e-cigarette use is widespread, while alcohol use is also elevated. Although adult obesity is relatively low, poor diets and some of the EU's lowest physical activity levels fuel rising adolescent obesity. Recent measures include higher tobacco excise taxes and school food standards, yet risk factors remain concentrated among less educated groups.
- Bulgaria operates a centralised social health insurance system with a single purchaser and GP gatekeeping, but low public funding leaves households financing the EU's highest out-of-pocket share. Spending is concentrated in hospitals and pharmaceuticals to the detriment of outpatient care and prevention. Despite above-average doctor density, primary care is weak and a severe nurse shortage creates a 1:1 nurse-to-doctor ratio, half the EU average. This financing and workforce mix limits effective coverage and strains care continuity for chronic conditions.
- Bulgaria's avoidable mortality remains among the highest in the EU: preventable deaths rose during the pandemic, and treatable mortality has seen little improvement for a decade and is more than twice the EU average, with stroke and ischaemic heart disease driving both. Policy responses are under way: free cardiovascular medicines, new interventional stroke centres and a shift to population-based cancer screening, including cervical screening launched in 2025 and colorectal plans. At the same time, vaccine uptake is persistently low, notably HPV, highlighting the need to pair service reforms with stronger prevention and communication.
- Coverage gaps and financing design continue to strain access and financial protection in Bulgaria, with an estimated 6-12 % of residents uninsured. The 2024 removal of hospital volume caps should reduce delays, but heightens the need for more strategic purchasing. Public coverage is comprehensive for inpatient care, but shallow for outpatient services and medicines, driving the EU's highest out-of-pocket share and widespread catastrophic spending, largely from pharmaceuticals. Geographic workforce imbalances further limit access, prompting new incentives and a national strategy for 2027.
- Bulgaria's hospital sector is oversized and inefficient: bed density is more than 50 % above the EU average, discharge rates are over twice as high, yet occupancy is only 57 % and stays are short, indicating a model of high-volume, inefficient care. Weak gatekeeping and case-based incentives steer demand to hospitals. Eliminating payment ceilings in 2024 improved access, but exposed liabilities and widened budget gaps despite a larger 2025 NHIF allocation. Workforce measures tie medical students to posts and expand GP training, but nursing shortages persist. Digital uptake remains low, while AMR efforts build on mandatory e-prescribing.
- Owing to its comparatively small total health expenditure, Bulgaria devotes a large share of its health spending to medicines. Caps and clawbacks have improved transparency and generated refunds, yet overspending persists. Public coverage for outpatient drugs is the lowest in the EU, leaving households to pay about three quarters out of pocket, with recent measures easing costs for cardiovascular treatments and children. Access to new medicines is broad but delayed by listing rules and budget cycles. While a national tracking system is significantly improving shortage management, brand prescribing and no pharmacy substitution limit generic savings.

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Country abbreviations

Austria	AT	Czechia	CZ	Germany	DE	Italy	IT	Netherlands	NL	Slovakia	SK
Belgium	BE	Denmark	DK	Greece	EL	Latvia	LV	Norway	NO	Slovenia	SI
Bulgaria	BG	Estonia	EE	Hungary	HU	Lithuania	LT	Poland	PL	Spain	ES
Croatia	HR	Finland	FI	Iceland	IS	Luxembourg	LU	Portugal	PT	Sweden	SE
Cyprus	CY	France	FR	Ireland	IE	Malta	MT	Romania	RO		

State of Health in the EU
Country Health Profiles 2025

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2025 edition of the *Country Health Profiles* provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- an account of the pharmaceutical sector and policies within the country.

Complementing the key findings of the Country Health Profiles is the *Synthesis Report*.

For more information, please refer to: https://health.ec.europa.eu/state-health-eu_en

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