

SOCIAL ISSUES, JUSTICE AND STATUS

**THE IMPACT AND  
IMPLICATIONS OF CRISIS**

**A COMPREHENSIVE APPROACH COMBINING  
ELEMENTS OF HEALTH AND SOCIETY**

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AND  
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EDITORS**



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*Chapter 15*

**A HEALTH SYSTEM IN THE ERA OF ECONOMIC  
CRISIS AND MEMORANDA: BEARING PATIENTLY  
THE CONSEQUENCES OR GRABBING THE CHANCE  
FOR INTRODUCING REFORMS?**

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**ABSTRACT**

The present paper discusses the impact of economic crisis and restrictive policies dictated by Troika on access to healthcare services in Greece. Horizontal cuts in public health expenditures, reductions in health benefits package, increases in user charges and copayments, as well as upper limits in the use of health services, resulted in increasing barriers to access to health services and serious gaps in the health coverage of the Greek population. Out-of-pocket and informal payments increased as a share of total health expenditure and a large percentage of the Greek population lost health insurance coverage. The measures introduced to address these problems were delayed while the diffusion of information to the potentially beneficiaries (vulnerable groups) has been limited. Facing these gaps, some major reforms came into effect supposed to provide free of charge access to improved and coordinated primary care. After various inefficient

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reforms, a legislation in 2016 granted access to the health system for the uninsured population. In 2014 a nation-wide primary health care network (PEDY) was developed functioning under the umbrella of Regional Health Authorities (YPE) while a recent legislation (August 2017) aimed to develop Local Health Units (TOMY) to provide family medicine and to navigate the citizens more effectively through the rest of the system. Moreover, since 2011 efforts were focused on improving the efficiency and coordination of the social health insurance. The unification of the large number of health branches of the social insurance funds and the formation of one unique organization (EOPYY) for purchasing health services was one of the most important reforms adopted. Despite these efforts, problems regarding the accessibility of the population to qualitative and coordinated health care services remain, and the transition from the existing health insurance to a tax-financed system is considered one of the ways to avoid the transformation of the Greek health care system to a residual healthcare net of last resort.

**Keywords:** economic crisis, out-of-pocket payments, National Organization for Healthcare Provision, primary health care, universal health coverage, Greece

## THE IMPACT OF THE ECONOMIC CRISIS AND AUSTERITY MEASURES ON THE GREEK HEALTH SYSTEM

Greece entered its eighth year of recession, operating within severely constricted fiscal limits. So far, the implementation of neoliberal restrictive income and fiscal policies dictated by the three IMF/EU/ECB Memoranda of Understanding (MoU) signed by Greece, has failed to deliver the expected results. At the time of writing, the Greek context is one of sustained economic recession, with very high unemployment, poverty and social exclusion levels. Employment rate decreased from 48.9% in 2008 to 41% in second semester of 2017 and the rate of unemployment increased from 7.8% in 2008 to 21.1% in the second semester of 2017. Approximately 74% of the 1,016,600 unemployed are long-term unemployed. In 2016, 25.2% of the Greek population was at risk of poverty before social transfers and 21.2% was at risk of poverty after social transfers, indicating the ineffectiveness of the welfare programs. Furthermore, 35.6% of the population was at risk of poverty or social exclusion and 22.4% was in a state of material deprivation. Inequality of income distribution also increased as the income quintile share ratio (S80/S20) reached 6.6 in 2016 from 5.9 in 2008 (Hellenic Statistical Authority, 2017a).

According to the MoUs, Greece is obliged to keep public health expenditures below 6% of the GDP and public pharmaceutical expenditures below 1% of GDP. The imposition of public health spending restrictions and the simultaneous decline in GDP observed since 2009, means that the public health sector is called upon to meet the increasing needs of the population with decreasing financial resources. Between 2009 and 2015, total current health expenditure in Greece decreased by €7.79 billion or (from €22.49 bn to €14.7 bn), public current health expenditure fell by €6.7 bn or 43.5%

(from €15.4 bn to €8.7 bn) and private expenditure decreased by €1.28 billion or 18.26% (from €7.08 bn to €5.8 bn). However, private current health expenditures as a percentage of total health expenditures increased from 31.5% in 2009 to 40.9% in 2015 (Hellenic Statistical Authority, 2017b). At the same time, the demand for public health services increased as visits to outpatient departments and the number of hospitalizations in public hospitals were increased between 2010 and 2015 by 2.3% and 10.5% respectively (Ministry of Health, 2017).

These evolutions raised serious doubts about the ability to ensure adequate public financing and provision of health services. Austerity fiscal policies and high unemployment resulted in diminishing revenues from state budget and social insurance contributions. In this context, a number of health policy measures introduced in Greece after 2010, posing limits to services covered, reducing the financial protection and increasing user charges. Horizontal reductions in health expenditures were accompanied by reductions in coverage of the population for health services.

Another domain of measures introduced, augmenting the burden of the citizens and imposing restrictions in access to health services, is user charges. In 2011 an increase in user charges from €3 to €5 was imposed in outpatient departments of public hospitals and health centers (this measure was abolished in April 2015), in 2012 co-payment rates for pharmaceuticals were increased and from 2014 onward an extra €1 for each prescription issued by NHS services has been introduced. As a result, the household expenditure for pharmaceuticals increased with the mean cost-sharing level for pharmaceuticals rising from 13.3% in 2012 to 18% in 2013 (Siskou, Kaitelidou, Litsa, Georgiadou, Alexopoulou, Paterakis, Argyri, Liaropoulos, 2014). Moreover, calls to make an appointment for any doctor under the National Primary Healthcare Network scheme have been outsourced to private telephone companies, with charges being increased ranging from €0.95 to €1.65 per minute, and patients using hospital afternoon surgeries pay additional fees ranging from €24 to €72 (Economou, Kaitelidou, Kentikelenis, Maresso, Sissouras, 2015).

An increase of the mean monthly household out of pocket payments was noted by 38% for private hospitals, by 34% for public hospitals and by 32% for pharmaceuticals between 2008 and 2015 (figures are in current prices but GDP deflator for the relevant period fluctuated between 4,7 and -2,2, following a decreasing rate) (Hellenic Statistical Authority 2008 and 2017c). At the same time, informal payments remain a characteristic of the Greek health system. According to the estimations of a recent study, hidden payments in the Greek health sector in 2012 were almost €1.5 billion, representing 28% of households' health expenditures (Souliotis, Golna, Tountas, Siskou, Kaitelidou, Liaropoulos, 2015).

The negative effects of the above measures, especially for middle and low income households, are reflected in the increase of self-reported unmet needs for medical examinations (Table 1). During the period 2008–2015 the percentage of the population



reporting unmet needs for medical examination due to high costs, low proximity or long waiting lists over doubled, increased from 5.4% to 12.3%. People with low incomes, the unemployed and the inactive population face the most serious problems of access to health services. According to the National Social Insurance Registry (ATLAS), approximately 2.5 million or 23% of the population had no insurance coverage for health care in 2013 (Economou, Kaitelidou, Katsikas Siskou, Zafeiropoulou 2014).

**Table 1. Self-reported unmet needs for medical examination in Greece  
(Too expensive or too far or extended waiting lists 2008-2015)**

	2008	2009	2010	2011	2012	2013	2014	2015
<i>Total population</i>	5.4	5.5	5.5	7.5	8.0	9.0	10.9	12.3
<i>By income quintile</i>								
<i>1<sup>st</sup> quintile</i>	8.7	11.2	9.2	11.6	11.7	14.9	17.3	18.7
<i>2<sup>nd</sup> quintile</i>	7.1	7.4	6.7	9.8	9.7	11.4	16.7	15.6
<i>3<sup>rd</sup> quintile</i>	6.1	4.6	5.9	7.6	9.1	9.7	13.5	12.6
<i>4<sup>th</sup> quintile</i>	3.4	2.7	3.3	4.8	4.7	7.8	6	10.6
<i>5<sup>th</sup> quintile</i>	1.8	1.7	2.1	3.6	4.8	1	1.1	3.9
<i>By labor status</i>								
<i>Employed</i>	3.3	2.7	3.1	4.7	5.6	6.1	7.4	8.8
<i>Unemployed</i>	8.6	7.5	9.5	11.4	10.8	11.7	15.7	15.6
<i>Retired</i>	9.3	9.3	8.9	11.7	10.8	11.2	12.5	15.6
<i>Other inactive</i>	5.8	7.3	6.4	6.9	8.1	9.7	11.7	11.5

Source: Eurostat, 2017.

## THE EFFORTS TO ACHIEVE THE FINANCIAL PROTECTION OF THE POOR AND THE UNINSURED

A first effort to confront with the problem was the “Health Voucher” program launched in September 2013, mainly funded by the National Strategic Reference Framework. It targeted people who had lost their insurance coverage and their dependent family members and allowed them access only to primary healthcare services, providing a limited number of visits to contracted physicians, NHS facilities and contracted diagnostic centers. The vouchers did not cover the cost for hospital care and had duration for four months without a potential to be renewed. They intended to cover those unemployed and uninsured that were actually more than two years uninsured, since O.A.E.D. (Manpower Employment Organization) provides the right for the unemployed to extend their insurance status up to two years after they lost their jobs. The specific criteria

set made it available only to people who were former insured in social security funds which joined the EOPYY, with an individual real or imputed income up to 12,000 euros (for singles) or family income up to 25,000 euros (for married) (Health Voucher, 2017). The program was limited to cover approximately 230.000 uninsured citizens for 2013-2014. However, no more than 23,000 health vouchers had been issued until March 2014. The small number of vouchers issued and the very limited scope raised serious doubts about the effectiveness of this provision and as a consequence the measure was abandoned (Economou, Kaitelidou, Katsikas Siskou, Zafeiropoulou 2014).

In June 2014, two joint Ministerial Decisions (No. Y4a/GP/oik.48985 and No. GP/OIK.56432) signed by the Ministers of Finance, Health, and Labor, Social Insurance and Welfare were issued, according to which all uninsured Greek citizens and legal residents of the country without social or private health insurance, not eligible for poverty booklets, or having lost their insurance right due to inability to pay their social insurance contributions, as well as their dependants, were covered for: (a) Inpatient care, free of charge, at the expense of public hospital budgets, provided that they have received a referral from a doctor of the National Primary Healthcare Network or an outpatient department of a public hospital and the special three-member medical committee which will be set up in each hospital, certifying the patient's need for hospitalization. (b) Pharmaceuticals, at the expense of the state budget, provided that they are prescribed by a doctor of the National Primary Healthcare Network or a doctor of a public hospital. However, beneficiaries were required to pay the same copayments that apply for the insured.

Although the above legislation was expected to have positive effects, three issues have to be considered (Economou, Kaitelidou, Katsikas Siskou, Zafeiropoulou, 2014). First, the stigmatizing procedure for accessing hospital services, given that a specific committee had to certify the need for hospitalization of uninsured patients, but not the insured population. Second, the legislative requirement that uninsured people should pay the same copayments for pharmaceuticals as those insured, with potential negative effects for those in difficult economic situations. Last but not least, it was not very clear how public hospitals implemented the ministerial decision on hospitalization of the uninsured. As a consequence, uninsured people seeking hospital services faced serious unjustified administrative barriers in access to health care due to their differentiated treatment by different public hospitals that conflicted with the legislation.

The ineffectiveness of the legislation resulted in its amendment in March 2016. The law 4368/2016 and the joint Ministerial Decision *A3(g)/GP/oik.25132/4-4-2016* came into effect in August 2016 providing for free access to care for the uninsured Greeks and immigrants who are legally residents in Greece. They are beneficiaries of the same coverage package with insured population to the National Organization for Healthcare Provision (EOPYY), subject of having a unique Social Insurance Number (AMKA). Moreover, all residents irrespective of legal status are entitled to access emergency

departments for the management of life-threatening conditions. Undocumented migrants in need of health services (e.g., pregnant women, children, and disabled persons, those suffering from mental diseases etc.) are entitled to access free of charge all public health structures, subject of having an Immigrant Healthcare Card (KYPA). Additionally, people living in refugee shelters and hot spots may access public services (e.g., pharmaceuticals from hospitals' pharmacies, emergency and inpatient services) with a referral from a physician providing care in these settings.

Even though these policies were introduced with a remarkable delay, they are of a major importance given their potential to remove barriers to access health care services for the vulnerable populations. Yet, some barriers regarding equity issues still exist. For example, the uninsured can only access public health care providers, but not private providers contracted with EOPYY (e.g., diagnostic imaging laboratories). Due to this limitation, accessibility problems are emerging in regions where public health care units are either understaffed or/and facing shortages of modern equipment (e.g., CTs and MRIs). Finally, problems associated with the electronic prescription system are still imposing barriers in accessing benefits in kind as for example consumables for diabetic patients.

A question to be answered is why it took so long for action to cover the uninsured and the poor while the access to health services is of major importance. In order to do this, three issues have to be considered: external commitments, inadequate institutions and inadequate information. External commitments refer to the MoU where emphasis is put on reduction of health expenditure and cost savings and not on access and on the pressure by Troika for implementing immediate measures without considering their impact on health sector. Inadequate institutions are related to low institutional capacity to analyze evidence, to clarify policy choices and to promote informed debate. They also point to no preparedness towards the impact of the measures adopted on health system and the absence of on time evaluation, sequencing and implementation of health policy measures. Inadequate information raises the problem of limited availability of official data about costs, outcomes, population needs as well as limited monitoring of the effects of the measures adopted and absence of timely response to these effects.

## MAJOR REFORMS ON HEALTH SERVICES PLANNING

One of the major reforms of the health system, in order to overcome inequalities in access to and financing of services was introduced in March 2011 with the unification of the large number of health branches of the social insurance funds and the formation of one organization called EOPYY/National Organization for Healthcare Provision (Law 3918), supposed to function as unique purchaser of health services. Initially, EOPYY was also tasked with managing primary care – the role that did not exist before, which



involved coordination of primary care, contracting providers of primary care services, as well as setting quality and efficiency standards, with the broader goal of alleviating pressures on ambulatory and emergency care in public hospitals. These responsibilities have been passed to Regional Health Authorities (YPEs) in 2014 while very recently (August 2017) a new legislation passed reorganizing the whole PHC system (see below).

Under the 2011 regulation, four major social insurance funds (IKA, OGA, OAEE, OPAD) formed EOPYY to act as a unique purchaser of health services and pharmaceuticals for all those insured. Subsequently EOPYY expanded to include more health branches of insurance funds. The benefit packages of these funds were standardized and unified to provide the same reimbursable services based on EOPYY's Integrated Health Care Regulation (EKPY), although there are still differences in arrangements, for example variations in size of contribution. Furthermore, there are still health insurance funds, which remain outside EOPYY, mainly mutual self-administered funds covering bank employees. A common benefit package was introduced, but a reduction in benefits that the insured are entitled took place, and ceilings were imposed on the activities of doctors contracted with EOPYY, including monthly patient visits, monthly amount prescribed pharmaceuticals, and monthly amount diagnostic and laboratory tests prescriptions. Patients are obliged to refer to several doctors in order to find one who has not reached his visits and prescription limits. According to the findings of a study conducted recently, 20% of the participating patients suffering from asthma had to visit two or more doctors in order to get their prescription (Kaitelidou, Katostaras, Konstantakopoulou, Siskou, 2017).

Another major reform currently in effect is the re-organization of Primary Healthcare (PHC) which has been recognized as a sector of high priority. According to the WHO Regional Director for Europe, Dr Zsuzsanna Jakab, (2016) PHC is considered as *"the stepping stone towards better health and equity and universal health coverage is the building and strengthening of a sustainable and integrated primary health care system."* However, in temporally, the Greek healthcare system has been traditionally focusing on curative inpatient care and consequently primary health care (PHC) has been under developed providing fragmented and uncoordinated care. Thus, restructuring and enhancing PHC consist one of the main issues

Until January 2014, about 200 Public Health Centers and 1,500 Regional Health Offices operated under the umbrella of the NHS were located in rural and semi-urban areas. Also, 250 Social Security Institution (SSI) Outpatient Clinics were serving urban population (Lionis, 2011). Moreover, 131 Public (NHS) and 162 Private Hospitals Outpatients Clinics operating all over the country were serving both urban and rural population. PHC was also delivered through private practicing physicians and a network of other health professionals, such as physiotherapists and private diagnostic centers (contracted or not with social security funds) (Karakolias and Polyzos, 2014).

In February 2014, a structural reform was undertaken to upgrade the provision of publicly funded primary care through improved co-ordination of the various providers. A legislation passed in 2014 (4238/2014) aiming to develop a Nation-wide Primary Health Care Service (PEDY), consisting of Health Centers, EOPYY Outpatient Clinics and contracted Health Professionals. According to Law 4238/2014 all public primary health care facilities passed under the jurisdiction of the Regional Health Authorities (YPE). Based on that reform these facilities were supposed to function 24 hours a day, seven days a week. In addition, the law introduced a referral system based on GPs. However, a gate-keeping system didn't come into effect and in general the implementation of the reform was quite slow due to human and economic restraints.

As a result, a new PHC reform was introduced in August 2017 (Law 4486/2017). According to the Health Minister the fundamental objective of the reform is that the *"health system regains control of healthcare, with the activation of the concept of the family doctor, either through public structures like the Local Health Units (TOMY) or through contracts with freelance doctors. The citizens will have their own health consultant, their family doctor, free of charge, who will navigate them through the rest of the system."* TOMYs are supposed to provide family medicine services via a group of professionals (including at least one GP or Pediatrician, one Nurse or Health Visitor and one administrative employee). TOMYs are affiliated/supervised by public Health Centers which have the responsibility for covering the population of a pre-defined catchment area. Moreover, the new legislation aims to the reorientation of the system towards prevention and health promotion, where other health professionals apart from physicians, such as nurses, health visitors and social workers, will play a crucial role. In the first pilot phase, the implementation of the PHC reform will be financed by EU funds, raising however doubts about the economic sustainability of the new PHC system after the depletion of the European funds.

Initially, the Prime Minister announced that 239 TOMYs will be set up by the end of 2017, in 80 different regions of the country. To staff these facilities, an invitation of almost 3,000 vacancies was published on August 2017. However, only a limited number of physicians (600 out of 1,200 invited) applied and thus these human resources shortages result remarkable delays in the operation of some of the 239 TOMYs especially those located in remote areas. Medical Associations attribute physicians' unwillingness to staff TOMYs to strictly working regulations (staff of TOMYs supposed to be fully and exclusive employees), while the MoH correlates the phenomenon to brain drain. Either one or the other reason result the same consequences: postponement of running an improved PHC system covering promptly population basic health needs.

Moreover, major reforms have been implemented in order to achieve cost containment for pharmaceuticals and inpatient care. Reduction of public expenditure for outpatient drugs, which should not exceed 1% of the GDP by the end of 2014 (law 4046/2012) was achieved by reducing medicine prices (generics and branded medicines),



increasing co-payments, imposing rebates and claw back measures for pharmaceutical companies and pharmacists, reducing pharmacists' and wholesalers' trade margins, applying compulsory e-prescription by active substance and protocols, updating the positive list of medicines.

Referring to hospital sector a new case based payment system KEN-DRGs was applied in 2012 (joint Ministerial Decisions Y4a/oik.85649/27-7-2011& Y4a/oik.18051/27-03-2012) in order to rationalize the reimbursement of hospitals. Additionally, cuts in hospital operational and wage expenses were imposed accompanying by other measures such as mobility of health personnel within and between health regions, and modification of activities of small hospitals towards specialization in areas such as rehabilitation and treatment of cancer or end-stage patients (Law 4046/2012).

## **THE WAY FORWARD: TOWARDS UNIVERSAL HEALTH COVERAGE**

The existing structure of social health insurance (SHI) does not deliver effective and universal coverage of the needs of the population. Occupational status and social insurance contributions as we knew them until now do not correspond to the new social, economic and productive conditions generated by the crisis and can't be the sole basis for entitlement. The nature of employment is changing and the typical dependent eight hours full employment is gradually replaced by different kinds of flexible, part-time, and in many cases unpaid informal work where the employees are involved in a portfolio of activities, challenging the basic core of the insurance relationship and resulting in inadequate contributions. Furthermore, the ability of households to pay taxes is exhausted. Horizontal measures of user charges and copayments lead to inequities and postponement or non-use of necessary and needed services.

Under circumstances of high unemployment rate and decreasing wages and household income, retaining a social health insurance system in Greece is a choice that deteriorates the health system's ability to achieve the overriding goal of delivering health care to those who need it. Instead, the transition to a tax-financed system has the merits of not leaving a large portion of the population with inferior health coverage, of avoiding many of the labor market distortions associated with payroll financing, and of raising revenues in an equitable fashion. The basic characteristics of such a system should be entitlement to the same health services package on the basis of citizenship or legal residency, and the abolition and replacement of employees' and employers' contributions by new sources such as a special health tax on personal income and a special health tax on enterprises' turn over or added value. As the share of labor in Greece decreases, wage income is insufficient to cover the cost of health care. At the same time, the necessity to increase contributions in order to cover the rising needs of the population may imperil the

competitiveness of the economy. The spreading of health care cost to all factors of production through comprehensive national health insurance financed by progressive taxation of income from all sources, instead of employer-employee contributions, may be considered as a potential solution for protecting the health system objectives and ensuring health system sustainability, especially during the economic recession (Liaropoulos and Goranitis, 2015). However, it is critical to consider that the prerequisite in order the proposed plan to be sustainable is the effective combating and the elimination of tax evasion.

The current phase of health reform in Greece faces a critical challenge and an evidence-based exercise for tradeoffs: crisis and memorandum cuts and pressures versus equity and delivery of quality healthcare services for the whole population. So far, the citizen/patient side has been ignored and a patient-centered health system seems to be out of the scope of the reforms introduced since 2010, given that the content and the process of change have been reduced to a strictly neoliberal technocratic/managerial exercise without adequate consideration of the real health needs of the population. Unless we shift the health policy paradigm, the race to the bottom will continue and the Greek health system will soon be transformed to a residual healthcare safe net of last resort.

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