GREECE: THE HEALTH SYSTEM IN A **TIME OF CRISIS**

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Summary: The international financial crisis has had a tremendous impact on Greece's economy, exacerbating existing problems. The health sector has been seriously affected by the economic situation, and the two Memorandums of Understanding that Greece has signed since 2010 dictate a series of measures that focus on the reduction of public expenditure. A broad range of health care reforms and policies have been implemented, which represent the biggest shakeup of the health care system in decades. Irrespective of their positive policy goals, these measures have started to affect public access to the health care system and to increase the financial burden on patients.

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Even before the advent of the global economic crisis that has had such a devastating effect on Greece, the country's health care system had been in a state of continuous crisis and in urgent need of deep structural reform. For over three decades, the main problems have included: a fragmented administrative and provision framework; low levels of public expenditure; significant private sector and out-of-pocket spending on health services by households; skewed human resource allocation; and a low level of primary care. In addition, the health sector faced economic difficulties even before the current crisis, with a large accumulating deficit and high recurrent costs. In the past, several ambitious reform attempts failed repeatedly owing to an array of interrelated economic, political and social factors that favoured the status quo.[1] In particular, powerful entrenched groups, such as doctors and civil servants, have persistently safeguarded their professional interests and acted as major obstacles to reform.[2]

In May 2010, Greece was set under the supervision of the European Commission, the European Central Bank and the International Monetary Fund due to the country's spiralling public deficit and debts that threatened imminent bankruptcy. As part of the deal to secure a rescue package of loans to repay its sovereign debt, Greece signed a Memorandum of Understanding (MOU) that includes a series of health sector measures, focusing especially on the reduction of public expenditure. In February 2012, Greece signed a second MOU, which also included measures targeting the health care system. The main measures are presented below.

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Policies targeting financial contributions to the health system

Three major strategies are affecting the resources available to the health system. In the context of the MOUs, public health expenditure must be reduced by 0.5% of Gross Domestic Product (GDP). Consequently, the health budget for 2011 decreased by €1.4 billion, with €568 million saved through salary and benefit-related cuts and €840 million saved through cuts in hospital operating costs.

In parallel, social health insurance (SHI) has been targeted in the cost cutting drive. From 2011, the government's (employer) contribution rate to one of the largest funds, the civil servants' social insurance fund (OPAD), was set at 5.1% of civil servants' salaries, while the contribution rate of the fund's retired employees will be gradually increased from 2.55% to 4% in 2013. Moreover, the contribution of insured people covered by the National Health Services Organisation (EOPYY, the new social insurance scheme covering approximately 95% of the population) for examinations in contracted private diagnostic centres has been set at 15%; prior to the merger of the SHI funds (see below) the contribution rate fluctuated between 0% and 25%, with almost 60% of the population paying no contribution for such examinations.

Thirdly, user charges have increased in an attempt to bolster the revenues of public facilities. From 2011, the examination fee in out-patient departments of National Health Service (NHS) hospitals and primary care health centres increased from €3 to €5, with exemptions for certain vulnerable groups.

Policies targeting volume and quality of care

Since June 2011, the benefit packages of the various SHI funds have been rationalised and unified to provide the same reimbursable services across all health insurance funds. As mentioned above, this process coincides with the effective merger of the health divisions of the four largest SHI funds (IKA, OGA, OAEE and OPAD, covering salaried employees, agricultural workers, the self-employed and civil servants, respectively) under the newly created EOPYY. An example of this rationalisation process is the removal of some expensive examinations (e.g., polymerase chain reaction (PCR) test and thrombophilia screening) from the EOPYY benefit package. Such diagnostic tests used to be covered on an out-patient basis, even partially, but now they must be paid for out-of-pocket.

> "the health budget for 2011 decreased by €1.4 billion

Regarding quality of care, significant increases in the number of admissions to public hospitals have been reported (at least 24% in 2010 compared with 2009)[3] and 8% in the first half of 2011 compared with the same period in 2010.[4] As a consequence, it is estimated that waiting times also have increased. According to the General Secretariat of the Ministry of Health (MoH), out-patient visits to public health centres also increased by 22% in 2011 compared to the previous year. Although there are no official data, health care personnel verify the extended use of public services. Thus, these increases in the volume of patients in public facilities may have an adverse effect on the health system's capacity to maintain standards of care.

However, considerable efforts also have focused on preventive action. For the period 2008–2012, quite a large number of health promotion initiatives have been established in the areas of cardiovascular disease, cancer, obesity, nutrition, oral health, and maternal and child health. A smoking ban in public places also has been implemented.

Policies affecting the costs of publicly financed health care

Not surprisingly, the different cost-centres of the health system have been targeted in an attempt to reduce expenditures. Firstly, from 2011, cuts in the salaries of health care personnel have been implemented. For example, nurses' salaries have been reduced by 14% compared with 2009.

In addition, temporary staff employed under fixed-term contracts have not had their contracts renewed and there has been a significant reduction in the replacement levels of retiring staff (for every five people retiring only one will be appointed).

Secondly, policies are focusing on the cost of medical products, particularly pharmaceuticals. The MOU aims to save €2 billion from pharmaceutical products (with a target of €1 billion in 2011), thus reducing pharmaceutical expenditure by 1% of GDP. According to estimates, pharmaceutical expenditure fell from €5.4 billion in 2010 to €4.4 billion in 2011 and, assuming targets are achieved, it is expected to fall even further in 2012[3,5], with a savings target of close to €1 billion in 2012 compared to 2011.

Moreover, from 2011, a positive list for reimbursable medicines was reintroduced (it was abolished in 2006) with a focus on generics. In parallel, the increased use of generics is being promoted in public facilities, with a policy that at least 40% of medicines used in public hospitals should be generics. In March 2012, a new law was passed stating that from 1 July 2012, doctors should prescribe by active substance rather than brand. In another complementary measure included in the second MOU, the maximum price of generic medicines cannot exceed 40% of their equivalent branded drugs. There also has been a reduction in value-added tax (VAT) for medicines (from 11% to 6.5%) to reduce prices for both citizens and health insurance funds. Finally, e-prescribing has been made compulsory (from 1 July 2012) and must include at least 90% of all medical activities covered by the health insurance funds (medicines, referrals, diagnostics, surgery). In terms of general procurement procedures in public hospitals, MoH data[3] show that a 21% reduction was achieved in 2011 (compared with 2010) on expenditure on pharmaceuticals, orthopaedic supplies, medical supplies, consumables and chemical agents.

A third category of cost saving measures has affected provider payments. A new pricing system for hospitals has been developed, based on Diagnosis Related Groups (DRGs), which will be used for setting hospital budgets from 2013. The other area of focus is pharmacies, with a reduction in pharmacists' profits of 15% to 20% and the establishment of a rebate system for sales over a predetermined threshold, from 2011. This has been accompanied by measures to liberalise the pharmacies market to introduce greater competition – pharmacies will be able to have more than one pharmacist working there and new pharmacies can be established in closer proximity to each other.

> "allow the expansion of private clinics to build infrastructure"

Fourthly, other measures have focussed on provider infrastructure. From 2011, a series of hospital mergers and closures have been planned, including merging hospitals run by SHI funds and those owned by the NHS. Efforts so far have focused mainly on administrative mergers of adjacent hospitals and merging similar departments within the same hospital. In addition, new measures in the 2011 Health Law allow the expansion of private clinics to build infrastructure, develop new departments, units and laboratories, and expand the stock of hospital beds, within certain defined limits.

Fifthly, structural reforms aim to achieve significant efficiencies. The 2011 Health Law provided for the establishment of EOPYY as the country's primary health care body, under the supervision of the Ministries of Health and Social Solidarity and Labour and Social Security. Although EOPYY is now operating, there are still administrative difficulties that inhibit its full functioning. The aims of EOPYY are to coordinate primary care, regulate contracting of health care providers and set quality and efficiency standards, with the broader goal of alleviating pressure on ambulatory and emergency care in public hospitals. As mentioned above, the health divisions of the main SHI funds have been transferred and are being integrated into this organisation.

Another significant development has been greater decentralisation. The "Kallikratis" Plan, introduced in June 2010, created thirteen regions to replace 76 prefectures and Greece's 1034 municipalities were reduced to less than 370. Under this re-organisation, regional health authorities are expected to play a much greater role in managing and organising the human resources of the NHS.

Prospects

The Greek health care system is currently navigating through a time of heightened crisis. The negative repercussions of this crisis have already led to increased demand for services – for example, admissions to public hospitals have increased. In particular, rising unemployment has led to falls in household income, resulting in patients seeking services covered by SHI rather than paying privately. This process will lead to additional pressures on the public health system, which is already overloaded. In addition, unemployment negatively affects the revenues of SHI, reducing the contributions of both employers and employees dramatically, and leading to larger deficits. Thus, the deficits of public hospitals and SHI funds are expected to increase, potentially affecting the quality of health services and patient satisfaction with these services. Moreover, austerity measures, particularly those that hit people directly, such as salary cuts for public sector employees, are deeply unpopular. The situation raises a number of concerns, namely that public access to the health system could worsen; the burden on family budgets could increase; the provision of health services could deteriorate; and private capital in the health sector could expand without adequate monitoring.

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