# Greece: Indebted Health


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**Summary**

In 2010, Greece faced an accelerated economic downturn and, under the fear of bankruptcy, the government requested financial assistance from the euro-area Member States and the IMF. The assistance was approved, and Greece signed an IMF/EU/ECB MoU. Under the provisions of the MoU, and creditors' pressure for rapid changes, the government introduced a number of health reforms. Horizontal cuts in public health expenditures, reductions in health benefits package, increases in user charges and copayments, upper limits in the use of health services, combined with a significant decline in the number of medical and nursing staff, cuts to social security, a sharp rise in unemployment and the pauperization of a large part of the population resulted in

Healthcare system in Greece can be described as a mixture of individual systems withsocial security being itsbasic organisational axis. The main elements are the insurance sector and the sector of healthcare services. The healthcare sector consists of the units of the National Health System (state hospitals and health centres), units owned by insurance funds, and the private sector affiliated with insurance funds. At the onset of the crisis, there were operatingapproximately 30 different health insurance providers.

The public system offers full medical coverage to the entire population through compulsory health insurance for workers, including eligible family members. The funds were the mainstays in the coverage, provision and financing of health services. The employees of the NHS hospitals and health centers were full time and exclusively employed as civil servants. Contracts for the provision of health services, and allowances to the insured, had to be approved by the Ministry of Health or the Ministry of Employment or the Ministry of Finance.

There was also a great deal of divisiveness in the management of the health system. The system is predominantly hospital-centric with emphasis on the highly specialized doctor.

NHS is funded by the state budget (direct, indirect and special taxation), social security (health funds) and private payments. Hospital care is covered by the contracts signed between the hospitals and the health funds which pay the expenses for the hospitalization of their insured. These medical expenses are lower than the costand the rest is usually covered by the state budget. To cover these deficits government grants often reached up to 74% of total hospital revenues.[1].

Since the mid-1980s, insurance funds also appeared to widen their deficits, primarily due to the rise in daily hospitalisation cost aimed at reducing government subsidies to hospitals. The deficits of the funds have been attempted to be covered by increased contributions, resulting in a wide range of charges, varying by insured and by fund.

Regarding the pharmaceutical expenses of prescription and non-prescription drugs, according to OECD data, public and private pharmaceutical spending increased significantly between 2004 – 2009 from EUR 2.4 billion to EUR 5.09 billion[2]. In 2009, public spending on pharmaceuticals accounted for 95% of total spending. At the same time, however, the overall public health spending, as a percentage of GDP, is lower not only by the European average but also by other EU countrie [3] with corresponding size and economy, suggesting ineffectiveness and disorganization of the management of health system's funds and the available financial resources. Hence the emergence of informal payments within the public health system that reach 2% of GDP (and losses for the state due to tax losses of around EUR 5 billion)[4].

Since the early 1990s, one of the major problems the National Health System had to face was lack of transparency in staffing, lack of staff and infrastructure, and a long waiting list for procedures and medical examinations. In findings of a foreign expert committee, set up in 1994 led by BrianAdel-Smith, noted that the Greek health system is characterised by lack of planning and organisation, underdeveloped public health, unethical behaviours of health professionals (bribing) and an anachronistic and fragmented funding system; particularly in hospitals there is a lack of clear guidelines on the management of costs or the selection of suppliers[5].

## 2. MEMORANDA's MEASURES

As part of the implementation of the Memoranda, specific conditions have been put in place for the country to obtain liquidity – loans, including explicit requirement of reducing public expenditure. This includes the adoption of a maximum level of public

From 2010 until at least February 2015, when a new government was elected, the Greek government continued to implement a health reform programme with the objective of keeping public health expenditure at or below 6% of GDP and pharmaceutical expenditure at 1%. Dictated by the Government's overall austerity policy, in practice this health policy has led to the deepest depression of the health economy. Between 2009 and 2013 total health expenditures dropped by 31.9% (from €23.2 billion to €15.8 billion)[6].

In summary, the measures concerning the health system, as expressed in the Memoranda, are the following:

| **Measures in the MoUs for the health system**<br>**GREECE – MEMORANDA OF UNDERSTANDING (MoU) ON SPECIFIC ECONOMIC POLICY CONDITIONALITY**<br>**(May 2010, February 2012, August 2015)** |
|---|
| **Expenditure and Financing** |
| · Separate the financing of health care and pension systems. |
| · Merge the funds to simplify the overly fragmented system. |
| · Increase health taxes (alcohol and tobacco). |
| · Ensure greater budgetary and operational oversight of health care spending by the Finance Minister. |
| · Public health care expenditure not to exceed 6% of GDP. |
| · Public pharmaceutical expenditure not to exceed 1% of GDP. |
| · Increase co-payments of outpatient and diagnostic services. |
| · Revision of the pharmaceutical co-payment system in order to exempt from co-payment only a restricted number of medicines related to specific therapeutic treatments |
| · Review fees for medical services outsourced to private providers with the aim of reducing related costs by at least 15 percent in 2011, and by an additional 15 percent in 2012. |
| · Limit the prices of diagnostic tests. |
| · Increase health insurance contributions. |
| **Pricing and reimbursement of pharmaceuticals** |
| · Reduce prices of generics and off-patent medicines. |
| · Use a new pricing mechanism based on the three EU countries with the lowest prices. The list will be updated on a quarterly basis. |
| · Reduce the price of all off-patent drugs to 50% and all generics to 32.5% of the patent price |
| · Introduce rebates and clawbacks received from pharmaceutical companies and pharmacies. |
| · Make use of a negotiating committee to develop price volume and risk agreements, in line with other EU countries standards and international expertise, especially for innovative and high cost drugs. |
| **Prescription and monitoring of prescription** |
| · Increase the share of outpatient generic medicines by volume to 60% and of inpatient generic medicines to 60%. |
| · Compulsory electronic monitoring of doctors' prescriptions for medicines, diagnostics, referrals and surgery in both NHS |

| |
|---|
| · Monitor doctors' prescription behaviour and their compliance with binding prescription guidelines. Enforce sanctions and penalties as a follow-up to the assessment and reporting of misconduct and conflict of interest in prescription behavior and non-compliance with the prescription guidelines. |
| · Introduce positive and negative list of reimbursed medicines. |
| · Increase the share of procurement by hospitals of pharmaceutical products by active substance to ¾ of the total. |
| · Set-up a health technology assessment centre that will inform the inclusion of medicines in the positive list. |
| |
| **Pharmacies sector** |
| · Abolish the 0.4 percent contribution of wholesale sales prices in favour of the Panhellenic Pharmaceutical Association. |
| · Starting from 2012, the pharmacies' profit margins are calculated as a flat amount or flat fee combined with a small profit margin with the aim of reducing the overall profit margin to no more than 15 percent. |
| · Readjust the pharmacies' profit margins and introduce a regressive margin is introduced – i.e. a decreasing percentage combined with flat fee of EUR 30 on the most expensive medicines (above EUR 200) – with the aim of reducing the overall profit margin to below 15 percent. |
| · Introduce a contribution in the form of an average rebate |
| · Reduce the wholesalers' profit margins to converge to 5% upper limit |
| |
| **Centralised purchasing and procurement** |
| · Set up the legislative and administrative framework for a centralised procurement system. |
| · Increase the proportion of centralized procurement to 80%. |
| · Use a consistent coding system for medical supplies and pharmaceuticals. |
| · Use capitation payments of physicians to all contracts with EOPYY in order to reduce the overall compensation cost (wages and fees) of physicians by at least 10 percent in 2011, and an additional 15 percent in 2012, as compared to the previous year. |

**Table 1: Source Economou Charalambos, 2018 [7]**

### 2.1 The Legal changes and the measures' implementation

Law 3863 of 15 July 2010 for the new social insurance system was one legislative act passed in the Greek Parliament, foreseeing the separation of social health insurance branches from the administration of pensions; merging of health funds to simplify the overly fragmented system; bringing all health-related activities under the Ministry of Health and Social Solidarity; and establishing the Health Benefit Coordination Council. The aim of this council was to simplify the overly fragmented system by establishing criteria and terms under which social security funds could conclude contracts with all health-care providers in order to achieve reductions in spending and initiate joint purchase of medical services and goods with the aim of achieving substantial expenditure reductions through price–volume agreements[8].

Following on from this, the most significant reform was Law 3918 of 2 March 2011, introducing a major restructuring of the health system. More specifically, the health-care sectors of all four major social insurance funds (IKA, OGA, OAEE, OPAD) formed EOPYY to act as a unique buyer of medicines and health-care services for all those insured, thus increasing bargaining power with suppliers. EOPYY formally began operations in June 2011 and, until 2014, was also the country's main body tasked with managing primary care. Its role was to coordinate primary care, regulate contracting with all health-care providers and set quality and efficiency

Following the merger, the benefit packages of the various social health insurance funds were standardized and unified to provide the same reimbursable services. A basic characteristic of the unified package is a reduction in benefits to which those insured are entitled. For example, some expensive examinations that had been covered, even partially – including polymerase chain reaction (PCR) tests and tests in case of thrombophilia – were removed from the EOPYY benefit package and must now be compensated on an OOP basis. In addition, restrictions in entitlement were introduced in relation to childbirth, air therapy, balneotherapy, thalassaemia, logotherapy and nephropathy. Moreover, introduction of a negative list for medicines in 2012 resulted in the withdrawal of reimbursement status for various drugs. Under the terms of the Memorandum of Understanding (MoU), this negative list should be updated twice a year. The over-the-counter drug list introduced in the same year comprises many medicines that had been reimbursed (e.g. some pain relief medicines) but must now be paid for out of pocket[9].

In 2011, an increase in user charges (from €3 to €5) was imposed in public hospital and health-centre outpatient departments. This measure was abolished by Ministerial Decision No. A3(g)/GP/oik.23754 of 1 April 2015 issued by the Minister of Health. Visits to health centres and outpatient departments of hospitals are now free of charge. The results of two studies show that the cost of establishing and maintaining the financing mechanism to gather the €5 patient fee in health centres exceeded the total revenues collected. Also, the way in which cost-sharing was implemented in PHC has not promoted a more effective delivery of services[10].

Law 4093/2012 introduced a €25 patient fee for admission to a state hospital from 2014 onward and an extra €1 for each prescription issued under the ESY (in both primary care and inpatient settings). However, the hospital admission fee was soon revoked and replaced with an extra tax of 10 cents on cigarettes, following strong reactions from health-care professionals and various other stakeholders.

Increases in medication copayments for specific diseases were also introduced in 2011 (Table 16). It is noteworthy that average monthly pharmaceutical expenditure increased between 2012 and 2013, despite price reductions in pharmaceuticals. This may be attributed mainly to increases in cost-sharing levels from October 2012. In general, average cost sharing for pharmaceuticals rose from 13.3% in 2012 to 18% in 2013. Indicatively, in 2013 only 8% of prescribed drugs (packets) required no copayment, compared with 13% in 2012.[11]

### 3. CONSEQUENCES

Until the start of the economic crisis, Social Health Insurance covered around 40% of current health expenditure. Its share declined to reach 30.1% in 2016, which represents about half of total public health expenditure. 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, due to the rise of unemployment and the demand for public health services. There was also an increase of the average monthly household pharmaceutical expenditure as well as of the average proportion of patients' co-payment for pharmaceuticals from 9% in 2009 to 30% in 2016. In addition, in April 2014, calls to make an appointment with any doctor under the National Primary Health Care Network (PEDY) scheme were outsourced to private telephone companies, with charges ranging from €0.95 to €1.65 per minute, thus increasing the financial burden of the patients[12].

In relation to health care personnel, in the drive to reduce health system input costs, salary cuts were applied after 2010 to all public health care staff, including administrative personnel, doctors, nurses, pharmacists and paramedical staff. Additionally, almost all subsidies to health care staff were abolished. In practice, three types of salary cuts actually took place: horizontal cuts

in the same period, including days and nights on duty that increased due to lack of medical staff. Moreover, planned performance-based productivity bonuses were not implemented as no targets were set, nor did any staff evaluations take place. Other workforce measures aimed at reducing costs include the non-renewal of contracts for temporary staff employed under fixed-term contracts and a reduction in the replacement levels of retiring staff (for every five people retiring only one will be appointed)[13].

The economic crisis – and total deregulation of the labor market via flexible industrial relations policies and redundancies dictated by the MoUs – increased unemployment in Greece and resulted, according to the National Social Insurance Registry (ATLAS), in more than 2.5 million people losing their social health insurance rights. Action to address this development was delayed, and the measures implemented were uncoordinated, insufficient and stigmatizing for the beneficiaries

At last, a new primary health care reform was introduced in August 2017. Under the new legislation, primary care is free of charge, and it operates on a 12 hour a day basis in areas where there is adequate hospital coverage and on a 24 hour a day basis where such hospital services are lacking.

### 3.1 Consequences by Sector

#### 3.1.1 Public Hospitals

The total number of beds in National Health System hospitals (ESY) decreased from 38,115 in 2009 to 29,550 in 2016. The number of medical departments and units declined by 600 and 15,000 hospital personnel were cut. Furthermore, 500 public hospital beds were set aside for priority use by private insurance companies for their clients[14].

Hospital supplies represent 68% of total hospital operating expenses (excluding salaries and wages). Thesecosts were cut by more than 38% between 2009 and 2011 due to streamlined procurement procedures,pharmaceutical policy reforms and horizontal cuts implemented by the Ministry of Health. On the otherhand, operating expenditures (consumables, overheads, security etc.) increased in many hospitals for reasonsnot immediately apparent. For example, in a sample of 40 general hospitals (out of 90) for which allexpenditure data were available for the three-year period (2009-2011), expenditures on outsourcing (legalservices, consulting services etc.) increased by 40% in 2010 (compared to 2009) with a further increase of27% in 2011. The results for other overheads or outsourcing services are similar. Examples include catering(up 22% in 2010 and 12% in 2011 for the 19 hospitals for which data were available for the three-yearperiod); cleaning (16% increase in 2010 and 24% increase in 2011 for 50 hospitals); and security services(23% increase in 2010 and a further 27% increase in 2011 for 34 hospitals)[15]. Considering this result,it is clear that the solution of outsourcing, chosen as a way to minimize the expenses, has failed completely.

More than half of the country's 283 hospitals (accounting for 35% of total bed capacity) are for-profit private hospitals, and there are more than 3,500 private diagnostic centers. Health facilities, staff and medical equipment are unevenly distributed across the country, with a higher concentration in urban areas and poor rural service, contributing to a high level of unsatisfied health care needs.For example, the number of hospital beds of increased medical care in 2015 (360 per 100,000 inhabitants) is not only below the EU average (418) but also demonstrates a threefold difference between the number of beds of the metropolitan region of Attica and rural areas of central Greece. "Freezing" public servants'recruitment imposed in 2010 stopped the steady increase in human resources in healthcare, a trend that marked the pre-crisis period. This led to a 15% reduction in hospital staff – despite this, Greece still records the highest proportion of doctors in terms of population (6.3 per 1,000) in the EU (this includes registered and unemployeddoctors). The vast majority of physicians are specialist physicians, and only a small minority (6%) are general practitioners or family physicians.Contrary to the number of doctors, the proportion of nursing staff to population is by far the

now unemployed, and 7,340 doctors left Greece between 2009 and 2015. The problem is, even more, pressing for the nursing staff[20].

From this point of view, interesting are the results of one of the most recent researches conducted by the University of Western Attica and the research department of the Helena Maternity Hospital, at the end of 2019, with a sample of nursing staff working in three maternity hospitals of the National Health System. According to the results, 26.5% of nurses admit that they feel they want to quit their jobs often (2.5%), more often (3.3%) or sometimes (20.7%). Only 19.8% has a feeling of high job satisfaction, while 65.8% report low level job satisfaction and 14.1% moderate satisfaction. Also, 5% of participants feel they are in a phase of severe "burn out", 54.5% experience moderate fatigue and 40.5% low fatigue. Finally, 73.9% of participants report high intensity compassion fatigue (secondary traumatic stress disorder), 19.8% moderate and just 6.3% low[21].

Several organisations have highlighted staff shortages in the health sector. The Greek Medical Association (PIS) claimed in February 2016 that the National Health System (ESY) needs an additional 6,000 doctors to operate effectively. The Panhellenic Federation of Workers in Public Hospitals (Poedin) reported in October 2015 that there were 26,347 vacant positions in hospitals (as reorganised under the memoranda policies). In addition, there were 3.6 nurses per 1,000 capita, compared with the EU average of 8 nurses per 1,000. Understaffing results in an excessive burden on hospital employees and insufficient support for patients and is one of the key issues frequently raised during demonstrations by staff in the health sector. Recognising the magnitude of the problem, and on the basis of a report recording staff shortages in hospitals (which established that there are about 4,000 vacant doctorsposts), in March 2016 the Health Minister demanded the immediate and urgent recruitment of 800 permanent and 700 auxiliary doctors and 2,500 nurses[22], which was never completed finally and largely involved non-permanent recruitments. The new government elected in July 2019 has said that it would proceed to permanent recruitments into the National Health System and especially into Public Hospitals but until the end of 2019 nothing has happened.

According to Elias Sioras, vice president of the Association of Athens and Piraeus Medical Doctors – EINAP- and a cardiologist at Greece's largest hospital, Evangelismos, pre-memorandum public and private health spending was € 26 billion a year, while in 2019 it did not exceed € 14,7 billion.Citing the most recent OECD data, MrSioras points out that public spending on health has fallen by 43% over an eight-year period (2009 – 2017) from 15.4 billion to 8.8 billion. By the end of 2019, vacant organic doctor positions in hospitals ranged from 6,500 to 7,000 while the total reduction in medical staff since the crisis began is estimated at 15,000.The vacancies for non-medical personnel (nursing, administrative – auxiliary of other nature) in hospitals at the end of 2019 were between 20,000 – 25,000. At the same time, it has been recorded an increase in flexible working relations, which meansif and when they are hired, it is for a specific period of time, and before the new staff gets adjusted to theirnew responsibilities, they leave, waiting for an unspecified time to go to another hospital and position.

Furthermore, as pointed out by H. Sioras, based on the latest budget of the current Government adopted at the end of 2019, for 2020, total health expenditure is further reduced by EUR 182 million, raising the total spending cut to approximately 700 million for the last six years. As far as public hospitals are concerned, the reduction goes up to EUR 37 million.

In addition to Mr. Sioras statements, the Panhellenic Federation of Workers in Public Hospitals – Poedin, in early November, has highlighted that of the 450 beds nationwide in intensive care units, 150, mainly in hospitals in Western Greece, are out of order due to a lack of staff[23]. And in some cases all the surgery or medical procedures are suspended due to lack of doctors[24].

#### 3.1.2. Mortality

estimated that there was an increase of more than 200 deaths per month after the onset of the crisis[26]. It is also worth mentioning two other substantial increases in cause-specific mortality: deaths from infectious and parasitic diseases as well as from mental and behavioural disorders.

The all-age, all-cause mortality rate in Greece was 1174 deaths per 100 000 in 2016 compared with 997 in 2010 and 944 in 2000. This finding corresponded to a 2,72% annualised increase from 2010 to 2016—with evidence of continuing acceleration. The rise in the ARC for all-age mortality was also threefold higher in Greece post-austerity than the 0,86% rise seen across western Europe for the same period, which was in the opposite direction of the global estimate of a 0,7% fall in all-age mortality from 2010 to 2016. As for specific causes of death, adverse effects of medical treatment, self-harm, and several types of cancer stood out as consistently increasing in Greece across all ages (figure 2). Within specific age groups, other causes are apparent, with rapid increases in deaths due to neonatal haemolytic disease and neonatal sepsis in children younger than 5 years, and prominent increases in self-harm among adolescents and young adults. Greek adults aged 15–49 years had increased mortality due to HIV, several treatable neoplasms, all types of cirrhosis, neurological disorders (i.e. multiple sclerosis, motor neuron disease), chronic kidney disease, and most types of cardiovascular disease except for ischaemic heart disease and stroke. In adults aged 70 years or older, only a subset of causes of death increased in Cyprus and western Europe, but nearly all increased—and increased more rapidly—in Greece between 2010 and 2016[27].

Findings of reduced improvement in age-standardised mortality after austerity are similar to those presented by Laliotis and colleagues[28], who also reported slowing of overall mortality reduction in Greece after the financial crisis despite differences in data sources and methods (official statistics from Hellenic Statutory Authority and EUROSTAT vs vital registration adjusted for incompleteness, misclassification, and comprehensive statistical modelling). In this research of Laliotis and colleagues was also mentioned that those older than age 75 years had more negative effects than remaining adult age groups, identified a reversed epidemiological transition manifested as a nearly 10% increase in mortality due to communicable, maternal, neonatal, and nutritional diseases, and reported a worsening of mental health in Greece. The Global Burden of Disease index and its 2016 findings of static child mortality also align with reports of increases in infant mortality and stillbirths post-austerity[29].

Several plausible explanations could account for the trends of disease burden observed in Greece recently; the full explanation is probably multifactorial. One of them is population ageing in Greece that preceded the economic crisis and could have contributed to the slow but measurable increase in all-cause mortality rates since 2000. Acceleration of population ageing since 2010 could be due to the massive emigration of early to mid-career educated professionals in pursuit of financial stability, in what has been referred to as brain drain[30].

Nevertheless, the findings for cause-specific mortality after 2010 do not support ageing as the only culprit, because increases were also noted in deaths due to neonatal hemolytic disease and neonatal sepsis in children younger than 5 years, self-harm among adolescents and young adults, HIV in young adults, and several treatable cancers in younger adults. And at the same time, the demographic changes in Greece cannot be considered independent to the economic crisis, because emigration can be triggered by crisis-related increments in unemployment, reductions in wages, and stringent taxation schedules[31].

Moreover, many behavioural risk factors in Greece are more common in people with lower levels of education or income. In 2014 32% of Greek men in the poorest income quintile, smoked daily (the figure was 24% across the EU), while the corresponding percentage for the Greeks with the highest income was 25% (16% in the EU).Similarly, one in five adults who had not completed secondary education is obese compared to one in seven adults who had completed tertiary education. This higher prevalence of risk factors in socially disadvantaged groups contributes to inequalities in health and life expectancy[32].

### 3.1.3. Catastrophic health expenses

Catastrophic expenditure is defined as the household's direct health expenditure in excess of 40% of its total expenditure, excluding basic living expenses (i.e. food, housing and utilities).In 2010, 7.2% of households experienced catastrophic out-of-pocket payments, but by 2015 this had risen to 10.5% of households, falling to 9.7% in 2016. They are heavily concentrated among the poorest consumption quintile. In 2016, nearly a third of Greek households in the poorest quintile experienced catastrophic spending on health; these poor households spent 1 in every 7 euros on health care. Medicines play an important and growing role in driving catastrophic spending. In 2016, 44% of out-of-pocket payments among households who experienced catastrophic health spending were for medicines[33].

The rate of poverty due to direct payments from patients has been steadily increasing since 2004, affecting 3% of households in 2014 (Figure 13). According to W.H.Oestimates, one in ten households in Greece suffered catastrophic direct spending in the same year, amounting to one in three for poorer households.[34].

| | **Unmet needs concerning medical care per income level** | | | | |
|---|---|---|---|---|---|
| YEAR | Very Low Income | Low Income | Middle income | High Income | Very High Income |
| 2007 | 9,2 | 5,5 | 5,1 | 3 | 0,8 |
| 2008 | 7,2 | 6,2 | 5,1 | 2 | 0,9 |
| 2009 | 8,5 | 6,2 | 3,4 | 1,9 | 0,6 |
| 2010 | 8,1 | 5,6 | 4,6 | 2,2 | 0,8 |
| 2011 | 10,2 | 8,2 | 6 | 3,7 | 3,2 |
| 2012 | 13,4 | 9,3 | 9,3 | 7,6 | 5,7 |
| 2013 | 16,2 | 13,4 | 11,3 | 9,9 | 5,2 |
| 2014 | 18,3 | 18,3 | 15,1 | 8,4 | 3,2 |
| 2015 | 19,7 | 18 | 15,1 | 12,1 | 6,7 |

**Figure 2: Source: Hellenic Statistical Authority – ELSTAT 2016 (Reference: ΓΚΟΥΝΤΟΥΜΑΣ ΜΙΧΑΗΛ)**

These figures show that the lower the citizens' income, the more they are unable to meet their medical needs. This inequality is

The surge in unemployment to 27% of productive capacity, the deregulation of labor relations and flexibility, as well as the reduction in wages, have resulted in a significant decrease in insurance fund revenue from insurance contributions.This, coupled with the reduction of the state subsidy to the National Health Service Agency (EOPYY) to 0.4% of GDP, against the initial projected rate (0.6%), makes the financial viability of the single health fund more complicated and necessitates the redesign of policy[35].

Inadequate official data on waiting lists makes it difficult to assess the current situation regarding the impact of measures implemented in the "prioritization» (rationing) to access health services. The difficulty relates to the absence of a well-organized time and waiting-lists management policy. However, some estimates can be made. For instance, it is necessary to investigate at what extent the EOPYY administrative staff reduction to least 50%, compared to initial staff of the four main merged funds (IKA, OGA, OAEE, OPAD) as well as the decrease in the contracting physicians by 25%, increases the time cost for the insured.

Besides, the imposition of ceilings on visits by EOPYY contracted doctors (10 per business day, 200 per month) burdens insureds with unnecessary wandering around the health system until they find a doctor who has not reached the ceiling to provide them with services needed.In other words, instead of promoting reforms that facilitate the patient's orientation in the health system, such as, for example, the General Physicia, the patient has the responsibility of seeking services, limiting his choices not only because of the number of visits but also due to the absence of an official mechanism for information on the availability of doctors.To these, it should be calculated and the additional cost of the insured to use the telephone appointment service since it has been assigned to private mobile phone operators[36].

Moreover, new types of informal payments have emerged recently, as patients seeking treatment have to pay an additional fee under the table to EOPYY contracted doctors, ranging from €10 to €20 for a service that is supposed to be free of user charges. This is the result of the low per visit remuneration of €10, but mainly of ceilings imposed in 2014 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, with the aim to avoid referring to several doctors in order to find one who has not reached his/her visits and prescription limits, are forced to informal payments[37].

#### 3.1.5. Chronic illnesses

MoUs have hit hard the patients with chronic illnesses who have been particularly vulnerable. They are affected by a lack of adherence to prescribed medication, reduced access to diagnostic services, poor monitoring of complications and increased risks of catastrophic expenditure. I.E. Patients with cancer are another group that have faced serious problems in accessing appropriate medicines[38]. Patient organizations have reported delays and disruption with drug supplies. All expensive cancer medicines are, in theory, available through hospital and EOPYY pharmacies, but in practice public hospitals are indebted to pharmaceutical companies and these, in turn, have discontinued supplies. Patients can order medicines through their local pharmacy, paying cash that they may then reclaim from EOPYY. However, this is not a common choice as many cancer medicines are very expensive and EOPYY reimbursement can take many months. Previously, this issue was even more critical for patients with cancer who had no health insurance as, if they did not pay for their treatment the cost of medication provided through hospital pharmacies was recovered through their income tax liabilities. However, after the implementation of legislation which provided coverage to the uninsured in 2016 those barriers were removed. In addition, unequal distribution of oncological resources created two tiers of patients, based on their ability to pay for travel/accommodation[39].

### 3.1.6. Mental Health

The long recession and the MoUs austerity measures affected, in many different ways, the physical and mental health of the Greek people as well as their access to public health services[41] (Kentikelenis et al. 2014).

Specifically, mental health services have been seriously affected. Rapid socioeconomic change can harm mental health, unless it is ameliorated by appropriate social policies. However, in Greece public and non-profit mental health service providers have scaled back operations, shut down, or reduced staff; plans for development of child psychiatric services have been abandoned; and state funding for mental health decreased by 20% between 2010 and 2011, and by a further 55% between 2011 and 2012[42]. Austerity measures have constrained the capacity of mental health services to cope with the 120% increase in use in the past 3 years[43].

***Figure 3: Source: Hellenic Statistical Authority and Police***

The available evidence points to a substantial deterioration in mental health status. Findings from population surveys suggest a 2·5 times increased prevalence of major depression, from 3.3% in 2008 to 8.2% in 2011, with economic hardship being a major risk factor[44]. Investigators of another study reported a 36% increase between 2009 and 2011 in the number of people attempting suicide in the month before the survey, with a higher likelihood for those experiencing substantial economic distress[45]. Deaths by suicide have increased by 45% between 2007 and 2011, albeit from a low initial amount. This increase was initially most pronounced for men, but 2011 data from the Hellenic Statistical Authority also suggest a large increase for women[46].

### 4. TOTAL HEALTH EXPENDITURE – Comparison with other EU countries

In 2010 total public health funding (by the General Government and Social Security Organizations) was € 14,920.8 million while private funding by private payments and private insurance was € 6,614.6 million. In 2015 total public funding was reduced to EUR 8,704.5 million and private financing to EUR 5,765.4 million.Private spending accounts for 40% of total funding while public spending 59%. Only 19% difference when in 2010 it was 40%. (Source ELSTAT, 2017). This means you can be heading into a fully

***Figure 4: Percentage Contribution per sector in funding health expenditure 2010 – 2016 – Source: Hellenic Statistical Authority, ELSTAT – Reference: Economou Ch. (2018)***

Policies aimed at reducing waste and enhancing efficiency contributed to the rapid decline in health spending during the economic crisis, with spending levels stabilizing from 2015 onwards. In 2017, Greece spent € 1,623 per person on healthcare, well below the EU average (€ 2,884).This amounts to 8% of GDP, well below the EU average (9.8%). Over one-third of health spending comes from households (including informal payments); it is one of the highest rates in the EU and is due to high direct private expenditures on medicines, outpatient (or open hospital) and hospital services[48].

Although, traditionally, public spending on health in Greece has never exceeded the EU average, the imposition of the Memorandaworked as a catalyst for further reductions. Despite the fact that 6% of GDP was set as a spending ceiling for Health in the first Memorandum and was no longer an explicit target in the next, it still sets out the fiscal sustainability measures. Public health spending accounts for 5% of GDP compared to 7.2% on average in the EU and represents only 59% of total health spending, the fourth lowest rate among EU Member States.

***Figure 5: Eurostat- Total general expenditure on health in 2017 as % of GDP***

High private spending on health, mainly in the form of direct patient payments, has always been an essential feature of the Greek health system and is still growing. In 2015 direct payments accounted for over one third (35%) of total health expenditure, more than twice the EU average (15%) and the fourth-highest among the Member States. The bulk of direct patient payments (90%) relate to the purchase of private services rather than participation in payments.

Overall, in 2017 in Greece, only 61% of spending on health care comes from public sources and 35% financed directly by households (the fourth-highest percentage in the EU). This rate ranged from 28% in 2010, which was the lowest, to 37% in 2014, which was the highest.High levels of cost-sharing largely stem from provocative demand (supply-driven demand) and are mainly due to the insured's participation in medicines and direct payments for services not included in the benefits package, such as visits to specialist doctors, nursing as well as dental care (see also figure 15).Also, informal payments represent more than a quarter of direct private payments, raising severe concerns about equality and barriers to accessing healthcare (WHO, RegionalOfficeforEurope, 2018).

In 2017, Greece had the second highest level of self-reported non-covered health care needs in the EU (after Estonia), as one in ten households reported having no access to health services when they needed it.Uncovered needs were also reported by nearly one in five households in the most deprived quintile, but only by 3% of the wealthiest households, revealing the widest income inequality gap in Europe. A more positive development is that 2017 was the first year in which the overall level of non-covered needs fell, after continued growth for six consecutive years[49].

Member States with a relatively high proportion of private health expenditures are Bulgaria (46% of total health expenditure), Greece (over 41%), Cyprus (54%), Latvia (44%) and Malta (42. The Czech Republic (23%), Denmark (24%), Germany (25%),

***Figure 6: Unmet needs due to cost distance or waiting time – Source: Eurostat – Reference:Economou Ch. (2018)***

In 2015 in the EU, public health spending averaged 15% of total public expenditure. The Member States that exceeded the EU percentage were the Czech Republic, Germany, Croatia, Ireland, Lithuania, the Netherlands, Austria, Slovakia and the United Kingdom. The Member States with the lowest rates were Cyprus (7.2%) and Romania (8.4%), followed by Greece, Latvia, Hungary, Poland (all below 11%), and Luxembourg (11.5%)[51].

In particular,in Greece, the sharp decline in wages and rising unemployment under a fragmented healthcare system with low redistribution has led to a significant reduction in coverage and eligibility for public health care. Greece, based on 2015 data, appears to be the EU country where a vast majority of citizens declare that they do not have access to health services due to increased costs[52].

The reversal in per-capita health expenditure inGreece in 2009–10, despite a continually ageingpopulation that would have been expected to lead toincreased spending, might have caused a fiscal andorganisational shock to the health-care system. Since theimplementation of the austerity programme, Greece hasreduced its ratio of health-care expenditure to GDP to oneof the lowest within the EU, with 50% less public hospitalfunding in 2015 than in 2009[53]. This reduction has lefthospitals with a deficit in basic supplies, while consumersare challenged by transient drug shortages.

Concurrently,nearly a quarter of the population lost health insurancefrom the national health-care programme due to longstanding unemployment, while more than 20%reductions in the minimum wage reduced consumer buying power[54].

Uncoupling of causes of health loss dueto existing unhealthy behaviours and rooted inefficienciesof the health system from those due to the effects ofausterity-related health policies is challenging and limitedby data availability. Nonetheless, steep changes in healthloss indicators since 2010 support a role of the austeritymeasures – MoUs in accelerating the pre-existing health burdensince 2000. Constriction of health-care provision in Greece has beenassociated with a decrement in self-rated health

The role of NGOs and other health and social networks should also be mentioned. In Greece, a few NGOs (up to seven) actively provide health services to migrants, uninsured people and other vulnerable groups. Dozens of clinics and drugstores have been developed in Athens and other cities, mainly offering PHC, provided by all the basic medical specialties (GPs, paediatricians, gynaecologists); preventive medicine (diagnostic tests), mental health services but also medicines to uninsured people who can't afford them. Some of them are running under the auspices of municipalities, but many others are just the outcome of communities' effort to support the most vulnerable and are completely depended on voluntary offering.

With demand increasing, and the public health system deteriorating, NGOs and other unofficial networks of health professionals and volunteers set up to help poor and uninsured patients contribute significantly to retain access to a basic set of medical services among poor and unemployed people. A network of around 40 community clinics operates across Greece, providing mostly primary health services and medications free of charge to people either unable or ineligible to use public services.

The Metropolitan Community Clinic at Helliniko is one of the most outstanding examples: offering services to more than 20 000 people since it was established on a volunteer basis in December 2011 in response to a society operating in austerity and difficulty. Its volunteers now number more than 200 and include a growing number of doctors, dentists, pharmacists, therapists and support staff. They are treating an ever growing number of patients, at times more than 100 per day[56].

The Social Mission Infirmary has been in operation since February 2012. A report published in 2014 identified a major problem: 10% of patients needed systematic continuous care or at least to be hospitalized, but this was not possible unless their situation could be classified as an emergency (Social Mission Infirmary, 2014). Thus, 86% of people visiting the Social Mission Infirmary lost their social insurance during the years 2010, 2011 and 2012. The organization has created a network of support with a number of hospitals, and could provide care to two to three cases each month[57].

After the first years, most of these voluntary ventures started to form a network and until now they are cooperating as much as they can to provide medical services and free medicines to the most vulnerable citizens, even for chronic and serious illnesses as cancer. They have also developed relations to similar ventures abroad. The Metropolitan Community Clinic at Helliniko was a pioneer as for this aspect[58].

## 6. CONCLUSION

On the eve of the financial crisis, in spite of a large number of legislative initiatives that took place over 30 years since its establishment[59], the NHS faced serious problems that could be summarized as follows[60]:(a) deficiencies in the functioning of primary health care where a fragmented patch of services could not meet the needs of the population, (b) severe problems in financing the health system where the absence of a concentration body and thesubsequent allocation of financial resources were evident; (c) outdated compensation schemes for suppliers that lacked any incentive to operate more efficiently; (d) outdated operation and management techniques of health units that led to waste of resources, (e) the absence of cost-effectiveness assessment, monitoring and control mechanisms; and (v) the lack of a rational allocation of health resources between services and between regions, based on the real needs of the population.These problems have made the country's health system particularly vulnerable to fluctuations in economic conditions. The NHS was not prepared and did not have the necessary institutional and functional immunity to face the new situation brought about by the financial crisis, thus becoming one of the main "target" of the Memoranda.

***Figure 7: Healthy life years in absolute value at birth, womenand men, Greece and EU 28 – Source: Eurostat – Reference: Economou, Ch. (2018)***

The crisis has exacerbated existing problems, and many of the policy measures introduced under pressure from bailout conditions have made health-sector financing more inequitable. The imposition of public health spending restrictions (to no more than 6% of GDP) and the simultaneous decline in GDP since 2009 (with further decreases forecast in the next few years) means that the public health sector is called upon to meet the increasing needs of the population with decreasing financial resources. This has negative effects, especially for the middle- and low-income households that lack the disposable income to buy private health services. Moreover, rising unemployment, part-time working, flexible employment and austerity measures (such as public-sector salary cuts) have led to falls in household income and the revenues of social health insurance systems' funds. This situation has led to additional strains on an already overloaded public health system. In combination, these factors could lead to a de facto two-tiered health system in which those who can afford to pay for private health services will be able to meet their health needs, while those without sufficient resources attempt to access services from a severely strained public system[61].

The majority of the reform measures introduced during the first wave of reforms (2010-2014) undermined the health system goals described in the typology adopted by WHO/EURO (health status, financial protection, efficiency, equity, quality, responsiveness, transparency and accountability)[62]. These included the reduction of the scope of essential services covered, the reduction of population coverage and increases in user charges for essential services (i.e. changes in all three dimensions of coverage), increases in waiting times for needed services, horizontal cuts in public health expenditure and attrition of health workers caused by cuts in salaries, reductions in the replacement levels of retiring staff and migration to foreign labour markets. On the other hand, introduced measures likely to promote health system goals were limited and, in many cases, not well planned and implemented.

The changes implemented based on Memoranda have not resulted from a systematic study guided by the needs of citizens. They were simply the "response" to the public spending cuts set by the Memoranda to secure the country financing for debt repayment.This alone, interprets some contradictions in the applied policy. For instance, without resolving the issue of the sources of NHS funding and the sustainability of Social Security Funds, the supplier compensation scheme is being institutionalized, increasing the burden on Funds dramatically.Without having a referral system in place for primary care, which is a key pillar of patient needs and guidance in the system, the reform of the country's hospital map is being announced. Instead of focusing on completing the online prescriptions and adequate prescription protocols, drug price reductions and positive and negative lists are constantly being promoted[63].

In other words, justified, necessary and substantial structural reforms to the NHS have not been made. Even though some of the measures implemented, one can say that had a generally positive direction, particularly in micro-management level, they are lost

After 2015, and the election of a new left-wing government, these neglected issues came to the forefront of the health policy agenda, building on increasing concerns about achieving universal health coverage (UHC) and reducing of barriers in access to health services. The 2016 legislation providing free access to care for uninsured Greeks and immigrants and the abolishment of some kinds of cost-sharing, resulted in a slight decrease of "out of the pocket" payments (Figure 2) and of self-reported unmet need for health care due to cost, distance or waiting time[65].

To all these, we have to point to a potential additive effect of the economic crisis to existing deficiencies in health services. contemporaneous to the economic crisis, Greece has been hosting an increasing number of refugees from Syria notably, which could pose an additional challenge for national health and welfare systems and warrants new investigations on the effect on the national health status.

In conclusion, the MoUsdirectly affected the Greek health system. First, austerity measures stipulated the reduction of public health expenditure with negative impacts on the volume and quality of services provided. Second, health insurance coverage and access to services were reduced via increases in user fees and co-payments, reductions in covered benefits and the imposition of ceilings in the use of services. Third, human resources for health have been affected via hiring freezes, salary cuts and brain drain. Fourth, the above mentioned impacts of EAP on the country's health system had negative follow-on effects on population health and unmet medical needs[66].

In Greece, austerity measures aimed directly at the reduction of the healthcare expenditure to GDP ratio[67] according to MoUs demands and calculations in order, as it was mentioned, to avoid bankruptcy and to serve the country's debt obligations without a structured plan for reform, without any serious research resulting to a more dysfunctional and excluding National Health System, a System more expensive and less effective that it raises the burden on the more vulnerable citizens .

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