Annual National Report 2011

Pensions, Health Care and Long-term Care

Greece

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1 Executive Summary

Greece is struck by recession for a third consecutive year. In 2009, the economy shrank by 2.3%; it dropped by 4.5% in 2010 (the largest contraction in more than 50 years); while a bleak forecast of about 3.5% negative growth in 2011 indicates devastating effects on the economy. In late 2009 - early 2010 soaring borrowing costs brought the country near bankruptcy, and in March 2010 a bailout loan package (€110bn) was agreed between Greece and the IMF-EU-ECB (ratified by the Greek Parliament) that covers the country's borrowing requirements for the next three years.

In the struggle to recovery severe (and unpopular) austerity measures and rigorous structural reforms have been progressively introduced. Sweeping cuts in public spending and wholesale reforms constitute agreed targets for the payment of the quarterly tranches of the bailout loan.

Pensions and the public health care system have been high on the reform agenda. The 2010 pension reform manifests a "pathbreaking" change from a highly fragmented, Bismarckian social insurance system (based primarily on the fist pillar), to a unified, multi-tier system that distinguishes between a basic (quasi-universal) non-contributory and a contributory pension. Furthermore, replacement rates are drastically reduced; pensionable income is redefined on the basis of total career earnings; stricter conditions are introduced for early and regular retirement; measures are taken for equalising men and women's retirement conditions (in a phased-in way); and provisions are made for linking longevity to retirement age (from 2021 onwards). The reform aims at securing long-term viability and promoting distributional justice by eliminating accumulated privileges and inequalities built into a system long nurtured by clientelistic criteria. Nevertheless, fairness problems remain, while drastic cuts in current and future pensions impact negatively on adequacy of benefits. Severe reductions in pension incomes for future retirees will encourage complementary private savings. Yet inequalities of access (that may arise) to a funded, occupational pension-tier (so far very little developed), as well as to private insurance will highly impair adequacy (and collective solidarity).

Equally, in public health care, cost-containment is a top priority, given the fact that medical debt crucially affects the public deficit. Significant legal and organisational changes were decided in the last year with the aim to improve costing mechanisms for medical treatment, pharmaceuticals and other medical supplies, upgrade hospital budgeting and accounting systems, contain drugs costs, facilitate all day operation of hospitals, amalgamate health insurance funds and create unified primary care. Undoubtedly, the country's serious debt problem has been compounded by the soaring hospital deficits, over the last decade, and persistent fragmentation of health insurance; hence reform is of utmost importance. So far however, there are no strong signs of cost rationalisation; while drastic cuts shrink coverage (e.g. reduction in the scope of diagnostic tests and drugs covered by social insurance organisations) and impact negatively on access and equity criteria.

Finally, long-term care is not an issue of public focus. Yet, as the economic crisis puts great strains on the family model of care provision, so far prevalent in Greek society, an urgent need emerges for reconsidering division of responsibilities (private/family – public) in funding and provision of long-term care services and redefining their role within the social protection system.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Overarching developments

Greece is facing the worst economic crisis since World War II. The sovereign debt crunch that emerged in 2009 (excessively high public deficit and debt levels disclosed after the revision of the budget gap) undermined the credibility of the country and led to escalating borrowing costs. In March 2010 a bailout loan package was agreed between Greece, the EU, the IMF and the ECB under the terms of severe austerity measures and structural reforms aiming to improve the fiscal situation in the country. The economy is struck by a deep recession for a third year in a row, unemployment is rising fast and social unrest is growing.

Overall, the main options of social reform, under the bailout agreement, embrace the drastic reduction of current and future pension incomes and social assistance benefits (which, however, have been quite low even before the crisis), and enforcement of fiscal discipline in public health spending - given the fact that medical debt has been a major component of rapidly increasing public debt over the last decade. Cost-control mechanisms and drastic cuts in health expenditure by merging (closing down) hospitals are among the main priorities of health reform, in parallel with policies shifting the cost to the "consumer" (enforcement of a so-called "ticket payment" for outpatient services provided by hospitals and promotion of private provision within the NHS).

Pensions have been the flagship of reform, though, under the "Memorandum" that the government signed with the international donors. The urgent need for a comprehensive reform has been at the forefront of the academic debate on social insurance over the last decade and various blueprints were put forward with an emphasis on medium and long-term fiscal sustainability and system rationalisation (tackling extreme fragmentation and inequalities in entitlement regulations and benefit levels). Debate has intensified since late 2009. A special Committee that was appointed by the Ministry of Labour and Social Insurance in December 2009 (involving the social partners, political party representatives[1], ministerial officials and experts) came up with significant proposals; while the bailout agreement signed in spring 2010 postulated specific reform measures. As a result, an overhaul of pensions (for both the private and public sector) was approved by parliament in July 2010. This signposts a "path-breaking" act that significantly changed the structure of the pension system, as it paved the way for a shift from the fragmented, Bismarckian earnings-related system to a (more or less) unified multi-tier system that distinguishes between contributory and non-contributory elements.[2] Insurance funds were further amalgamated and a new pension formula basing pension income on the entire working-life earnings was introduced, in parallel with an annual adjustment of pensions (from 2014 onwards) on the basis of a coefficient drawing on GDP fluctuations, the consumer price index and the financial situation of pension funds.

The new structure will be in operation from 2015. An immediate impact, however, will be made on all new retirees, as provisions will apply to insured working time from January 2011. Moreover, the viability of auxiliary pensions is under scrutiny at present.

Pension reform - as well as drastic cuts in current pension income - met the strong resistance of trade unions that criticised governmental action as an attempt to eradicate social rights and

[1] Though not all political parties agreed to participate.

[2] The state's responsibility is limited to a (flat) basic pension (first-tier), to which a second-tier contributive pension will be added, as well as a defined-contributions auxiliary pension.

demolish the welfare state. Most importantly, the government's decision to include in the pension reform bill the issue of easing dismissals stirred a strong reaction by the trade unions and left-wing opposition parties. Strikingly, also, despite the government's claims that the reform intended to promote distributional justice through system unification and financial rationalisation, some socio-professional groups succeeded in keeping their independent insurance status (journalists and media workers, doctors, engineers and lawyers).

The introduction of a (more or less) unified multi-tiered system is expected to have long-term positive fiscal effects. Yet significant questions emerge in respect to distributional impact and benefit adequacy. Across-the-board drastic cuts in pensions may foster privatisation in social insurance for the well-off social groups and, progressively, deepen inequality. They, also, will considerably limit the rather weak redistributive effects of social transfers; the more so as other categories of social transfers (apart from pensions - that is, any universal or categorical benefits) are a very feeble component of social expenditure in Greece, which is further squeezed under the EU-IMF aid programme.

Cost-containment in health care is also high on the reform agenda. The huge deficits persistently incurred by the NHS constitute a serious predicament that needs to be effectively dealt with. Some steps have been taken so far (e.g. measures to rationalise and discipline hospital financing, price-reducing and benchmarking actions as to pharmaceuticals and medical supplies procurement, e-prescribing, greater penetration of generics, improving accounting and auditing techniques at hospitals). However, due to technical complexities in the health sector and the political controversies and pressures arising out of multiple changes (and conflicting interest configurations), a considerable time is required for reform measures to materialise in concrete terms and yield results. Meanwhile, creeping privatisation in the NHS is evident, without any strong indications of extensively eliminating waste of resources so far; and private health spending remains high (nearly 40% of total health expenditure[3]). Fiscal discipline criteria are the main drivers of public hospital merging and closures, while equity and accessibility concerns play a minor role. The same holds for recent legislation stipulating the merging of the four biggest health insurance funds, so as to create a unified primary care system. The legal enactment leaves a host of significant issues[4] open for future negotiation and decision endorsement through presidential and ministerial decrees – not to mention service quality that is scarcely tackled. Uncertainties in respect to working conditions in the new plan caused vehement criticisms and big demonstrations by the medical staff of IKA (the Social Insurance Fund), the association of NHS doctors and Medical Associations. Furthermore, the "no-pay movement" (no payment of road tolls and public transport costs) that gathers momentum in the country, affects hospitals too, as industrial action by medical staff occasionally embraces the occupation of administrative offices by union members so as to allow "free entrance" to hospital outpatient departments.

Social care services are easy victims of austerity measures. This is mostly the case for the "units" and "programmes" established partly by EU-funding, and most often in a highly fragmented way (e.g. centres of creative activities for children, day care centres for frail elderly people, home-help for elderly and disabled people). Persistent reliance on external sources of funding and precariousness of employment for much of the staff (as hirings are on a temporary basis) contribute to making the above services highly vulnerable to spending cuts.

[3] 95% of it being out-of-pocket payments.

[4] For instance, working conditions of medical doctors, types of contracts and mode of remuneration of medical staff in the context of the new system.

In sum, austerity measures exert high strains on social spending, even though increasing need for softening the impact of the crisis requires the bolstering of social protection. So far structural adjustment drastically diminishes incomes, squeezes job opportunities (particularly for the young, as the unemployment rate for this group reached almost 40%), heightens insecurity, increases uncertainty about the circumstances of retirement and intensifies the need for social protection, albeit, from an enfeebled welfare state. Combined with the recent decision by the government to relax the application of collective (minimum) wage agreements, under the IMF's strong insistence on dismantling labour rights (as a condition for Greece to get the next bailout instalments), social reforms lend support to a trajectory prioritising flexibility, with no substantial security guarantees though, that will have serious negative, and most probably, irreversible effects on social protection.

2.2 Pensions

2.2.1 The system's characteristics and reforms

In Greece pensions are based on the public (first) pillar that constitutes a pay-as-you-go system. It provides basic and auxiliary pensions. Social insurance funds are self-governing bodies operating under the auspices of the Ministry of Labour and Social Insurance and managed by representatives of employees, employers and the state. Until recently the pension system was characterised by a high degree of fragmentation across sectors of employment and economic activity. Law 3755 of April 2008 (for the Administrative and Organisational Reform of Social Insurance Organisations, see Petmesidou 2009 and 2010) significantly reduced the number of social insurance funds in Greece (from one hundred thirty to thirteen), while legislation approved by Parliament in mid-2010 introduced "pathbreaking" changes.

(a) The main provisions of Laws 3863/2010 & 3865/2010

In view of the demographic pressures[5] that according to available projections could raise social security spending from around 13% of GDP in 2010 to about 25% in 2060, and the economic crisis conditions, the reform laws aim at drastically curbing pension expenditure and boosting budget savings.[6]

The aim is to bring uniformity to a system embracing numerous exemptions granted over decades by governments yielding to pressure form various socio-professional groups and their trade unions, and ensure its long-term viability. The major principles of the reform were laid out in the agreement Greece signed for the bailout loan package. They boiled down into moving to a unified, multi-tier system that separates contributory from non-contributory elements, and introduces a new pension formula basing pension income on the entire working life earnings as well as a price-based pension indexation (used by most OECD countries).

Although Greece has a statutory retirement age of 65 years (and 60 for women), exemptions and special rules in many cases allow a full pension at the age of 58. Until now, those who have completed 35 years of work had the right to full retirement at age 58 (while those with 37 years of work could retire without any age-limit requirement). New legislation equalises retirement age (at 65) across the working population; it allows retirement after completion of 40 years of work, but only if people reach the age of 60 years. Equally important is the

[5] Currently the ratio of workers to pensioners is 1.7, compared to four workers for each pensioner in 1950.

[6] As stressed by an OECD report (2009: 13) concerns about Greece's long-term pension expenditure played a significant part in steeply widening the spread of Greek bonds over those of Germany.

provision that the statutory retirement age for men and women will be revised from 2021 onwards (and every three years) so as to reflect changes in longevity.[7]

Particularly pension legislation for public servants aimed to comply with the European Court of Justice Ruling of 26th May 2009 that found the differences of pensionable age and minimum number of contribution years between men and women, in the Greek civil and military pension code, incompatible with EU legislation on equal treatment (Article 157 of the Treaty on the Functioning of the European Union). Existing regulations until 2010 offered favourable pension conditions to women (and particularly to mothers), principally justified on the ground of offsetting disadvantages faced by women because of their shorter (and often disrupted) working career. The option chosen by the government is to phase in regulations that by 2013 will bring the pensionable age and the minimum length of service for retirement of female civil servants to the level required for men.

Of crucial importance is system rationalisation attempted through the further amalgamation of the 13 social insurance funds that emerged out of the 2008 legislation. Three major social insurance funds will embrace the largest part of the working population: (a) IKA (the social insurance organisation covering the majority of private sector employees) will be the fund of "all employees", and new entrants into the public sector, from January 2011 onwards, will be insured in IKA; (b) OAEE (the social insurance fund for self-employed workers), and (c) OGA (the farmers' retirement fund). Despite pressures by the "international donors" to create a single retirement fund for all self-employed, including the liberal professions and avoid "exemptions" for specific categories, the government stumbled into a setback. Strong resistance by journalists and media workers, doctors, engineers and lawyers resulted into keeping their independent insurance status (the Bank of Greece employees also maintained their prerogative for separate social insurance).[8] Similarly, particular retirement conditions applying to public utility workers, journalists/media workers and banking employees appointed before 1983 remained intact.

A significant structural change introduced by the recent reform is the distinction between a basic and a contributory pension that will be in force from January 2015. The amount of the basic pension is set at €360. The contributory part is linked to paid contributions (since 2011, for persons retiring from 2015 onwards). In case of early retirement the basic pension will be reduced in accordance with the reduction rate of the contributory part (penalties have also risen from 4.5% to 6% for each year of early retirement).[9]

The basic pension is granted to old-aged uninsured persons (including people who paid contributions for less than 15 years) under the following conditions: (1) claimants must be 65 years and over and their personal and family income should not surpass €5,040 and €10,080 respectively (income thresholds being adjusted to changes in the level of the basic pension); (b) they must have been permanent country residents for a minimum of 15 years between their 15th and 65th year of age. Those who satisfy the above conditions and are permanent residents for 35 years and over are entitled to a full basic pension (the amount is reduced by 1/35 for each remaining year up to 35 years).[10] The basic pension is paid by OGA (for those with no

[7] At the initial implementation of this provision the changes in life expectancy of the decade 2010-2020 will be taken into account.

[8] Though all other bank employees have come under IKA. In exchange for maintaining their separate insurance status, however, the respective funds should undertake the cost of the basic pension. Furthermore, it is not particularly clear if any change will occur in the near future in respect to the state subsidies received by these funds.

[9] Different rates hold for early retirement in case of invalidity (early retirees with invalidity 67% to 79.99%, receive 75% of the basic pension, while those with 50-66.99% receive only 50% of the basic pension).

[10] There is no survivors' entitlement in respect to this category of basic pension beneficiaries.

rights to a pension), and by the social insurance organisations and the state to all those who receive a contributive pension.

Most importantly, as from 2015 the state's responsibility is limited to the "basic pension" and hence any deficits by social insurance organisations will not be covered by the public budget. In light of this the contribution of the state budget to pension expenditure should not surpass an increase by 2.5 percentage points of GDP through to 2060. According to article 15 of Law 3863, any deficits incurred by social insurance organisations should henceforth be dealt with by reducing pensions and/or increasing contributions. The law provides for an annual adjustment of pensions (from 2014 onwards) on the basis of a coefficient drawing on GDP fluctuations, on the (CPI) consumer price index[11] and the financial situation of pension funds.

The government guarantee of auxiliary pensions was also abolished. Though, in a last moment attempt to appease dissenters within the government (and party) ranks, the Labour Minister introduced a vague statement in the bill that goes as follows: "the state guarantees the viability of the pension system so as to secure a decent pension for retirees".

Major changes in pensionable income and replacement rates were also introduced by Laws 3863/2010 & 3865/2010. Pensionable income will be calculated on the basis of earnings during the whole working career, rather than those of the last five years before retirement (as was the case until recently). Also the replacement rate (for the contributory part of the pension) is considerably reduced: from 70% of pensionable income to about 34% (for 35 years of work, a 50% reduction compared to previous regulations), while for 40 years of work it is set at about 41% of pensionable income.[12]

Table 1: Replacement rates (in the private and public sector)

Years of insurance		**Yearly replacement rate of pensionable income**
From	**To**	
1	15	0.80%
16	18	0.86%
19	21	0.92%
22	24	0.99%
25	27	1.06%
28	30	1.14%
31	33	1.22%
34	36	1.31%
37	39	1.40%
40	50	1.50%

Source: Laws 3863/2010 & 3865/2010 electronically accessed at http://www.et.gr/ on 5 September 2010.

Recent legislation stipulates an overhaul of the conditions concerning entitlement to disability pensions with the aim to rationalise the system and crack down on abuse. The aim is to reduce beneficiaries of this category from 14.5% of the total number of pensioners (as the rate stands currently), to about 8-9%. A Disability Certification Centre at IKA, to be established during 2011, will be responsible for the development and application of a unified disability evaluation (and scoring) system in all insurance organisations (including the public sector, as well as uninsured persons claiming disability benefits). In the place of a fragmented system of a multiplicity of disability evaluation committees (in the various social insurance

[11] The mean of GDP and CPI growth will be taken into account; however, the adjustment coefficient in no case can exceed the CPI rate (a condition that diminishes the real value of pension income when inflation rises faster than GDP, and keeps it stable in the opposite case).

[12] The period up to 2011 will be calculated on the basis of the old replacement rates.

organisations, the prefectures and the central state), a unified registry of persons with disability will be created at the Disability and Occupational Medicine Directorate of IKA on the basis of the common scoring system to be introduced by a joint decision of the relevant Ministries (Health and Social Solidarity and Labour and Social Insurance) on the recommendation of an experts' committee (to which a representative of the National Confederation of Disabled People also participates).

Equally, a revision of the list of "arduous and unhygienic" professions is pending that will drastically reduce the range of professions in this category (workers of such professions are entitled to special allowances and can retire earlier than normal). The new list should be decided by July 2011 and will be put into force in early 2012.[13] Consultation procedures will be followed for this change with the relevant actors.

Legislation makes obligatory the carrying out of actuarial studies every couple of years for closely monitoring pension expenditure. Moreover, until the end of 2011 the National Actuarial Authority is obliged to perform actuarial valuations of auxiliary pension schemes on the basis of which it will be decided whether there will be any cuts in benefits (according to existing regulations, for labour force entrants since 1993 auxiliary pensions cannot be higher than 20% of pensionable income, and this is considered a ceiling to which cases of excessive rates should be reduced).[14]

Other conditions revised by the reform laws concern survivor's pensions as well as pension reductions for employed retirees. Widows under 50 years are no more eligible for a survivor's pension, while those under 65 will get a benefit depending on income criteria. Moreover, under the existing system unmarried (or divorced) daughters of civil servants, banking employees and army officials could "inherit" their deceased parents' pension benefit. This "right" is abolished with the exception of handicapped female persons belonging to this category,[15] and daughters that base their "right" to an inherited pension from parents that were hired in the public sector and the armed forces before 1983. The latter category can claim a survivor's pension if income does not surpass the minimum pension income in the public sector, and only if they reach the age of 50 years. Stricter rules were also introduced for unmarried (or divorced) daughters of deceased civil servants, banking employees and army officers, who already receive such a pension: after reaching adulthood (and/or after completion of studies) beneficiaries can continue getting a pension if their annual income does not surpass the threshold of thirty times the wage of the unskilled worker (about €990); the pension benefit is reduced in a scaled way, if annual income increases up to 60 times the wage of the unskilled worker (about €1,980), and is withdrawn if income is higher than that.

Regulations for the employment of pensioners stipulate the withdrawal of pensions for working retirees below the age of 55 years. For retirees over 55 years of age who take up work as employees, the gross amount of pension that surpasses 30 wages of the unskilled worker) is reduced by 70%.[16] Those who take up work as self-employed and receive a monthly pension up to €2,000 are obliged to pay to OAEE contributions increased by 50%; if their pension income exceeds €2,000, this amount is suspended.

[13] As stated in the bailout agreement, the number of workers in "arduous and unhygienic jobs" should not surpass 10% of the total working population (there are about 750,000 workers insured under this regulation currently).

[14] It is highly probable though, that, further cuts will be made in case of dismal fiscal performance of auxiliary funds.

[15] And in this case benefit provision conditions are equalised with those for male handicapped persons.

[16] This amount is increased by 6 wages of unskilled workers (about €200) for each underage or protected child (and student up to the age of 24 years).

With Law 3856/2010, concerning public sector pensions, retirement age of women with underage children will be raised progressively from 50 to 52 years in 2011 (having completed 25 years of work), to 55 years in 2012, and as from January 2013 it will reach 65 years (a reduced pension can be claimed at the age of 50 in 2011, 53 in 2012 and 60 from 2013 onwards). The law extends the application of these conditions to fathers with underage children too. Similarly, the above law provides for a phased-in increase in the (early) retirement age (and the years of service required) for mothers with three children; and, again, revised conditions apply to both parents. Also, from January 2011, both parents with a severely disabled child (67% disability) can retire at the age of 50 years after completion of 25 years of service.

As a counterbalance to the significant increase of retirement age the law provides the possibility of "buying off notional insured time" of up to 5 years for parents (1 year for the first child, and 2 years respectively for the 2nd and 3rd child). In addition, seven more years of notional insured time can be added for military service, study leave, maternity/parental leave, unemployment and sickness, subject to payment.

Finally, with Law 3863/2010 the health insurance branch of IKA is separated from the social security branch to form part of the a unified system of health services together with the health care branches of other social insurance organisations. These together with primary and secondary health care services provided by the NHS will form the National Health Services Organisation (EOPYY, see below). As to investment regulations for social insurance funds, the 2% limit for the purchase of composite bonds was lifted and the possibility of inter-fund borrowing and lending was restated.

(b) Other developments

Pensions were frozen in 2010 and 2011 and this is expected to continue in 2012. In 2010, the 13th and 14th pension payments were permanently cut. In their place a "vacation" benefit of €800 is paid only to pensioners with monthly gross income up to €2,500 (the benefit is granted in three tranches, €400 in Christmas and Easter and €200 in the summer).

Additionally, from August 2010 a special levy was imposed on monthly pension incomes over €1,400 so as to create a contingency fund for social insurance organisations (the so-called LAFKA, Solidarity Account for Social Insurance). This fund will operate under the auspices of the Insurance Fund for Inter-generational Solidarity (AKAGE) that was established under the pension reform of 2008 (Law 3655). The levy is charged on gross (primary) pension income and rates vary from 3% to 10%, depending on the amount of retiree's income.

Pension payment via bank accounts by all social insurance funds has been made obligatory from 2011 onwards. IKA had already introduced a payment system via bank accounts and the same holds for public sector pensioners. OAEE introduced the new payment method in October 2010, while OGA is poised to start implementation.[17] A census of pensioners took place recently and a unified monitoring system of pension payment was established under the management of HDIKA S.A. ("The Electronic Governance of Social Insurance S.A."). Electronic transfer (via bank accounts) of contributions to the employee's accounts in social insurance organisations is another measure to be soon implemented for improving efficiency in contributions payment and strengthening the system's monitoring capacity.

[17] Particularly in the case of OGA, if beneficiaries are unable to use this system (because of invalidity and/or serious chronic illness, or because they live in remote rural places) payment can still be made in a giro account at the Hellenic Post and the benefit delivered at home.

In an attempt to boost revenues of social insurance organisations, the Ministry offered opportunities to enterprises for settling contribution arrears (with significant reductions to penalties) three times during 2010 and early 2011. The Deputy Minister of Labour reported a 2.5% increase in social insurance contributions collected in 2010 (€550m against a target increase of €720m, though) mainly due to collection of arrears. Nevertheless, increasing unemployment over the last year had a serious impact on social insurance organisations finances, and the first quarter of 2011 the revenues of IKA were reduced by 16.5%.[18]

The income ceiling for the provision of the Social Solidarity benefit to low-income pensioners increased by 4% in 2010. Roughly about 375,000 low-income pensioners were eligible and received the benefit (ranging from €57.5 to €172.5 monthly) retrospectively by the end of 2010. An extra one–off benefit for low-income pensioners was announced just before the local elections of October 2010 (€300 for pensioners with an individual annual income up to €7,000 / or family income up to €12,000; €200 for incomes over €7,000 - up to €8,500 and over €12,000 – up to €14,500 respectively; and €100 for incomes over €8,500 - up to €10,500 and over €14,500 – up to €16,500 respectively). Initially the government limited eligibility to the urban sector (roughly about 500,000 pensioners met eligibility criteria), but later on OGA pensioners were included too.

In addition, the government decided a low-income discount in electricity prices. It was forecasted that roughly about 1,200,000 people would benefit from this measure. However, in early 2011 only about 150,000 applications were made under this scheme, mostly because of significant application costs limiting gains.

2.2.2 Debates and political discourse

Pension reform is a key performance benchmark for Greece under the €110bn bailout programme. Accordingly any failure in meeting reform objectives could raise doubts about the government's determination to carry out the adjustment plan.

As shown in Table 2, state subsidies to social insurance funds amounted to 61.4% of public deficit (and 6.0% of GDP) in 2010. The largest amount of subsidies is received by OGA[19] and IKA.

The reform partly draws upon the dialogue developed in the context of the special committee appointed by the Ministry of Labour and Social Insurance in late 2009, as well as upon the views of academics and experts expressed at various occasions over the last decade (see Petmesidou 2010 and Matsaganis 2010).

[18] It is estimated that if this trend continues over 2011 IKA's revenues will be reduced from about €15 billion in 2010 to about €12 billion in 2011 (yet only for payment of pensions to 1,030,000 pensioners €11 billion are required on an annual base). See Newspaper "Eleftherotypia", 30 April 2011, accessed at http://www.enet.gr/.

[19] Until 1998 farmer's pensions were funded through taxation; a contributory scheme has gradually been introduced only since 1998.

Table 2: State subsidies to social insurance organisations (million Euros)

	Review 2009	Estimates 2010	2011 Budget
OGA	4,563	4,950	4,600
IKA-TEAM	4,000	2,460	2,310
OAEE	1,080	850	800
NAT[a]	1,318	1,160	1,200
TAP-OTE[b]	800	678	600
EKAS (except public sector retirees)	1,034	889	940
Public sector pensions	2,573	2,421	2,471
Total[c]	15,445	13,440	13,505
Subsidies as % of GDP	6.6	6.0	6.2
Subsidies as % of public deficit	42.7	61.4	79.4
Public deficit (with zero subsidies)	8.9	3.8	1.6

Source: KEPE (2011: 44)

[a] The Social Insurance Fund of Merchant Navy Personnel

[b] Social Insurance Fund of the Greek Telecommunications Organisation Personnel

[c] Some categories are omitted (e.g. subsidies to OAED – Greek Labour Force Employment Organisation- and other subsidies to social insurance)

Public debate on the draft bill took place, on the one hand, under the pressures by the crippling debt and deficit crisis and the austerity plan of the bailout agreement, and on the other, amidst serious protests by the trade unions. What is more, trade union criticism intensified as parliamentary debate on radical pension reform overlapped with a debate on drastic changes in employment conditions as well. The government's decision to include in the pension reform bill the issue of easing dismissals, as well as the relaxation of the application of collective (minimum) wage agreements, stirred a strong reaction from all relevant parties (particularly the trade unions and left-wing opposition parties). The sweeping reforms even caused divisions within the Panhellenic Socialist Party, as several MPs of the governing party expressed strong reservations. There were fears that the party's narrow majority (of 157 in the 300-seat assembly) would be undermined;[20] however, even with a narrow majority, the bill was approved, signalling a major structural change in the country's pension system.

In public consultation, unions strongly argued in favour of cracking down on contributions evasion as a way of securing funds for social insurance, instead of drastically cutting benefits and raising the retirement age.[21] In parallel unions expressed worries about rampant unemployment, estimated to affect 1,000,000 persons by the end of 2011, with detrimental effects on contributions. The Labour Institute of GSEE (the General Confederation of Greek Labour) estimates that contributions amounting to about €1.8bn will be lost until the end of 2011 due to wage/salary cuts and rising unemployment. As soon as the draft law was submitted to Parliament GSEE and ADEDY (the public sector's umbrella union)[22] called for protests and a general strike. They declared their opposition to the draft law on the ground that it dismantles social security rights and severely limits redistribution; while, in parallel, the fact

[20] Three PASOK deputies were already expelled in May 2010 because they did not support the austerity package.

[21] Contributions evasion is estimated at between 20% to 30% of revenue collected (information obtained from the Ministry of Labour and Social Insurance).

[22] Supreme Administration of Greek Civil Servants Trade Union.

that the state will no longer guarantee financial support is considered to have a high toll on younger generations. Equally critical were opposition parties in the whole spectrum from right to left.

Developing a private pillar social insurance does not garner support in public debate. However, given the fact that replacement rates will progressively drop for future retirees leading to drastic cuts in pension incomes, it is highly likely that complementary private savings (and a funded, occupational pension tier) will need to be encouraged. Inequalities as to the extent to which this could be afforded by various income-groups are a crucial issue in respect to adequacy criteria.

2.2.3 Impact of EU social policies on the national level

The looming fiscal predicament and pressures on the pension system were repeatedly stressed over the last decade by academics and researchers, yet reform was sluggish. The borrowing crisis, in late 2009, after the bursting of the state-spending bubble, greatly precipitated change. The need for rationalising a pension system ridden with inefficiencies and numerous exemptions (and inequalities in coverage, benefit level and funding) became a top priority in a reform stipulated by the bailout agreement that Greece signed with the IMF-EU-ECB. Hence "outside influence" is paramount, and the country's keeping on track with the reform is among the major requirements set by the international donors for the payment of the quarterly instalments of the loan.

Major issues of the OMC in social protection and the "EU Green Paper on Pensions", such as demographic pressures, pension viability, intergenerational justice, adequacy of benefits, system transparency were prevalent in the public consultation process preceding the reform. The rapidly increasing dependency ratio over the next decades poses a major challenge to the viability of the pension system. In 2010, the old-age dependency ratio stood at 28.2% (higher than the EU-27 average, 25.9%). This is expected to rise to 38.5% in 2030 and 57.1% in 2060. Concomitantly, pension expenditure (without reform) was estimated to increase from 12% of GDP in 2010, to 24% in 2060 (and total old-age related expenditure, including health and long-term care to 34.1% of GDP, compared to the EU-27 average of 23.1%). After the reform, it is forecasted that expenditure for the major social insurance funds (IKA, OAEE and public sector pensions) will not surpass the 2.5% increase ceiling set in the so-called "Memorandum" (i.e. the bailout agreement). Linking retirement age with longevity, in the long-term, is also a provision of recent legislation.

2.2.4 Impact assessment

It is important to stress, however, that ministerial and governmental documents praise the (estimated) positive impact of the reform on pension sustainability but gloss over adequacy. For instance in the National Reform Programme (NRP) 2011-2014 (Ministry of Finance 2011), fiscal consolidation – through significant cuts in current and future pensions – is considered tantamount to adequacy.[23] Particularly across-the-board reductions in current pensions and stricter targeting of EKAS (a social solidarity supplement for low-income pensioners, introduced in 1996) are most likely to have an immediate negative effect on poverty among the elderly that was comparatively high even before the onset of the crisis (see Table 3). To mention also the detrimental effects of a protracted deep recession on the

[23] Moreover, confusedly the special levy (ranging between 3% to 10% of gross income) imposed on monthly pension incomes over €1,400 (the so called pensioners' solidarity contribution), so as to create a contingency fund for covering deficits of social insurance organisations is considered a measure "safeguarding" adequacy of the system (Ministry of Finance 2011: 51).

revenues of social insurance funds, a factor that might seriously detract from the viability estimates of the reform plan.

The NRP 2011-2014 sets the target, for 2020, to reduce the number of people living in poverty and/or social exclusion by 450,000. There are no specific commitments and targets, however, in respect to older poor (including the working poor 55 to 64 years[24]). Totally absent is any estimate as to the poverty impact of some of the pension reform measures.

Table 3: Poverty and deprivation in old age

	2005			2008			2009		
	Total	*Men*	*Women*	*Total*	*Men*	*Women*	*Total*	*Men*	*Women*
At-risk-of poverty (65+)	**27.9**	25.2	30.0	**22.3**	20.8	23.6	**21.4**	20.9	21.9
At-risk-of-poverty (75+)	**32.7**	32.4	32.9	**28.0**	27.4	28.6	**23.9**	24.3	23.6
Severe material deprivation (65+)	**19.4**	15.3	22.7	**14.8**	11.1	17.7	**12.1**	10.0	13.8
Severe material deprivation (75+)	**23.1**	11.8	26.9	**17.9**	10.1	20.4	**12.3**	10.2	14.1
At-risk-of-poverty of older people by tenure status (tenants)	**20.2 (17.3)[a]**	-	-	**17.0 (19.6)[a]**	-	-	**18.8 (19.5)[a]**	-	-
At-risk-of-poverty of older people by tenure status (owners)	**26.6 (17.7)[a]**	-	-	**22.6 (17.2)[a]**	-	-	**21.3 (16.3)[a]**	-	-

Source: Eurostat data, accessed at http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home on 4 April 2011.

[a] = In parenthesis the EU-27 average.

[Poverty threshold = 60% of median equivalised household income after social transfers (including pensions)]

Note: There are no significant differences in the poverty risk in terms of tenure status (this is linked to the fact that the owner occupation rate is high in Greece – as is also in other South European countries).

As shown in Table 3, poverty among the elderly (65 years or over) slightly decreased between 2005 and 2009 (from 27.9% to 21.4%). Also poverty among people 75 years or over dropped from 32.7% in 2005 to 23.9% in 2009. Gender differences are not particularly pronounced. Nevertheless elderly women have persistently been more vulnerable to poverty. Strikingly, in 2009 the poverty risk was higher among elderly males 75 years or over than among females of this age group (24.3% and 23.6% respectively). The risk of material deprivation was considerably reduced between 2005 and 2009. Though, still about 10% of males and 14% of females 65 years or over experience severe deprivation. Particularly high is economic strain among households with a single person 65 years of age or over, with income below 60% of the median household equivalised income (39% of these elderly people cannot keep their house adequately warm, 94% cannot afford to pay for one week holiday, 36% are unable to afford a meal with meat, chicken or fish every second day, and 83% cannot face unexpected financial expenses). The respective rates for two-person households, with at least one person 65 years or over (and income below 60% of the median household equivalised income) were

[24] In-work at-risk-of-poverty rate for this age group stood at about 15% in 2009.

28%, 83%, 25% and 56%. Support measures for these groups of households should be of high priority.

To stress, however, that available data refer to incomes incurred just before the eruption of the crisis.[25] Pension cuts, abolishment of the solidarity benefit (provided by the National Social Cohesion Fund, itself abolished too under the austerity plan, see Petmesidou 2010), and stricter targeting rules for the provision of EKAS to low-income pensioners will most probably have aggravated deprivation and poverty risks among the elderly by now.

Table 4: Tackling poverty in old age: context indicators

		2005		2009	
		Men	*Women*	*Men*	*Women*
Adequate income support in old age	**Aggregate replacement ratio** [b]	0.56 (0.54) [a]	0.47 (0.51)	0.46 (0.54)	0.44 (0.50)
	Relative median income ratio (65+) [c]	0.83 (0.89)	0.78 (0.83)	0.88 (0.90)	0.85 (0.84)

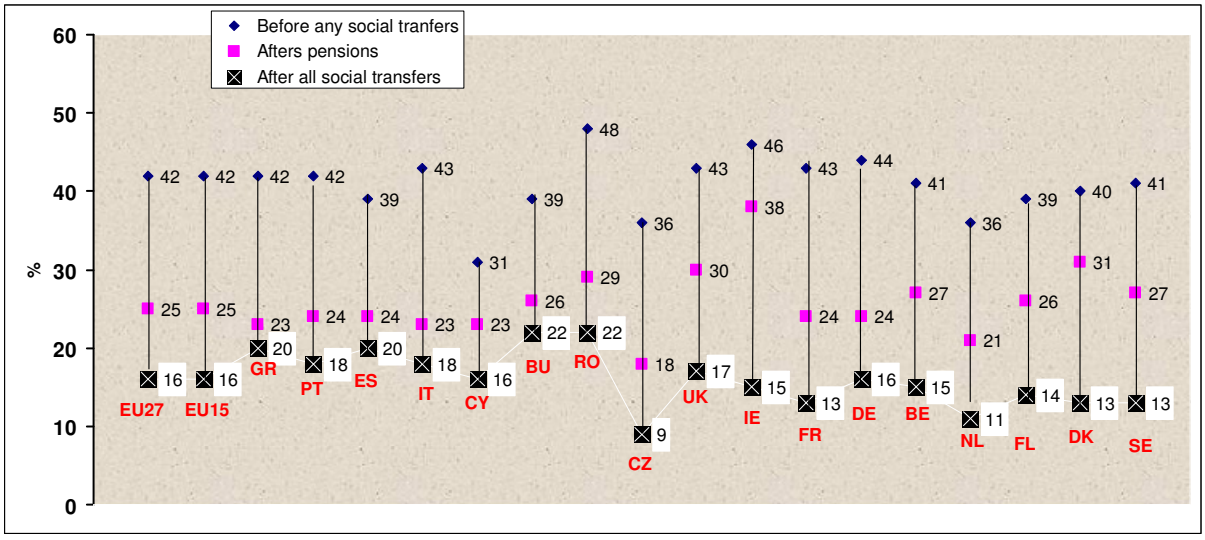
Source (see Table 3).

[a] = In parenthesis the EU-27 average.

[b] = Ratio of income from pensions of persons aged between 65 and 74 years and income from work of persons aged between 50 and 59.

[c] = Persons aged 65 years and over compared to persons aged less than 65 years.

Figure 1: At-risk-of-poverty before and after social transfers (2009)



Source (see Table 3).

Note: In 2009, among women of 65 years or over the poverty rate before social transfers stood at 86%; it was reduced to 29% after "pensions" and to 22% after "other social transfers". The respective rates for men were 65 years or over were 84%, 24% and 21%.

In the second half of the 2000s, up to the time of the start of the economic crisis, aggregate replacement ratios for old-age men and women slightly dropped; though the relative median income ratio improved and the gap with the EU-27 average significantly diminished. The impact of the crisis and austerity measures on these dimensions remains to be monitored.

[25] 2009 data refer to incomes incurred in the previous economic year.

The NRP 2011-2014 acknowledges the low effectiveness of social transfers in reducing poverty in Greece. This is a characteristic that Greece shares with the other South European countries (see Figure 1), in contrast to a number of North-west European countries where both pensions and "other social transfers" impact more effectively on poverty reduction. In the light of this, the NRP states as main priority the enhancement of policy coordination and introduction of monitoring and evaluation procedures. Two things should be stressed here. First, the low redistributive effect of "other social transfers" in Greece is to a large extent the result of the low level of expenditure on social assistance and other non-contributory benefits; thus better coordination may have a limited redistributive impact. Second, given the fact that in the pre-crisis period, it is particularly pensions that had a significant redistributive effect, it is highly likely that pension cuts (and reduction of replacement rates in the medium- to long-term) will aggravate the incidence of poverty (and deprivation) among the elderly.

Apart from benefit adequacy, "blurry messages" in policy terms emerge in respect to active ageing. On the one hand, early exit penalties have been decided so as to increase the effective retirement age from 61.4 years now to 63.5 years by 2015. And retirement opportunities below the age of 60 were thoroughly curtailed by recent legislation.

However, on the other hand, particular clauses in recent legislation (and further details provided by Ministerial circulars) tend to favour early exit for certain categories of workers.

First, a temporary measure (for 2010) allowed women, who, when they completed 18.5 years of work, had an underage child, to retire at the age of 55 years with a full pension, or at the age of 50 years with a reduced by 30% pension (according to previous regulations, in the private sector, women could make use of this early retirement condition only if they had an underage child when they completed 18.5 years of work and reached 50 years of age). The relaxation of the latter condition is thought to have led about 50,000 women to early retirement in 2010.

Second, notional time (either bought off or not) is provided to people retiring after the 1st January 2011 in a scaled way (4 years for those retiring in 2011, 5 years in 2012, 6 years in 2013 and 7 years from 2014 onwards). In addition, parents can recognise notional insured time up to 5 years for 1 to 3 children. This measure, as well as the recognition of notional time for studies (provided one has 12 years of service), are new in the public sector (in the private sector notional insured time for up to three children was already in force according to Law 3655 of 2008). In addition a new regulation in the private sector allows up to 600 days for which a person received unemployment and sickness benefit to count as worked time.

Differences as to the amount that needs to be paid for buying off notional insured time between the public and private sector remain. In the former sector payment is set at the level of employee contributions for the primary pension (that is 6.67%) charged on pensionable income applicable at the time of the submission of the application; while in the latter sector, payment amounts to 20% of the monthly salary (for primary pension), and 6% for supplementary pension at the time of the application.[26]

The panic created by the structural pension reform, in parallel with significant reductions in salaries across the public sector functioned as a push to early retirement by the end of 2010 (an increase of about 115% compared to 2009 is recorded); and "notional time" conditions will encourage early exit in the immediate future too. In light of the terms of the bailout agreement requiring a significant reduction of public sector salaries bill (and of the public

[26] However, in the case of buying off notional insured time for up to three children, the amount paid equals 20% and 6% for primary and supplementary pension on an amount of 25 times the wage of the unskilled worker at the time of the application.

sector sise) the government opted for early retirement instead of dismissals and further slashing salaries.

2.2.5 Critical assessment of reforms, discussions and research carried out

The predicament of the pension system and how to get out of it has been an issue of debate among academics and researchers for a long time (Spraos Committee 1997, Boersch-Supan & Tinios 2001; Featherstone & Tinios 2006; Nektarios 2008; Tinios 2010). The eruption of the state debt crisis in late 2009 highly precipitated a pathbreaking reform aiming to tackle major problems such as long-term fiscal sustainability; improvement of budget allocation transparency (by clearly distinguishing between insurance and social assistance, as well as by separating pension funds from health insurance funds); and harmonisation of rules and regulations across the funds. Poverty among the elderly is also a major issue. Yet fiscal consolidation and sustainability concerns greatly overshadowed attention to adequacy of current and future pension benefits.

Furthermore, controversies are found in the harmonisation of regulations, and the principle of universality in respect to the basic (flat rate) pension. Despite the aim to build a unified, multi-pillar system (out of a highly fragmented one) and promote distributional justice, discretionary exemptions remained, and some socio-professional groups succeeded in keeping their independent insurance status, as indicated above. Furthermore, regulations for the provision of the basic pension manifest that this is not a fully universal benefit (old-age persons not entitled to a contributory pension must fulfil certain income criteria in order to get the basic state pension). Another controversy concerns the stated aim of the reform to put the brake on early retirement; yet decisions taken recently facilitate early exit in the short- and medium-term for specific groups. Overall, crucial challenges remain in respect to all three dimensions (distributional justice, benefit adequacy and fiscal rationalisation), as well as in respect to thoroughly encouraging active ageing.

Surely the common objectives set by the EU in the context of the OMC have been highly relevant for pension reform in Greece. Yet awareness and visibility of the OMC in respect to all three strands (social inclusion, pensions, health and social care) is rather limited to a few government officials and policy experts involved in the preparation of national plans and/or participating in EU committees and other bodies, as well as among social, economic and political science academics. Furthermore monitoring of common objectives set by the EU has been cumbersome so far due to the lack of reliable data. Provision of data in respect to the whole range of agreed indicators in the context of the OMC will be a considerable progress in planning, monitoring and evaluating social policies, a process that has been rather weak in this country so far.

2.3 Health Care

2.3.1 The system's characteristics and reforms

Greece introduced a universal health system (NHS) in the early 1980s. However until now it hardly reached the state of a fully-fledged national health system. Both in terms of funding and service delivery a mixed system continues to operate: an occupation-based health insurance system is combined with a national health service, but private provision is expanding too.

The NHS comprises primary and secondary care. It also employs some physicians and particularly in some rural areas it is the main provider of care. Overall, however, primary and specialist care is characterised by a noticeably mixed system of service delivery by public,

health insurance and private providers. The employed population is enrolled in one of the sickness funds that are occupation based. Diversity of coverage by the social insurance funds, the NHS, and for some people by private medical insurance contributes to high inequalities.[27] Multiplicity of funding also accounts for lack of coordination of purchasing policies and system inefficiencies. Roughly about 85% of the population has health insurance that covers primary care, but access to hospital care is universal.

The crisis has significantly increased demand of public health services by roughly about 20-30% as stated by the Ministry of Health in June 2010. Also attendance at the health care services of IKA (measured on the basis of the number of appointments made for seeing a medical doctor) rose by 20% in the first semester of 2010, as indicated by IKA's governor.[28]

Soaring deficits by public hospitals and rapidly increasing pharmaceuticals expenditure constitute a major fiscal problem. According to the Ministry of Labour and Social Insurance, public expenditure for pharmaceuticals rose by roughly 10-15% annually over the last ten years.[29] Despite comparatively high (total) health expenditure (around 10% of GDP, 6% being public spending) life expectancy over the last decade rose by only one and a half year, indicating a limited effectiveness of health care.

Table 5: Health indicators

	2009			2005		
	Bottom quintile* (%)	**Mid quintile (%)**	**Top - quintile (%)**	**Bottom quintile (%)**	**Mid quintile (%)**	**Top quintile (%)**
Self-perceived "very bad" health status (age group: 55 to 64 years), Greece	5.8	5.0	0.7	4.3	1.6	1.3
Self-perceived "very bad" health status (age group: 55 to 64 years), EU-27	4.1	2.1	0.8	4.7	2.7	1.3
	2009					
	Males			**Females**		
Life expectancy and healthy life years in absolute value at birth, Greece	77.8 yrs / 60.2 yrs			82.7 yrs / 60.9 yrs		

Source: See Table 3.
* Of equivalised household income

Moreover, as indicated by the EU-SILC data on "self-reported health status" (Table 5), inequalities increased in respect to people with "very bad" health status in the second half of the 2000s. The gap between the top and mid quintile significantly increased, as the percentage

[27] To give an indication of the inequalities in terms of coverage among social insurance funds: "in 2006 health care expenditure (including health care services and benefits) per head of the insured in the social fund for the self-employed (OAEE, excluding the professions) amounted to €344; the corresponding rates for IKA, OGA and some of the 'noble funds' for public utility employees, like those in telecommunications and electricity, were €635, €648, €1,040 and €980 respectively" (Petmesidou & Guillen 2008: 115).

[28] As a result, long waiting lists were maintained. For instance in a public hospital of Athens (Tzaneio) the waiting list numbers for an orthopaedics operation are over 2,000; while an appointment with a specialist at IKA can take roughly about two to three months.

[29] From 2000 to 2009 drugs expenditure rose by 400% in IKA (from €583m to €2.4bn) and by 450% (from €279m to 1.2bn) in OGA.

of people 55 to 64 years, in the latter quintile, who perceive their health status as "very bad" rose notably in 2009. A worsening condition characterises also people in the bottom quintile. Also a difference of about 20 years for women and 17 years for men between life expectancy and healthy life expectancy (at birth) indicates a bad health status for old-aged people (and particularly for old-aged women). Poorly developed public and preventive care policies partly account for these conditions.

A significant reform effort in health care was initiated in 2010 and is carried over in 2011. The overarching objective is to enforce fiscal discipline (keep public health expenditure at or below 6% of GDP), while maintaining universal access and improving the quality of care delivery.

Significant structural changes were introduced by new legislation voted through parliament in July 2010 (Law 3868/2010 on the "Improvement of the National Health System") and in February 2011 (Law 3918, "Structural Changes in Health Care"). Law 3868 of 2010 provides for the all day operation of hospitals and health centres (afternoon shift) with the aim to increase the system's efficiency. It also introduced a €3 co-payment for all (regular) outpatient services (increased to €5 since January 2011). Fees per visit charged to outpatients in the afternoon shift vary according to grades and specialities of medical staff. This is only partly covered by the social insurance organisation. On the other hand the cost of diagnostic tests is fully covered by the social insurance funds (according to contracts signed by them and hospitals). The measure aims to transfer contracts by the major social insurance funds from private diagnostic centres to public hospitals and, thus, reduce costs for insurance funds (as diagnostic tests are charged a much higher cost by private diagnostic centres compared to public hospitals), and create an additional source of revenue for the NHS.

Other measures include the establishment of a Health and Social Care Committee at the level of the municipality and region so as to monitor health and social care needs and make proposals for efficient coverage. The relevant regional committee is principally assigned the responsibility to contribute to planning actions, promote accountability and evaluate performance of health units. Of significant importance is also the total smoking ban for public places, in accordance with EU-regulations, introduced by this law (in effect since September 2011).[30] A partial smoking ban in public places legislated a few years ago did not produce much result. Despite huge fines, violation of the new law has been widespread prompting the Minister of Health to admit failure of implementation (non compliance with the law is estimated to 80% of the cases). Restaurant, bar and café owners severely complain about the negative effects of the anti-smoking law on their businesses at a time of economic crisis. Under mounting pressure the Ministry considered the possibility of allowing exceptions to the rule. However, after exhortations by the Prime Minister, thoughts about backtracking were abandoned, and announcements were made by the Ministry of Health for the deployment of more state inspectors for effectively monitoring the enforcement of the law.

Significant measures, also, are under way with the aim to rationalise expenditure by public hospitals and health insurance funds. First, policy measures for containing the cost of pharmaceuticals have been initiated. A new drug-pricing system (IRP, International Reference Pricing) has been introduced, which sets the price of drugs on the basis of the average price of the three lowest-priced markets in the EU (that have such pricing data). A drug-pricing observatory was established for this purpose and about 12,000 pharmaceutical products started being re-priced on the basis of the new system. Meanwhile, as a provisional measure,

[30] Roughly about 40% of adult population in the country smoke, a proportion well above the EU average (29%).

in May 2010, the Ministry of Regional Development and Competitiveness issued an ordinance for an across-the-board price cut of about 20% on pharmaceuticals.

The measure caused problems in the market as some drug makers withdrew products creating serious shortages. The new (reference-) pricing system has progressively been introduced since September 2010. It is planned to be fully in place by late spring 2011.[31] According to new legislation, the relevant authorities will review pharmaceuticals prices three times a year. In parallel the National Organisation of Medicines (EOF) has so far issued twice a negative list of drugs, considerably reducing the number of pharmaceutical products whose cost is covered by the health insurance funds (a number of prescribed drugs by doctors were eliminated). The aim is soon to shift from a negative to a positive list, as this is considered to be a more efficient measure.[32]

The government estimates social insurance organisations to save about €1.2bn per year with the new pricing system. This combined with the electronic monitoring of prescriptions (e-prescribing) – progressively implemented –, is expected to considerably reduce public health expenditure. Objections to the new pricing system continue to be expressed by drug makers, however, on the grounds that price cuts will make medications so cheap in the Greek market (compared to other European markets) that enterprises will have incentives to export pharmaceuticals. Drug shortages, thus, have been a recurrent phenomenon in the last year.

Equally important is the emphasis by the Ministry of Health (and the Ministry of Labour and Social Insurance) on an expanding use of generic medicines (including prescribing by active substance) so as to converge to the average EU generic drug penetration rate. Among the measures introduced is the provision for the cost of generic drugs (included in the pricing list) not to exceed 70% of the price of the original product, and the progressive increase of generic usage in hospitals (with the aim to reach a usage rate of 30% of the prescribed drugs).[33]

The adoption of an e-prescription system constitutes another important measure for rationalising health costs. The measure was introduced in IKA on a pilot basis some years ago, but implementation was stuck at an incipient stage. A new start for monitoring electronically doctors' prescriptions was made this time in OAEE in mid-October 2010 with the view to extend implementation to IKA and other health insurance funds until May 2011. Strikingly, in three months since the launching of the electronic prescription system in OAEE pharmaceuticals expenditure fell by 45% compared to the same period of 2010 for this social insurance organisation.

Hospitals are also obliged to submit reports on pharmaceuticals expenditure every three months for monitoring cost, while hospital computerisation is in progress in parallel with the upgrading of hospital budgeting and accounting system (double-entry accrual accounting). Furthermore, the Central Health Care Council undertook the task of improving costing mechanisms and re-pricing per diem hospital reimbursement as well as fees per medical case. Given the fact that pricing has been relying until recently on 1998 rates, a readjustment has

[31] Until this time a ceiling imposed by the Ministry of Finance does not allow the wholesale price of any medicine to increase by more than 10%, and no reduction can exceed 40% (the latter was decided so as to inhibit drug enterprises to hugely lower the price of the drug so as to make it "unprofitable" for the enterprise to provide the product in the Greek market and turn into exporting it).

[32] As stated by the Ministry of Regional Development and Competitiveness, the new pricing system significantly lowered the price of most of the top 300 drugs in terms of sales. Legislation approved by Parliament in early February transferred responsibility for the pricing of pharmaceuticals from the Ministry of Regional Development and Competitiveness to the Ministry of Health.

[33] Currently the rate of generic medicines stands at about 12% to 13% of prescribed medicines (in social insurance organisations); while in some EU countries (e.g. the UK) generic prescribing is over 55%.

been highly overdue. The operation is due to be completed in June 2011 and is expected to raise hospital revenue by 30%.

A major predicament of the national health system has repeatedly been the accumulation of huge hospital arrears and unpaid bills making medical debt an issue of major concern in light of the pressing need for significant deficit-cutting efforts in this and next year's budgets. In June 2010 the outstanding deficit by public hospitals (for the period 2005-2009) amounted to about €5bn.[34] After heated negotiations with the Hellenic Association of Medical Equipment Suppliers and the Hellenic Association of Pharmaceutical Companies, the Ministry struck a deal according to which part of the debt would be paid upfront in cash, while for the remainder zero coupon bonds would be offered to suppliers. Such bonds have no interest payment and can be sold at banks at a rate lower than their face value (with an estimated 20% loss for medical suppliers).[35] Delays in the implementation of the deal further heightened the conflict with medical equipment suppliers and drug makers who imposed an all-out boycott on the NHS, in autumn 2010, causing serious shortages of essential items in the public hospital system that blocked medical treatment and in certain cases put patients' lives at risk.

In February 2011 a new law on "Structural Changes in Health Care" was voted in Parliament. Further to the provision of the recent pension law that established financial and accounting independence of health funds, the above law on health care stipulates the merging of the four biggest health insurance funds – IKA, OAEE, OPAD[36] & OGA (as well as the health fund for merchant navy personnel), so as to create a unified primary health care system (named by the Ministry the "National Health Services Organisation" - EOPYY). Through this amalgamation a network of primary health care services will be formed combining health insurance funds' services and their contracted doctors, health centres (located mostly in rural areas), outpatient public hospital departments and primary health care units operating under local authority administration.[37] The law regulates the above amalgamation; however, a number of important issues concerning, for instance, working conditions of medical doctors, types of contracts and mode of remuneration of medical staff in the context of EOPYY remain to be solved through negotiations with the relevant parties and decisions be finally adopted through presidential decrees and ministerial decisions. Given the fact that working conditions and mode of remuneration vary considerably among the health insurance funds to be amalgamated, the new law has met the strong resistance particularly of medical doctors serving at IKA.[38] The association of public sector doctors took part in the mobilisations opposing reductions in health expenditure, and the Hellenic Medical Association equally expressed support for doctors' demonstrations addressing vehement criticisms to the government.

As to medical procurement, a unified system is currently being implemented and each health care unit should draw up a plan for the medical devices and services required on a yearly basis. The plan should observe budgetary limitations, be based on the real needs of the health

[34] According to a representative of the European Diagnostic Manufacturers Association (EDMA), "Greece holds a negative record in respect to delays in payment by public hospitals, that can go up to 800 days and is five times higher than the EU average" ("Iatrtikos Typos" 28 April 2010, accessed at http://www.iatrikostypos.com/content/ellada/xoris-analosima-apo-simera-ta-nosokomeia).

[35] The deal is indeed a fist attempt at a "haircut" of government debt. According to the provisions of the bailout agreement the Greek authorities must accelerate settlement of outstanding hospital deficits and avoid accumulation of arrears in the future.

[36] The Social Insurance Fund for Civil Servants.

[37] Also the five hospitals of IKA will come under the authority of the NHS.

[38] Medical doctors at IKA are employees (they are mostly under open-ended contracts, with a monthly salary of about €1,200) and they can combine their service to IKA with private practice. At OAEE medical doctors have a work contract (with a monthly fee of about €650) and examine OAEE patients in their private practice; while contracted doctors under OPAD are paid on per capita, per visit basis (€20 gross-fee).

unit, which must be thoroughly justified, as well as on reported data of the last couple of years. The aim is to initially rationalise procurement through the clear identification of needs. Recent legislation also provides for the non approval of procurement plans in case they transgress set budgetary limits. Overall, the government argues that the above reforms will significantly slash health cost, while at the same time they will bring into effect a unified system of primary care that has repeatedly been considered by government authorities, since the establishment of the national health system, but has barely come into effect so far.[39]

Organisational and administrative rationalisation is also high on the agenda through the amalgamation of clinics and hospitals (or even the closing down of some health care units); while shortages in administrative staff are planned to be met through the transfer of personnel from prefectural services that have been abolished in the context of the local & regional government reform under way (or from public enterprises that are being restructured).

Finally, in light of the commitment of the government (under the bailout agreement) to liberalise a number of "closed professions", recent legislation introduced significant changes in regulations concerning the profession of pharmacists. Existing regulations, until recently, allowed a pharmacy to operate per 1,500 inhabitants; the new law reduces it to 1,000 inhabitants and increases the number of pharmacies operating within a radius of 100m to 150m from hospitals. It also lifted restrictions on working hours of pharmacies. Initially the government also announced the abolishment of the guaranteed minimum rate of pharmacists' profit (around 30% of the end price), but in the final version of the bill it opted for a reduction to about 15-20% of the consumer price.

2.3.2 Debates and political discourse

Political discourses and debates focused primarily on the need to cut waste and contain health costs, given the fact that medical debt has been a major component of rapidly increasing public debt in Greece over the last decade. Bitter conflicts, however, gathered momentum around overdue medical bills to suppliers (including pharmaceuticals bills of hospitals and social insurance organisations to pharmacies and drug producers); "creeping privatisation" in the NHS (through increasing co-payments, and in respect to the all day operation of hospitals introduced by Law 3868/2010); and working and remuneration conditions of medical staff under the unified system of primary care (to be established).

The provision of all day operation of hospitals was strongly criticised by all opposition parties and was voted through parliament only by the governing party MPs. The Minister of Health argued that all day operation could attract around €1.5bn to the NHS that are currently going to private health care and could contribute to the effective use of public hospital facilities. The main party of opposition (New Democracy, ND, a right-wing party) focused on the incomplete financing forecast in respect to the bill, while the left-wing parties were overwhelmingly against increasing co-payments. Equally strong were criticisms to the recently passed health care bill (3918/2011), and all four opposition parties voted against it. According to the government the new law will slash waste and, at the same time, improve primary health care particularly by giving people insured at the overburdened IKA the opportunity to choose among a larger number of contracted doctors. Existing conditions push desperate patients to the private sector; though the fact that medication must be prescribed by IKA doctors further complicates matters, unless patients are willing to pay for it out of their own pocket.

[39] Health insurance funds spent €10.2bn on health care (including pharmaceuticals) in 2009. Expenditure was reduced by €850m in 2010; reduction is expected to reach €1.4bn in 2011 and €3.5bn in 2012 (statement issued by the Deputy Minister of Labour and Social Insurance).

Strikes and massive protest rallies were organised by state doctors and pharmacists during the time the health care bill was discussed in parliament. Particularly the rolling strikes for nearly two weeks by IKA doctors highly disturbed service provision (over 300,000 appointments were cancelled nationwide). In an attempt to provide solution, the Ministry, in agreement with IKA issued a circular so that IKA patients could visit private doctors (contracted by OPAD and OAEE) who would be paid extra for such consultations. This move further intensified conflict and divisive battles with medical associations.

Changes in the working conditions of doctors have been the major issue of conflict. State doctor unions (strongly supported by medical associations) denounced the government's strategy of not clearly "fleshing out" crucial principles of operation of the unified primary health care system, to be decided through a large number of ministerial decisions and presidential decrees. Medical doctors expressed worries about increasing flexibilisation of their employment conditions, as it might be likely that appointment at EOPYY could be on minimum-wage, short-term contracts and/or on a standard fee at the rate characterising OAEE.[40] However, the Ministry repeatedly stressed that all these major issues for the implementation of the law will be negotiated with all relevant parties before a decision is reached on crucial aspects of the system's operation.

Another issue hotly debated is overtime payment of state hospital doctors. The regulations of Law 3868 of 2010 led to an overall reduction of overtime putting high strains particularly on hospitals outside the major urban centres lacking adequate number of medical staff. The budget for overtime in public hospitals was reduced by about €75m in 2010 (compared to 2009). Hospital managers reschedule (regular) overtime into "on-call" work that is less expensive and in certain cases they cannot fully cover needs for required overtime even under such an arrangement, while doctors persistently complain for significant delays in overtime payment (of three or more months; this being often the cause of doctors' mobilisations).[41]

In the backdrop of the various "adjustments" of the health care system introduced over the last year a new front of mobilisation of the medical staff of public hospitals has been the co-payment ("entrance coupon") for all regular visits to outpatient hospital departments introduced in September 2010. Mobilisations consist in the occupation of cashier's office by medical staff so as to allow patients free entrance into outpatient departments.[42]

2.3.3 Impact of EU social policies on the national level

Undoubtedly, as emphasised in the 2009 & 2010 Annual Reports, reform of Greece's financially (and functionally) ailing health care system was overdue. Rapidly rising public

[40] Medical doctors have indeed good reasons to assume such a possible scenario given the fact that the November 2010 Update of the Memorandum of Economic and Financial Policies signed by Greece and the IMF-EU-ECB clearly states that "[the] Government extends the use of capitation payment of physician, currently used by OAEE, to all contracts between social security funds and the doctors they contract. The new payment mechanism starts for each new contract renewed in 2011 and for all contracts from 2012" (IMF 2010: 118). On the basis of this the Medical Association of Athens figures that private doctors under short-term contracts will be required to assume responsibility for 3,000-5,000 patients. In parallel, a bleak scenario raised by medical associations concern possible developments under the new legislation that could allow "private medical companies to create primary care franchises, where the plethora of unemployed Greek doctors will work for a minimum wage - a sort of medical sweatshop".

[41] In addition the shortage of nursing staff seriously affects service delivery (in Greece there are 3.2 nurses per 1,000 inhabitants, while in Sweden the respective rate is 30 and the OECD average 9.6).

[42] This is part of a broader mobilisation that emerged over the last few months in Greece under the name of "the non-payment movement" where people refuse to pay highway tolls (demonstrators occupy highway stations letting people pass free), or refuse to pay tickets for public transport (particularly after the approximately 40% rise in ticket prices in Athens public transportation this year).

health expenditure (including soaring drug costs) has been a key source of pressure to the state budget, making health reforms a major priority in the context of the structural adjustment that Greece has been undergoing since May 2010. Thus, as in the case of pension reform, fiscal concerns were the primary drivers of health care reform too. Issues of equity are also raised, particularly in respect to the attempt to create a unified system of primary care. Yet, given the fact that decisions about major dimensions relating to the structure and functioning of the system, work relations and form of remuneration of medical staff are still pending, strong reservations remain in respect to administrative efficiency and equity criteria.

As a report by the Health Experts Committee recently submitted to the Minister of Health indicates, the planned 0.6% of the budget is not enough for funding EOPYY.[43] Needless to say, also, fiscal bottlenecks and confrontations between the Ministry of Health, on the one hand, and medical suppliers, pharmaceutical firms and medical staff, on the other, cause severe disruptions of service delivery with serious effects on access, quality and user satisfaction.[44]

The salience of fiscal problems overshadows any other issues, ideas and priorities in the health policy area. Again, as in the case of pension reform, awareness of the OMC (and its common objectives) is found primarily among officials and experts familiar with EU policies. Debates and confrontations between relevant parties in the ongoing health reform process (doctors and medical staff associations, associations of medical suppliers etc.) hardly embrace OMC issues, and procedural impact of the social OMC (e.g. in terms of improving coordination between policy fields, levels of government, relevant parties etc.) remains rather limited.

2.3.4 Impact assessment

As indicated above significant steps have been taken so far (e.g. measures to rationalise and discipline hospital financing, price-reducing and benchmarking actions as to pharmaceuticals and medical supplies procurement, e-prescribing to be progressively extended to all major funds, greater penetration of generics, improving accounting and auditing techniques at hospitals). Needless to say, however, that due to technical complexities in the health sector and the political controversies and pressures arising out of multiple, simultaneous changes, reforms take a considerable time to take roots and bear results. Hence a considerable time-span is needed before any comprehensive assessment can be made.

Undoubtedly, tackling entrenched problems linked to a high degree of fragmentation in social insurance is a difficult task, worth the effort, though, given the savings that can arise. This is an argument often used by the government in order to mobilise support and overcome reactions by those groups who fear loosing out with the reform (e.g. IKA affiliated physicians who fear changes in their work and payment conditions). So far, however, under pressure from the European Union and the International Monetary Fund due to the Memorandum Greece has signed with these bodies, the emphasis is primarily on cutting costs and enforcing fiscal discipline, while issues of upgrading service quality and effecting distributional fairness are only vaguely alluded to in public debate. It is as though the Greek authorities assume that by dealing with the administrative issues of creating a single pool of medical personnel (amounting to about 26,000 doctors affiliated in one way or another with the main health insurance funds, covering about 95% of the population), out of five "ailing" health insurance

[43] See Newspaper "Eleftherotypia" 19 April 2011, accessed at http://www.enet.gr/.

[44] Due to outstanding debts to suppliers by the Ministry of Health (around €90m in spring 2011) the panhellenic association of suppliers repeatedly suspended supply of consumables. Similarly, due to outstanding debts to pharmacists by some social insurance funds (as for instance the ailing OPAD) pharmacists repeatedly stopped supplying prescription drugs to the insured.

funds, improved quality of service provision by the unified primary health care system will be secured. To the extent, however, that major principles of the system's operation remain to be decided, the verdict is still out as to the system's fairness and effectiveness. Though one should not discount the possibility that fiscal pressure may damp down quality even lower and increase privatisation trends to the detriment of equity criteria. Furthermore, given past experience, any delays in the required presidential decrees (and ministerial decisions) pose the risk that much of the legislation will not be enforced.

2.3.5 Critical assessment of reforms, discussions and research carried out

In a nutshell, under the macroeconomic surveillance required by the bailout agreement, cost-containment in health care is top priority. In this light a major challenge concerns the (effective) implementation of new measures, such as hospital merging, price-reducing and benchmarking action in respect to pharmaceuticals and medical supplies procurement, e-prescribing by the major health insurance funds, greater penetration of generics, and improvement of accounting and auditing techniques in hospitals. However, serious questions emerge as to how cost-containment and fiscal consolidation policies will impact on access and equity criteria, not to mention service quality (official documents make only scant reference to these). Equally crucial are the challenges posed by the new plan to merge the five biggest health insurance organisations.

It is too early to pass judgement on a reform that is still in progress amidst serious sovereign debt problems and acute confrontations among the relevant actors. Suffice it to say, however, that drastic cuts and deterioration of public health provision will deepen inequalities across a number of dimensions (coverage/access, equity and sustainability). Under these conditions, a drift towards "residual social protection measures" is emerging (e.g. in the NRP 2011-2014) addressed to the "most needy" (or those "mostly affected by the crisis") that does not augur well for the rather weak welfare state in Greece (for a commentary on the effects of the crisis and austerity measures on social welfare in Greece see Petmesidou 2011 and forthcoming).

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

As stressed in the Annual Reports of 2009 and 2010, long-term care is a little developed area of social protection in Greece. Personal social services (to children, the elderly, the disabled and other vulnerable groups) have developed slowly and in a fragmented way, while informal care within the family (in relation to privately financed care services provided mostly by legal and illegal migrant women) has persistently played a crucial role in covering needs (Petmesidou 2006, Kallinikaki 2008, Guillen & Petmesidou 2008). Widespread and uniform provision of first-stop systematic services addressed to all the population is still lacking, while systematic data on care needs and differences in access to services by gender, age, health status, ethnic minorities and geographical location are absent.

Significant developments were recorded over the second half of the 1990s and the 2000s, though provision departed from comparatively very low levels. Expansion of social care "units", over the above period, was largely funded by specific programmes and measures under the Community Support Frameworks (CSFs). A number of social care and employment service "units" were thus formed (nurseries, centres of creative activities for children, day care centres for frail elderly people, home-help for elderly and disabled people, centres for promotion to employment etc.) in the context of EU-wide programmes, such as the reconciliation of professional and family obligations, measures encouraging increased

participation of women in the labour force, providing individual counselling to the unemployed and promoting active labour market policies.

Particularly regarding long-term care for the elderly, there is a mix of services provided: (a) by social insurance schemes (mainly nursing care in private clinics for chronically ill elderly people, though the extent and level of coverage significantly differ among the various social insurance funds), (b) by "new units" for elderly care - home-help, day care for frail elderly people - operated under the auspices of local authority agencies, and (c) by the family, as informal (unpaid or paid) care. Most of the "new units"[45] have for a long time operated as distinct programmes (funded by EU sources) under the management of local agencies (e.g. authority enterprises). Initially it was considered that the "new structures" would be integrated in unified local authority social services for which national funding would progressively be provided so as to secure their operation after the termination of the specific EU programmes. However, this plan has not been realised so far; temporary employment (short-term contracts and stagiaires) is the rule and sparse national funding disrupts service provision.

Social insurance funds exhibit high inequalities as to the range and quality of services (for long-term care) offered. Per diem cost is kept low and the quality of services is deficient. Thus, extra care needs to be provided by the patient's family or by privately (often informally) paid nurses.

The interaction between health and long-term care does not constitute an area of significant policy concern. In official documents (e.g. the National Programme for Social Cohesion and Solidarity 2007-2013) the link between these two care fields is very superficially touched upon (with an emphasis on ongoing de-institutionalisation efforts).[46]

Table 6: Nursing and caring professionals & expenditure on care for the elderly

	Nursing and caring professionals (absolute numbers, per 100,000 inhabitants)		Expenditure on care for elderly (% of GDP)*	
	2008	2004	2008	2004
Greece	431.1	421.8	0.09	0.09
Austria	820.2	786.0	1.00	0.97
Netherlands	1,564.4**	1,531.1	0.72	0.87
Denmark	2,479.0**	2,510.5	1.68	1.77

Source: See Table 3.

* Data for these two countries refer to 2007

** Percentage share of social protection expenditure devoted to old age care in GDP (it covers care allowance, accommodation and assistance in carrying out daily tasks).

Compared to some other EU countries, Greece exhibits a rather low number of nursing and caring professionals per 100,000 inhabitants (Table 6). Equally low and stagnant is expenditure on care for elderly as per cent of GDP (among the lowest in the EU, below Greece are ranked Belgium, Bulgaria and Romania); though, as stressed below, need for care services increased in the same period.

Other social care institutions operating at the interface with health services (concerning disability and rehabilitation) are the Centres of Social Support and Training for People with Disabilities, KEKYKAMEA, and the Centres of Physical and Social Rehabilitation, KAFKA. Most of these centres remain understaffed and with very low budgets (over the last few years

[45] Called "new structures" in the parlance of social workers in Greece.

[46] However, in the field of psychiatric medicine, reform grew with very low pace or even stagnated over the last few years due to lack of financial resources.

most of the personnel were "stagiaires" or other temporary-contract workers, though the specialised services that these centres should provide require high expertise and efficient performance that the short-term contract conditions do not facilitate).

The Home-Help and Day Care Centres for the Frail Elderly People are currently funded under the National Strategic Reference Programme, and particularly under the measures of "Support to Frail Elderly People for Promoting the Employability of the Indirect Beneficiaries to the Programme" (i.e. female carers). A voucher system, aimed to spur competitiveness between public, private, and third sector care services, was piloted over the last couple of years; it is currently expanded to most home-help units.

Various stumbling blocks limit efficiency and effectiveness of these care units. First, the fact that local authority run "care units" have persistently depended on EU-funded programmes makes provision highly vulnerable to the fluctuations (or even the withdrawal) of external funding resources. Second, spending cuts under the austerity programme severely limit revenues from national sources. High uncertainty of future operation of the services and the continued risk of funding discontinuity affect negatively personnel morale and service quality. Third, precarious employment conditions of staff are a major negative factor in terms of quality standardisation and improvement. In addition, there are serious doubts whether the voucher system can improve efficiency, as eligible persons (mostly old-aged, deprived persons, with low level of education) often lack information about alternative providers (and how to get better value-for-money).

Finally, the restructuring of local government and administration (as stipulated by Law 3852 of 2010, the so-called "Kallikratis plan") extensively reshaped local authority boundaries and the way local government works. From January 2011, 1,034 municipalities were reduced to 370 through amalgamations. Existing second-tier local government (consisting of 76 prefectures) were abolished and replaced by the 13 regional authorities whose governing bodies are directly elected by the local population. First-tier local government is expected to be the focal point of social service delivery and social welfare tasks undertaken by prefectures are transferred to the newly created local authorities. The extent to which the existing "fragmented" welfare structures will be integrated within a single local social service depends on concomitant breakthroughs in substantive matters of management, organisation and funding. It is too early to forecast developments, but the crisis conditions do not leave much room for optimism. What is more, up to now there are no strong signs of experimenting with alternative ways for enhancing local governance and combating fragmentation and marginalisation of social care - that is, through networking, partnerships and other joint arrangements in the context of a mixed economy of social care.

2.4.2 Debates and political discourse

Long-term care hardly figures in public and political discourse, as a distinct policy area. In respect to elderly care (as well as other care units and programmes initiated through EU financial support over the last fifteen years) it is particularly fiscal problems and precarious employment that attracts publicity. At times, when the funding period of the "co-financed" (by the EU and national sources) programmes is over, serious confrontations emerge between the state and the personnel employed under contract in these units. This was the case in late 2010, when the government sought 20% co-funding from the EU under the National Programme of Regional Development (in the context of the "Female Competitiveness" actions). These conditions highly contribute to staff turnover with negative effects on service provision and quality of care.

In the last couple of years, another issue that attracted publicity by the media and sparked confrontations with governmental authorities and parents' associations are serious problems in the operation of "Special Schools" (for disabled students). In the academic year 2009-2010 from a total number of 561 "special nurseries", 2,262 primary and 604 secondary "special schools", 217, 526 and 139 respectively were not in operation, due to appropriate personnel shortages. Equally problematic is implementation of the all-day schooling programme. In the current school year, eight hundred new (all-day) schools are implementing new curricula on a pilot basis. However the existing 5,500 all-day schools suffer from serious staff shortages and inadequate infrastructure.[47]

Obviously, long-term care in Greece is mostly confronted by government officials and political actors as an adjunct to programmes and measures concerning encouragement of female employment (female competitiveness, reconciliation of family and work life and other similar projects), rather than as a more or less distinct, though, complex field of policy requiring substantial analysis and a comprehensive national policy framework.

2.4.3 Impact of EU social policies on the national level

As indicated above, EU funding under the Community Support Frameworks (CSFs) involved a major push in the establishment of a number of social care "units" (nurseries, centres of creative activities for children, day care centres for frail elderly people, home-help for elderly and disabled people, centres for promotion to employment etc.) over the last two decades.[48] Nevertheless, progress in promoting a systematic policy framework is rather slow, and the OMC in this policy field has not had any significant impact so far. Multi-lateral learning in respect to policy planning, monitoring and evaluation, as well as in respect to evidence-based practices and innovation is still rather limited.

Demographic ageing is a prevalent issue in public debate, though mainly insofar as it impacts upon pension and health care expenditure. Strikingly, long-term care is totally absent as a policy concern in the NRP 2011-2014, and the serious challenges in respect to care needs posed by rapid demographic ageing are not touched upon. Introducing social insurance for long-term care has never been an issue of serious debate in Greek society, and indeed the crisis conditions hardly favour such a concern. Crucial challenges, such as coordination between medical and care services, systematic networking of diverse providers (social insurance funds, health units, local services etc.), as well as a host of policy initiatives for assessing future needs and sustainable funding opportunities, monitor adequacy of coverage and control quality of care, have so far been low visibility issues in the public domain.

2.4.4 Impact assessment

Over the last 10 to 15 years informal privatisation of long-term care (provided within the family by paid carers most often than not by – legal or illegal – migrant women working in the informal labour market) rapidly expanded in Greece (as in other South European

[47] Moreover, according to estimates by KANEP (Centre for the Development of Education Policy of GSEE), the EU target for 95% of children 4-5 years old to have access to pre-school education by 2020 is rather difficult to be attained in Greece, if expansion of pre-school education proceeds with the low pacing recorded unitl recently (in 2005 only 57% of children of the above age group attended a nursery school, while in 2008 the rate fell to 52.4%) (accessed at http://www.kanep-gsee.gr/ereynes-meletes/44-ethsia-ekthesh-gia-thn-typikh-ekpaideysh-2010/ on 10 March 2011).

[48] The review of the 3rd CSF indicates the creation of 492 nurseries for babies and pre-school children, 4,300 all-day primary schools, 2,070 all-day preschools, 1,126 home-help "units" and 119 centres for promotion to employment (Pini 2008). For a directory of the established "units" of Home-Help and Centres of Creative Activities for Children (KDAP) see website of the Central Union of Local Authorities of Greece (http://www.kedke.gr/) and of the Association of Personnel employed in KDAP (http://www.kdap.org/).

countries). This condition significantly reduced the burden of care for women and contributed to rising female employment in the country. The economic crisis, however, increased economic hardship among low-income (but also some middle-income) households, making it difficult for them to afford a (full-time) paid caretaker. Such a development makes reconciliation of family care and work, particularly for women, a major policy challenge, and the need for a new framework for sharing of public/private responsibility in social care is of utmost importance.

Table 7: An indicator of care needs

	2009			2005		
	Bottom income-quintile** (%)	Mid income-quintile (%)	Top income-quintile (%)	Bottom income-quintile (%)	Mid income-quintile (%)	Top income-quintile (%)
Self-perceived limitations in daily activities* (age group: 65 to 74), Greece	29.6	20.6	8.2	16.0	14.2	6.6
Self-perceived limitations in daily activities (age group: 65 to 74), EU-27	17.8	14.3	9.1	17.1	13.5	9.1
Self-perceived limitations in daily activities (age group: 75 years and over), Greece	35.3 %			21.7 %		
Self-perceived limitations in daily activities (age group: 75 years and over), EU-27	24.8 %			21.9 %		

Source: See Table 1.
* Activity restriction for at least the past 6 months: people "severely hampered" in their daily activities
** Of equivalised household income

As we can infer from Table 7, care needs have increased over the second half of 2000s, and at the same time inequalities in respect to need widened. Conditions worsened particularly among elderly people in the bottom and mid income quintiles: one fifth of elderly people with income in the mid quintile and a little less than a third of elderly people in the bottom quintile appear to be "severely hampered" in their daily activities. Also the percentage of people 75 years and over that experience severe limitations in their daily activities rose from 21.7% in 2005 to 35.3% in 2009. These data indicate a steadily increasing need for care among the elderly, particularly in the bottom and middle of the income distribution that can scarcely (or with great difficulty) be met through private arrangements as the economic crisis intensifies economic hardship.

2.4.5 Critical assessment of reforms, discussions and research carried out

In sum, long-term care receives far less policy attention than pensions and health care, though it is an area were problems abound, ranging from unmet need (for those who lack family and kin support and have no financial means for private procurement), to serious burdens placed on families (and particularly women). As the population ages, the pressures to increase visibility of this policy area will grow. Major policy questions to be addressed include: What private/public mix in funding and provision can secure affordable protection? What balance between institutional and noninstitutional care? How to integrate acute and long-term care and assure high-quality care?

EU support for establishing new units in social care has been significant; though discontinuity in funding (by national sources) severely affected service provision. It remains to be seen

whether local authorities' reform will promote an integrated plan for service provision, to the extent that funding will be available (though there is not much room for optimism under the crisis conditions and the high debts incurred by many local authority organisations). Further EU cooperation and coordination in the social field may have a positive effect in mutual learning and exchange of experience in this field of policy. The main challenge for Greece, however, in the immediate future, is how to operationalise objectives and targets set in the context of the "adjustment plan" in a way that will enhance rather than residulise social protection.

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3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R2] ANGELIDIS, Timotheos and TESSAROMATIS, Nikolaos, The efficiency of Greek pension fund portfolios, *Journal of Banking and Finance*, 34: 2158-2167, 2010.

The article examines the costs of investment constraints on Greek pension fund portfolios. The emphasis is on "the losses that portfolios suffer due to under-diversification and sub-optimal asset allocation". The findings stress the negative effects of high degree of concentration and lack of international diversification of investments.

[R2] MATSAGANIS, Manos, Η. μεταρρύθμιση των συντάξεων και το μέλλον του κοινωνικού κράτους στην Ελλάδα, *Επιθεώρησις Δικαίου Κοινωνικής Ασφαλίσεως*, Νοέμβριος, 2010.

"Pension reform and the future of the welfare state in Greece"

The article briefly reviews the recent pension reform process. The first part describes the "deadlocks" of social insurance; the second part critically discusses the political context in which public dialogue developed with an emphasis on the harmful consequences of political confrontations on pension reform; the third part summarises the recommendations of the special Committee (appointed by the Minstrer of Labour and Social Insurance) on pensions issued in March 2010; the fourth part traces the guidelines of pension reform included in the bailout agreement that Greece signed with the IMF-EU-ECB; the fifth and sixth part discusses that the provisions of the reform bill passed into law in July 2010; while the last part assesses the pension policy issues that remain open even after the passing of the reform bill and traces the prospects of the welfare state in Greece under the crisis conditions and the austerity measures of the bailout plan.

[R5] MATSAGANIS, Manos, LEVY, Horacio and FLEVOTOMOU Maria, Non-take up benefits in Greece and Spain, *Social Policy and Administration*, 44: 827-844, 2010.

On the basis of preliminary estimates, and an examination of the methodological problems inherent in the analysis of the issue of non-take up, the authors examine the extent of non-take up of two pairs of means-tested retirement benefits in Greece and Spain: (1) the social solidarity benefit (EKAS) for low-income pensioners in Greece and complementos por mínimos in Spain; and (2) the social pension benefits in each country. The findings show that

"non-take up of social benefits in the two countries is rather extensive". The article concludes on the implications of the findings.

[R1; R2] STERGIOU, Angelos and SAKELLAROPOULOS, Theodoros, Η. Ασφαλιστική Μεταρρύθμιση. Πόρισμα – Εισηγήσεις - Άρθρα, Αθήνα, Διόνικος, 2010.

"Social Insurance Reform. Findings – Presentations - Articles"

This book is a compendium of articles (published over the last few years) on the pension system in Greece, the need for reform, and proposals for proceeding with it. It also includes reports and articles on reform proposals produced in the context of the debate that was launched by the Ministry of Labour and Social Insurance in late 2009, as well as the findings and proposals of the special Committee appointed by the Ministry of Labour and Social Insurance in December 2009.

[R1; R2] TINIOS, Platon, Ασφαλιστικό. Μια Μέθοδος Ανάγνωσης, Αθήνα, Κριτική, 2010.

"Social Insurance. A Reading Method"

As the author stresses, "the book offers a *reading method* of an absurd social insurance system". The first part presents and discusses the contradictions and "absurd" characteristics of social insurance in Greece and lays out the arguments for a "reading method" that unveils the major problems and can trace possible solutions. The second part constitutes "an analysis reading". It attempts an in depth analysis of major theoretical issues and arguments lying at the core of the problem; while the third part offers a "reading in statistical terms" that contributes to a comprehensive understanding of the social insurance predicament in Greece. The fourth part (written by A. Lymberaki) deals with a number of "specific riddles" around social insurance (e.g. in respect to women's privileges, retirement age in the public sector and the invisible debt). The last chapter (written by Tinios, in collaboration with E. Poupaki) presents and discusses the results of a survey carried out in summer 2009 that aimed to tap public opinion on crucial aspects of social insurance.

[H] Health

[H1; H2; H4] LIAROPOULOS, Lycourgos, Διεθνή Συστήματα Υγείας, Αθήνα, Εκδόσεις ΒΗΤΑ, 2010.

"International Health Systems"

The book examines various health care systems developed in the context of different welfare state regimes. It provides a comparative analysis on the basis of main variables such as equity, efficiency, effectiveness, extent of coverage, the public/private mix in funding regulation and delivery, and service quality. Evaluation of reforms is also another major theme of the book. The European dimension is examined too, and the prospects of the welfare state in the "new economic environment" as well as the lessons that Greece can learn from reform experience in other countries are extensively discussed.

[H5] NOTARA, Venetia, KOUPIDIS, Sotirios, VAGA, Elissavet and GRAMMATIKOPOULOS, Ilias, Economic crisis and challenges for the Greek health care system: the emergent role of nursing management. Commentary, *Journal of Nursing Management*, 18: 501-501, 2010

This is a short commentary on the basic implications of the economic crisis on policy developments and prospects from a nursing management perspective.

[H3] OIKONOMIDOU, Eirini, ANASTASIOU, Foteini, DERVAS, Dimitris, PATRI, Fani, KARAKLIDIS, Dionisis, MOUSTAKAS, Panagiotis, ANDREADOU, Niki, MANTZANAS, Evangellos and MERKOYRIS, Bodossakis, Rural primary care in Greece: working under limited resources, International Journal for Quality in Health Care, 22: 333-337, 2010.

This article constitutes a brief presentation and analysis of data from an empirical study of rural health services in Greece with an emphasis on personnel and equipment.

[H6] PAPPA, Evelina, KONTODIMOPOULOS, Nick, PAPADOPOULOS, Angelos TOUNTAS, Yiannis and NIAKAS, Dimitris, Prescribed-drug utilisation and polypharmacy in a general population in Greece: association with socio-demographic, health needs, health-utilisation, and lifestyle factors, *European Journal of Clinical Pharmacology*, 67: 185-192, 2011.

On the basis of multivariate analysis, this article examines the impact of socio-demographic factors, health-service utilisation, health needs, and lifestyle risk factors on drug utilisation and polypharmacy (PP) in a general population in Greece.

[H5] TOUNTAS, Yiannis, OIKONOMOU, Nikolaos, PALLIKARONA, Georgia, DIMITRAKAKI, Christine, TZAVARA, Chara, SOULIOTIS, Kyriakos, MARIOLIS, Anargiros, PAPPA, Evelina, KONTODIMOPOULOS, Nick and NIAKAS, Dimitris, Sociodemographic and socioeconomic determinants of health services utilisation in Greece: the HELLAS HEALTH I study, *Health Services Management Research*, 24: 8-18, 2011.

On the basis of data from a cross-sectional nationwide household survey (Hellas Health I) this article discusses the demographic and socioeconomic determinants of the utilisation of the Greek primary and hospital health care services. The major findings are: Access to a "family doctor and higher use of private services were reported in a higher degree by participants of higher social classes and individuals with private insurance". During the four weeks prior to the study, contact with health care professionals (after adjusting for self-perceived general health and chronic illness) were less frequent among residents of rural areas. Also contacts with health care professionals during the last 12 months prior to the study were found less frequent among men than women, among individuals without private insurance and also among individuals of lower-level education. Out-of-pocket payments were more frequently reported "by the 34–44 age group, rural area residents and individuals with private insurance". On the other hand, demographic and socioeconomic factors do not appear to influence hospital admissions.

[L] Long-term care

[L] SKAPERDAS, Ioannis, LAVDANITI, Maria, DIMITRIADOU, Alexandra, PSYCHOGIOU, Maria, SGANTZAS, Markos, KREPIA, Vassiliki and SAPOUNTZI-KREPIA, Despoina, Satisfaction from the "Help at Home" programme in a prefecture of central Greece, *International Journal of Nursing Practice*, 16: 342-351, 2010.

The article draws upon an empirical study examining the elderly's satisfaction from the 'Help at Home' programme in a prefecture of central Greece. Data were collected from a 300 elderly people sample with the use of questionnaire. The findings show that the majority of

participants were satisfied with provided services and interpersonal relations with the staff of the care scheme, but found the scope of services very limited.

4 List of Important Institutions

Ινστιτούτο Εργασίας της ΓΣΕΕ (ΙΝΕ-ΓΣΕΕ) – Labour Institute of GSEE (General Confederation of Greek Labour)

Contact person: Savvas Rombolis
Adress: 71A, Emmanel Benaki Street, 106 81 Athens, Greece
Webpage: http://www.inegsee.gr/

A non-profit organisation under the auspices of GSEE. It was established in 1990 with the aim to promote research that allows for an evidence-based intervention of GSEE and its trade unions members to policy areas that are of crucial interest to the trade union movement. Among its activities are: the carrying out of research on labour markets trends, poverty and living standards, social insurance and social protection and other issues. It also organises and implements vocational training programmes and supports similar activities organised by GSEE members. Furthermore, it promotes education and training on trade union issues. Apart from various monographs based on specific research it also publishes periodical reports on the Greek Economy and Labour Market and a monthly newsletter. Two observatories on Labour Relations and Migration Trends are also functioning under INE.

Ινστιτούτο Κοινωνικής Προστασίας και Αλληλεγγύης (ΙΚΠΑ) – Institute for Social Protection and Solidarity

Contact person: Efstathios Triantafyllou
Adress: 6, Ypatias Street, 105 56 Athens, Greece
Webpage: http://www.ikpa.gr

It is a public institute operating under the auspices of the Ministry of Health and Social Solidarity. It took its present form in 2005 (under the Law 3370) and its main aim is to promote scientific research on areas of primary concern to the Ministry so as to provide the required evidence-base for policy development, contribute to innovation diffusion and support evaluation processes in the health and social care sector. Since the mid-2000s it has participated in various EU funded projects concerning family policy and disability issues. It also issues opinion for the accreditation of private non-profit social care units and keeps the national registry for adoptions. [No recurrent publications are available].

Ινστιτούτο Κοινωνικής Πολιτικής του Εθνικού Κέντρου Κοινωνικών Ερευνών (ΕΚΚΕ) – Institute of Social Policy of the National Centre for Social Research

Contact person: Maria Topali
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Webpage: http://www.ekke.gr

EKKE is a public agency operating under the auspices of the Ministry of Development (General Secretariat of Research and Technology). The above Institute was established in 1995 with the aim to conduct research basic and applied research in the broader areas of employment, social policy, inequalities, demography, and family issues.
Recurrent publication of EKKE: The Greek Review of Social Research.

University research: Research on various fields of social policy (health and social care, poverty and social exclusion, migration, comparative social protection systems) is also carried out by the members of staff of the two Departments of Social Policy in Greek Universities.

(a) The Department of Social Administration at Democritus University of Thrace (established in 1996), http://www.socadm.duth.gr; and
(b) the newly created Social Policy Department at Panteion University Athens (first established in 1989 as Department of Social Anthropology, Social Geography and Social Policy, but since a few years ago social policy became a separate department), http://www.koinpolpanteion.gr
Also in the University of Athens, at the Department of Nursing there is a Research Unit on Health Services Management and Evaluation [Εργαστήριο Οργάνωσης και Αξιολόγησης Υπηρεσιών Υγείας] http://www.chesme.nurs.uoa.gr/; and at the School of Medicine, in the Laboratory of Hygiene and Epidemiology, there is a Research Unit on Health Services [Εργαστήριο Υγιεινής και Επιδημιολογίας – Κέντρο Μελετών Υπηρεσιών Υγείας] http://www.cc.uoa.gr/health/socmed/hygien/kentromeleton.htm

Ίδρυμα Οικονομικών και Βιομηχανικών Μελετών (ΙΟΒΕ) – Foundation for Economic and Industrial Research

Contact person:	Takis Politis
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Webpage:	http://www.iobe.gr

The Foundation for Economic and Industrial Research is a private, non-profit, public-benefit research organisation. It was established in 1975 with the aim to promote research on current problems and prospects of the Greek economy and its sectors and develop reliable data and information that is useful for economic policy making. It is closely linked to the Hellenic Federation of Enterprises (SEB). It primarily carries out applied economic research, it monitors and analyses economic trends and provides systematic information on various sectors of the Greek economy. A "Health Economics Observatory" is operating within IOBE. Its purpose is to monitor and evaluate economic trends in the health care sector. However, up to now the Observatory's research focus is mainly on pharmaceuticals market trends (prospects of pharmaceuticals enterprises in the Greece economy, pricing policies, employment patterns in the pharmaceuticals sector).
Recurrent publication of IOBE (in respect to issues of health economics): Annual Review of the Pharmaceuticals Market in Greece.

Κέντρο Προγραμματισμού και Οικονομικών Ερευνών (ΚΕΠΕ) – Centre for Planning and Economic Research

Contact person:	Professor Kyprianos PRODROMIDIS
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The Centre for Planning and Economic Research (KEPE) was established in 1957 but took its present form in 1964. It operates under the auspices of the Ministry of the Economy to which it provides technical advice on issues of economic and social policy. Among its main aims are the promotion of economic research on various aspects of the Greek economy, socio-economic data analysis, preparation of forecasts and the drafting of development plans. Although social policy issues are within the scope of KEPE's research activities, its publications (e.g. on pensions) are a bit dated. On the other hand, from a social policy perspective, there is important ongoing research by the Centre on issues of taxation and income distribution, the evolution of household borrowing in Greece, migration issues, education expenditure patterns, employment patterns and labour market trends.

Recurrent publication of KEPE: Quarterly economic review on "Economic Developments".

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en