Annual National Report 2009

Pensions, Health and Long-term Care

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Author: Maria Petmesidou

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1 Executive Summary

Greece experienced comparatively high economic growth rates over much of the 2000s (4% on average from 2001 to 2007). In 2008, however, growth decelerated to 2.9% and the prospects for 2009 are rather gloomy (estimates are fluctuating between a near stagnation level – or even a negative growth rate – and a slightly positive rate around 1%). The country is also facing serious fiscal strains, as the public deficit shot up to 5% in the previous year and public debt is over 95%; while unemployment is rising fast too, and long-term unemployment remains persistently high. Equally alarming is the high incidence of poverty, particularly among the elderly.

These conditions indicate strong opposite running pressures. On the one hand, fiscal constraints put the brake on public expenditure expansion, yet on the other hand there is considerable unmet need and wide scope for public intervention for welfare policy development, e.g. Greece still lacks a universal minimum guaranteed income, significant inequalities in health care persist due to deficient public provision, while social care is a chronically ailing policy area. Adverse conditions are further compounded by the current economic crisis.

In the field of pension policy a significant reform was approved by Parliament in 2008 aiming both at the administrative modernisation of social insurance by tidying up a traditionally highly fragmented system, and at securing sustainability particularly through excepted economies of scale that the reorganisation may yield. The reform law stipulates the reduction of the number of pension funds through large scale amalgamations, a considerable levelling out of regulations and benefits, measures discouraging early retirement and promoting active ageing, as well as supporting gender equality (in terms of early exit pathways and parental leave provisions). How far the reform will contribute to pensions sustainability remains an open question though, given the fact that sound actuarial evidence for planning and implementing the reform is lacking, as are also effective implementation tools and monitoring processes. Furthermore, adequacy of pensions has not seriously been tackled.

Regarding health and long-term care there have been no major changes over the past year. A new law that passed in March 2009 concerns primarily employment terms, working time schedules and career paths of public hospital doctors. Other important legislation approved in previous years (e.g. for coordinating procurement of medical equipment and consumables and controlling pharmaceuticals markets) has not so far produced any significant effects in terms of cost containment. Important issues concerning underfunding and blatant quality deficiencies of public health and social care organisations, deepening inequalities due to fast expanding private expenditure (particularly out-of-pocket payments for health care and informal privatisation in social care provision), defective information systems and allocative and distributional inefficiencies do not seem to be high on the agenda. Obviously rationalising funding processes for public health and social care provision so as to improve cost efficiency and equity develop a better integrated primary health care and establish effective monitoring and regulation mechanisms are major challenges that will shape future trends.

2 Current Status, Reforms as well as the Political and Scientific Discourse during the Previous Year

2.1 Pensions

2.1.1 Overview of 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 Employment and Social Protection and managed by representatives of employees, employers and the state. Until recently the state pension system was characterised by a high degree of fragmentation across sectors of employment and economic activity. There were approximately 130 social insurance funds operating on the basis of labyrinthine rules and great differentials in coverage and provisions (as well as in retirement pathways, particularly for entrants into the system before 1993).

Taking into account population ageing, if the system continued unchanged, pension expenditure is projected to rise from 11.9% in 2006 to a maximum level of 24.8% of GDP in 2050 (twice the rate of the expected EU-25 average, for alternative projections see OECD 2007, p. 55).[1] The need for reform has persistently been stressed in the academic debate as well as in relevant reports by European and international organisations (EU 2006; OECD 2007; ILO 2007). On the basis of a protracted social dialogue between the social partners, political parties and other relevant actors, a major reform was introduced by Law 3655 of April 2008 for the "Administrative and Organisational Reform of Social Insurance Organisations".

The new law constitutes a further step to previous legislation (of 1992 & 2002). Its major provisions require the amalgamation of pension institutions so that their number will be reduced to 13 major funds. It also stipulates the phased elimination of diverse regulations. The reform underway aims primarily at improving efficiency of the public (pay-as-you-go) system through administrative and organisational changes. No major changes in the mode of financing social security were included in this law. Funding of the PAYG system is based primarily on employer and employee contributions. Pension benefits are implicitly guaranteed by the state. To mention that, in Greece, for a long time, the level of financial support provided by the state to the various social insurance funds greatly varied. But differences in state subsidies were hardly due to need. They mainly resulted from the differential access to the poles of political power and the state machinery that the various socio-professional groups and their respective trade unions traditionally developed. Evidently this condition aggravated inequalities (e.g. the subsidy to IKA, which is the largest social insurance organisation for private sector employees, has persistently been much lower than that to "noble funds" – i.e. the funds for bank and public sector employees). Legislation passed in 2002 addressed this issue and explicitly set the state subsidy to IKA at 1% of GDP annually for a period up to 2032.[2]

[1] The scenario of pension costs explosion in 2050 becomes even more alarming if one takes into account the comparatively low overall employment rate in Greece (60%); a condition that makes the Lisbon employment targets highly unlikely for the country to achieve by 2010.

[2] However, from the time this provision was legally introduced (2003) until recently the state did not entirely abide by its obligation (see Papadis, 2007).

The second pillar (occupational pensions) has scarcely developed so far in Greece.[3] It currently amounts to a little less than 0.3% of GDP (Guillen & Petmesidou, 2008, p. 68). There are four occupational funds operating in Greece, and two more are at the stage of being established. These are run by the social partners on the basis of capitalisation. The National Actuarial Body has monitoring and control powers over them. The percentage of the working population contributing to personal pension is very low too, less than 2%. Voluntary (third pillar) pensions are mostly provided by the life insurance industry. In life insurance schemes, lump sums are preferred to annuity benefits (see Guillen & Petmesidou, 2008).[4] Expansion of funded occupational and personal pension schemes very much depends on the extent of generosity of the public system in the future. Additionally, closer integration of insurance markets in the EU will impact upon personal pension savings.

A means-tested social pension is provided by OGA (the Agricultural Insurance Organisation) to people aged 65 and over who lack a sufficient insurance record. Since 1996 low-income pensioners (except OGA pensioners) are eligible for a supplementary means-tested benefit (EKAS).

2.1.1.1 Main reform measures

Law 3655 of 2008 laid out an agenda for administrative and organisational reform in three phases. The first phase was concluded in early August 2008. The major step was bringing to completion the provisions already introduced by legislation in 2002, namely the merging of a number of funds of bank employees and public utility corporations employees with IKA. The second phase - with a time horizon until beginning of October 2008 – paved the way for all other amalgamations stipulated by the above law; whilst the following third phase focuses on measures aiming to progressively eliminate diverse regulations.

On the administrative side, the reforms have substantially changed the constitution of the first pillar, which now comprises only five major funds: 1) IKA-TEAM (the Social Insurance Organisation for private sector employees), including a number of funds of bank employees and of public utility corporation employees. 2) OAEE (the Social Insurance Fund for Self-Employed Workers), that merged with NAT (the Social Insurance Fund for Merchant Navy Personnel), the Welfare Fund of Hotel Keepers and some other smaller funds. 3) The new Fund for the Professions (ETAA); which emerged from the amalgamation of the funds covering different professional occupations (lawyers, doctors, engineers and other professional categories) merged into a single organisation. 4) The new Fund for Mass Media Corporations Personnel (ETAM-MME), which also emerged from the amalgamation of

[3] The reasons why second pillar social insurance has not developed in Greece are straightforward: the first pillar (primary and supplementary pensions) extensively covers all the working population (in the formal sector), and is guaranteed by the state; in addition, contributions are rather high (occupational funds would increase total contributions, and consequently would raise labour costs). Moreover, due to the high level of "theoretical" replacement rates, there has been no substantial demand for occupational insurance. The second pillar was introduced fairly recently (by Law 3029 of 2002, with the aim of bringing insurance legislation in line with directive 2003/41 of the EU for the functioning and regulation of occupational pension funds). Contributions paid to occupational funds are tax exempt. However, as stressed by policy experts this has not been a strong incentive for the establishment of occupational pension schemes so far. Favourable tax regulations are being contemplated by the Government. At the same time it is expected that the merging of social funds (particularly the merging of a number of social funds to IKA-TEAM) will bring down contribution (as well as replacement) rates for supplementary pensions and this may encourage the establishment of second pillar schemes. However, such issues do not figure prominently in public debate.

[4] Total premiums stood at 2.17% in 2005 (EU-25 average being 8.5%; Association of Greek Insurance Companies, 2007, pp. 13-4).

existing smaller funds. And 5) OGA (the Agricultural Insurance Organisation) that covers farmers and associated agricultural workers (not affected by the reform).

Mergers of auxiliary, welfare and health funds are taking place progressively, so that there will be eight more social insurance organisations in addition to the above five major funds. These are the following: 1) ETEAM, the auxiliary pensions fund for workers; 2&3) TEAIT & TAPIT the private sector auxiliary pensions and welfare fund[5]; (4) TAYTEKO, a fund covering supplementary pensions, welfare benefit and health insurance for bank and public utility corporations employees; (5, 6 & 7) TEADY, TPDY & OPAD, respectively, the auxiliary pensions fund and the welfare and health insurance fund for public employees; and (8) TEAPASA, the auxiliary pensions, welfare and health insurance fund for the police, fire and rescue services forces.

Specifically for those funds amalgamated into IKA, uniformity in replacement rates is to be progressively phased in.[6] Moreover, the new law sets a ceiling for supplementary pensions to 20% of pensionable earnings; the funds that surpass this ceiling should proceed to phased reductions from 2013 onwards (to be completed in an eight-year period through eight equal instalments).[7] In parallel, a plan for developing a single register for all insured persons has started being implemented. From June 2009 onwards, a National Insurance Number will be allocated to all insured persons (this will be essential for employment and social and health insurance coverage). This measure is believed to substantially combat the evasion of contributions and avoidance, and thus increase resources for funding social insurance in the following decades.[8] In the same vein, the law specifies a gradual increase of the minimum time in work, required for establishing access to health care benefits (in cash and in kind).[9]

Other major provisions of Law 3655 of 2008 are in line with strengthening the links between contributions and benefits, tightening eligibility to early retirement, encouraging older people to stay in employment and promoting gender equality (in terms of early exit pathways and parental leave provisions).

a) Incentives to work longer include a special increment in the pension (of 3.3%) for all those remaining in active service for three years (after the age of 60, for entrants before 1993; or after the age of 65 for entrants since 1993; and upon the condition of having worked for 35 years [or 10,500 days]).

b) Early exit penalty was tightened (pensions will decrease by 1/200 – instead of 1/267 as it was until recently – for every month that a pensioner falls short of the relevant age limit). Also, from 2013 an age limit of 58 years will be introduced for retirement after completion of 37 years of employment.

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5 Covering various blue-collar employees, e.g. private insurance, trade, private general education, travel agencies and others.

6 Contribution rates will gradually decrease so that in 10 years' time they will reach the level of IKA rates (namely 6.67% of gross salary for the primary pension and 3% for the auxiliary pension paid by employees, and 13.33% of the employees' gross salary for the primary pension and 3% for the auxiliary pension paid by the employer).

7 To mention also that on the basis of Law 3029 of 2002, on 1st January 2008 a phased reduction in the replacement rate of basic pensions in the public sector (including public corporations, banks and the police force) was introduced. Reduction will be by 1% per year, so that by 2017 the replacement rate will be reduced to 70%. Additionally, on the basis of the above law, since 1/1/2008 pensionable income, in the broader public sector, refers to the mean salary of the last five years in service before retirement, instead of the last salary.

8 For combating contributions evasion the law also encourages a closer cooperation between the Social Insurance Control Service (EYPEA), the Labour Inspectorate (SEPE), the Social Insurance Funds and the Manpower Organisation (OAED).

9 From 50 days of employment per year to 100 days for benefits in kind, and 125 for cash benefits (and 80 and 100, respectively, for construction workers).

c) Retirement age of women with dependent and/or handicapped children increased from 50 to 55 years. Furthermore, this condition is made applicable to widower or divorced fathers with children under their custody. In parallel, the law makes provision for crediting one extra pensionable year for every child (and up to a maximum of three years) to working mothers (fathers can benefit from this provision as well if their spouse does not make use of this right). Working mothers (insured in IKA) can also benefit from an additional six-month maternity leave; the lowest wage plus contributions for this period are paid by the Manpower Organisation (OAED). The extension of the "revised" preferential treatment to both spouses (provided that only one of them benefits from it) is in line with equal treatment, individualisation of rights and changes of family patterns.

d) The retirement age for women that entered the labour market until 1992 (either as dependent workers or self-employed) and have completed 35 years of employment (or 10,000 days) will be raised gradually to 60 years. Furthermore, for all entrants into the labour market after 1993 and insured in IKA (including the funds merged with IKA) any provisions for early exit (before the age of 60) upon completion of 35 years of employment are abolished.

e) Another major provision for guaranteeing the adequacy of pensions concerns the creation of a reserve fund (AKAGE, "Generational Solidarity Insurance Fund") that from 2019 onwards will be able to support social insurance expenditure. Its resources will derive from government revenues resulting from privatisation of public utilities and enterprises, VAT, as well as from specific charges (the so-called "social revenues" levied upon "third parties" in particular transactions[10]) that constitute a funding element of a number of social insurance funds.[11]

Additionally, measures planned in the context of the NAP for Social Inclusion (2008-2010) encourage active ageing. They comprise a range of life-long learning programmes addressed at old-aged workers, subsidies to firms in order to hire male unemployed workers 50 years and over (and special programmes for female unemployed workers 45 years and over), as well as earmarked subsidies to firms for hiring unemployed persons close to retirement.

Age limits for those employed in "arduous and unhygienic" occupations will increase as from 2013 (from 53 to 55 years for a reduced pension, and from 55 to 57 for a full pension). Moreover, the Ministry of Employment is currently re-examining the rather extensive list of occupations classified as "arduous and unhygienic" with the aim of restricting eligibility to favourable conditions for early retirement under this scheme. EU and OECD recommendations have repeatedly stressed that these favourable conditions apply to an obviously large scale (roughly about 40% of male and 15% of female pensioners of IKA take advantage of this scheme). This is a blatant case of using social insurance for social assistance purposes, with adverse effects on equity. Besides, the large scale of this preferential treatment greatly surpasses the rationale of this scheme "which is to take account of the adverse effects that some occupations have on life expectancy" (OECD, 2007, p. 15).

2.1.1.2 Effective retirement age, replacement rates, increases of pensions and social assistance benefits

Data from the EU Labour Force Survey indicate that in 2005 the median effective age of retirement in Greece was 61.7 for men and 58.4 for women (65 years for entrants after 1993). Projections (before the enactment of Law 3655 of April 2008) expected theoretical replacement rates to remain at their current high level (in 2006 gross replacement rate

[10] E.g. charges levied for legal transactions, for advertising in the media etc.

[11] The latter funding source of AKAGE implies a redistribution of resources among social insurance funds.

amounted to 105% on the basis of the ISG methodology) until 2030, and to fall by about 15 percentage points until 2050, given the fact that entrants into social insurance schemes after 1993 will be subject to tighter rules (European Commission 2006b, p. 176). High theoretical replacement rates, however, can barely be realised due to low numbers of contribution years because of disrupted working careers (and/or working in the informal economy), considerable contribution evasion practised by firms as well as by individuals because of strong disincentives built into the system, and a tendency among the self-employed to underreport their income in order to pay lower contributions (Papatheodorou, 2006). Consequently, a large number of pensioners receive very low pensions.

Uniformity among entrants before and after 1993 is attempted by the new law that stipulates the progressive phasing in of a 70% replacement rate for basic pensions and a maximum of 20% for supplementary pensions. It equally introduces stringent regulations for early retirement and provides incentives for prolonging working life. In addition, a recent ruling by the European Court of Justice (March 2009) pressures Greece to abolish preferential treatment as to retirement provisions for women in the public sector (women can retire five years earlier than men) on the ground that this runs counter to gender equality and creates obstacles to career advancement of women. If the equalisation of the retirement age of men and women in the public sector is effected, it will further increase the effective retirement age.

Each year pension increases are decided in the context of the incomes policy of the Government and in respect of the financial conditions characterising social insurance funds. For 2008, a 3% increase was provided in January and a further 2% in October; while EKAS increased by 21% (for income policy – including pensions and social assistance benefits – of 2009 see Chapter 3 on the measures taken in response to the economic and financial crisis). A heating allowance (to be administered by the newly created – but still not fully in operation – National Social Cohesion Fund) was announced in 2008 but soon was postponed to 2009. It initially concerned low-income pensioners but in early 2009 the Government decided to include other categories of deprived groups as well (see Chapter 3 below).

Also a favourable measure for people 65 years and over (entrants into social insurance before 1993), who do not fulfil the requirements for retirement pension, will be in force until/by the end of 2009. People falling under this category can claim a pension between 2/3 and 1/2 of the minimum pension granted under the respective social insurance fund which covers them. Similarly, elderly people insured under existing schemes (excluding OGA) with the age limit of 65 for men and 60 for women (for dependent workers) and 65 for both men and women (for self-employed workers) can be credited with up to 150 days of insured working time in order to satisfy the conditions of old-age pension.

2.1.2 Overview of debates/political discourse

The urgent need for a comprehensive pension reform has been at the forefront of the academic debate for a long time (Spraos Committee, 1997, Boersch-Supan & Tinios, 2001, Tinios, 2003, Featherstone & Tinios, 2006). Major reform priorities stressed by academics, and frequently mentioned in relevant documents by the European Commission and OECD, are the following: secure long-term fiscal sustainability of pensions, improve administrative efficiency and effect transparency of budget allocation (for instance by clearly distinguishing between insurance and social assistance), eliminate disincentives for working at older ages and tackle effectively poverty among the elderly (which is comparatively high in Greece). The recently introduced legal changes to some extent respond to these issues. As stressed earlier, the emphasis of the reform is primarily on tackling administrative inefficiencies and promoting (in a phased way) uniformity of rules across sectors.

At the time the draft law was discussed in Parliament heated political debate centred primarily on the enforced amalgamations, the curbing of gender differences in retirement age and the phased abolition of differences in coverage and provision among merging funds. The increase of the retirement age of women with dependent children became a highly politicised issue, as did also the levelling of regulations concerning replacement rates for supplementary pensions among pension funds (this measure hit predominantly the so-called "noble funds" – among others the funds of bank and public utility employees enjoying more extensive benefits).

Debate was extensive (particularly through the media), but it scarcely drew upon evidence-based arguments and systematic research, neither on the part of political parties, social partners or other interest groups. What is more, there are no significant (independent) think tanks in Greece that undertake systematic policy research and can actively contribute to public debate and policy making. Given the absence of policy-oriented (social science) epistemic communities in the country, usually debate is monopolised by lawyers with an emphasis on legal minutiae and issues of compatibility of specific clauses with other national (or international) legal provisions (including constitutional provisions).

Sometime before the drafting of the reform law, an actuarial study for IKA & OGA was completed by the ILO (2007). This study was commissioned by the Greek Government, and on the basis of the data made available to the relevant ILO service the report concluded that IKA's sustainability is secured until 2030 provided that the state fulfilled its overdue payments and future obligations. A previous actuarial study undertaken by the INE-GSEE (only for IKA-TEAM, Rombolis et al., 2005) came up with similar projections that showed the fiscal sustainability of IKA until about 2020-2025 and serious fiscal problems afterwards. It needs to be stressed also here that in particular with regard to IKA, all available actuarial projections clearly emphasise, additionally, the need to tackle contribution evasion practised on a large scale, and to ensure an efficient management of its financial assets. Certainly, the reform in progress will change considerably the conditions for IKA's sustainability, given the fact that its finances will be burdened by the deficits characterising some of the funds that have merged with it. Thus, projections of the above actuarial studies need to be re-estimated in the light of the current reform. Rising unemployment under the present economic crisis is another major factor that will considerably strain IKA's revenues in the coming years (see also Chapter 3 below).

The need for carrying out actuarial studies for all funds to be amalgamated, before the launch of the reform process, has been stressed repeatedly in public debate. From a legal perspective, this is a prerequisite inscribed in the Constitution (under a clause concerning the assurance and promotion of insurance protection) and consolidated – through case law – by the Supreme Administrative Court.[12] Thus, in the debate on the draft law that took place in the context of the Parliamentary Committee for Social Affairs, representatives of various bodies and interest groups strongly put into the fore that the implementation of the reform without any systematic and transparent actuarial information on the fiscal conditions of the numerous social funds will raise serious questions as to the legality of the process (see for instance the special issue of the Review of Social Insurance Law, vol. MI, 2008). Nevertheless, up to now there is no available information on whether any such studies are under way.

The General Confederation of Greek Labour and the Social and Economic Committee also delivered their opinion on the reform law. Both expressed harsh criticism for the increase of the retirement age (as described above), the stringent regulations for those employed in

[12] See Matheou, 2008. Also, in respect of the funds for bank employees and persons employed in public corporations (to be amalgamated with IKA) Law 3655 does not even refer to actuarial studies, but more vaguely to economic studies that must be carried out within a six-month period after the launching of the law's implementation.

"arduous and unhygienic jobs" and the changes in the provisions concerning early retirement for mothers with underage children. With respect to the latter, the Social and Economic Committee argued that the preferential treatment of mothers with underage children should not be eliminated for demographic reasons, given the low fertility rate in the country (see for instance GSEE, 2008).

Other participants in the public debate include trade unions and associations like the Confederation of Employees in Social Insurance Organisations (POPOKP) as well as the Society for the Support of Social Rights (EPKODI). Both of these bodies expressed criticisms for the reform, and particularly for the absence of a systematic planning and implementation process. POPOKP also expressed worries about the steeply declining ratio of actively employed persons to pensioners (from 2.33 to 1 in the early 1990s to 1.7 to 1 in 2008).

POPOKP repeatedly emphasised that the 20% ceiling for supplementary pensions will lead to a substantial decrease of pensions for certain occupational groups. It strongly criticised the lack of systematic actuarial evidence for planning the reform (and particularly the merging process). In its annual conference, debate focused on the debts of the state and the enterprises to social funds, estimated at about EUR 16.8 billion (EUR 8.9 billion of which are public debts).[13] POPOKP estimates that the reform measures may spare resources of up to EUR 13 billion for social insurance funds; yet this amount is much less than contribution arrears by enterprises. Furthermore, if contribution evasion and avoidance continues unabated, it is highly likely that by 2030 such arrears will reach over EUR 200 billion, i.e. an amount 18 times higher than the fiscal gain from the reform measures. Regarding expenditures of health funds for pharmaceuticals, they are estimated to have risen by 150% between 2003 and 2008. Also the debts of social insurance funds to hospitals and other public bodies are estimated to be around EUR 14 billion (EUR 12 billion are debts incurred by IKA). The deficit of major pension funds (IKA, OAEE etc.) were considered to be close to EUR 4.5 billion in the end of 2008 and an increase of EUR 1.4 billion is estimated to incur annually in the immediate future.

Harsh criticisms are also expressed by GSEE and POPOKP in respect of dealing with the problem of undeclared work. This is estimated to about 17% of the labour force and concerns 5.5% of enterprises. Doubts are expressed as to the extent to which the reform can tighten control of undeclared work. It is argued that the maintenance of such a high level of undeclared work would rather indicate an "implicit policy" to combat unemployment by reducing, in this way, the non-wage cost of labour. Hence, it is not a matter of incompetence of control mechanisms but an intended marginalisation of a part of the labour force.

According to OECD data, tax revenues in Greece are rather low (27.4% of GDP in 2006, compared to 39.8% in EU-15).[14] That means that if the Greek tax collection system could reach the levels of efficiency of the EU-15 average, then roughly about EUR 30 billion could flow into the state treasury and the social insurance funds. This is a considerable amount of revenue; it equals state expenditure for public employee salaries, pensions, insurance and social protection.

2.1.3 Critical assessment of reforms, discussions and research carried out

The main challenge ahead pointed out by the 2007 Joint Report of the European Commission for Greece in respect of pensions was "to increase efforts to ensure adequacy and long-term

[13] Out of EUR 7.9 billion debts of enterprises, EUR 6.9 billion constitute an estimated contribution evasion (employment not declared in IKA) and the rest are contribution arrears.

[14] Despite the fact that tax rates are at the EU-15 average and contribution rates much higher than the average for EU countries. Yet social insurance is beset with problems and services and provisions are of low quality.

sustainability of the pension system by increasing employment and promoting longer working careers, so as to broaden the contribution base". The administrative and organisational overhaul attempted by the recent law constitutes a significant step to address these issues; yet it remains to be seen how successful implementation will be. This indeed raises serious doubts since official reports accompanying legislation (as well as the section on pensions in the NSR 2008-2010, Ministry of Employment and Social Protection, 2008) hardly develop any strategic perspective on main targets, implementation issues, monitoring and evaluation processes; also medium and long-term projections of the expected benefits is rather thin. Shortly after the enactment of the Law debate subsided, even though implementation is a crucial task and scarcely any tools for monitoring and analysing developments are available.[15]

2.1.3.1 System modernisation, sustainability and adequacy of pensions

Undoubtedly recent legislation constitutes a major step towards administrative modernisation of social insurance in Greece. However, the success of the reform very much depends upon how implementation will progress. The above mentioned legal and policy documents emphatically stress that the administrative modernisation of social insurance will increase financial resources for social insurance. Yet reference to expected financial impacts has so far been rather cursory. Vague arguments about economies of scale, to be realised as a result of a more tidy structure of social insurance, are not supported by solid (quantitative) evidence.

The law stipulated that over a six-month period as from its introduction, actuarial studies for the merging institutions were to be carried out. However, as mentioned above, no information has been available at the Ministry on the progress made in this respect. Furthermore, major issues such as, for instance, how IKA will deal with the debts of Funds of Public Utility Corporations and Banks amalgamated into it, have not effectively been tackled and a detailed, comprehensive implementation plan has not been available so far.[16] On the basis of POPOKP's estimates it seems that mergers will transfer financial liabilities to some of the major funds (e.g. IKA, OAEE – which are already ailing, though) and incurred cost will surpass gains from cost-containment following administrative modernisation.[17]

Arguments expressed by governmental bodies and trade unions (e.g. POKOPK) support contradicting estimates as to the effects of the reform on pensions sustainability, while the problem of how to generate an adequate evidence base for examining sustainability and

[15] For the deficiencies characterising the "legalistive administrative tradition" in Greece and the slow development of "new governance structures" (i.e. in particular the separation of politics from administration/execution and the establishment and operation of independent bodies overseeing and auditing service outcomes) see Guillen & Petmesidou, 2008. Equally lacking are nationwide, systematic monitoring and performance evaluation mechanisms of public policy.

[16] To mention also that, in addition, 175,000 workers in the tourist sector have come under IKA's social and health insurance by recent legislation. Particularly as regards health insurance, this development will negatively affect IKA, given the fact that the deficit of its sickness branch amounted to nearly EUR 2 billion in 2008. The pensions' branch will also face serious problems, as the ratio of pensioners to persons employed in the banks and public utilities, which have come under IKA's coverage with the new law, is rather low.

[17] For instance, in the case of the amalgamation of the pension fund for the employees of the Bank of Greece and the National Bank of Greece, the recently approved law stipulates that a) the employer (i.e. the respective bank) will pay to IKA an amount that equals the deficit of the pension fund on 31. December 1992 (this will be paid without interest, in equal instalments, over a period of fifteen years), and b) the state takes responsibility for the fund's deficits. Firstly, no reasons are given why it was decided that the "employer" would cover the deficit as it stood in 1992 (and not in 2008!), and, secondly, the expression that "the state takes responsibility of the deficit" is rather vague as it does not exactly define whether the state will provide financial resources or simply act as guarantor.

adequacy is seldom addressed in public debate that more often than not is fuelled by party political expediency.

Regarding adequacy, theoretically the system provides a very generous average gross replacement rate[18] (this is reduced for entrants since 1993, and recent legislation introduced phased reductions for older cohorts as well). But, as stressed above this can hardly be realised for a considerable part of retirees.

Despite the high aggregate pension expenditure (51.2% of total social protection expenditure in 2005), the risk of poverty among people aged 65 years and over remains comparatively high in Greece (as Table 1 shows). Evidently, more targeted benefits to those most in need are required in order to achieve adequacy of pensions.

Table 1: At risk of poverty (cut-off point 60% of median equivalised income after social transfers)

	2004			2006		
	Total	**Men**	**Women**	**Total**	**Men**	**Women**
EU-15	19* (17)**	16 (15)	21 (18)	20 (16)	17 (15)	22 (17)
EU-25	18 (16)	15 (15)	20 (17)	19 (16)	16 (15)	21 (17)
Greece	28 (20)	26 (19)	30 (21)	26 (21)	23 (20)	27 (21)

Source: Retrieved from: http://epp.eurostat.ec.europa.eu
* 65 years and over / ** total population

2.1.3.2 Active ageing

New legislation enforces increases in the retirement age (particularly by progressively eliminating preferential regulations for certain groups – women with underage children, differences for entrants into the labour market before and after 1993, persons employed in "arduous and unhygienic jobs"). However, available official reports (e.g. NSR 2008-2010) hardly provide any documentation on how employment rates evolve or what changes are expected to occur in the future. Neither do they set any targets, nor provide any projections for effective retirement age.

The employment rate among older workers (aged 55 to 64) is comparatively low (42% in 2006, data of the EU Labour Force Survey), with no clear signs of a strong upward trend (remarkably low is the employment rate of women aged 55-64, 26.5%). A recent OECD report clearly shows that, in Greece, the financial disincentives to remain in work at older ages are among the highest in the EU and OECD countries. This is mostly due to "high statutory replacement rates and benefits and a range of special provisions that allow early retirement before the "normal" retirement age of 65" (OECD, 2007, p. 15). Recent legislation constitutes a step to addressing this issue. Other recommendations by international organisations like, for instance, linking pensions to lifetime contributions, periodically increasing retirement age with respect to increases in life expectancy, changing the basis for self-employed pensions from notional to actual earnings (or "some proxy measure such as

[18] For example, for a worker with average earnings and a career of 40 years (theoretical) gross and net replacement rates stood at 108% and 120% in mid-2000s (European Commission, 2004). More recent calculations by the Indicators Sub-Group of the Social Protection Committee put the corresponding replacement rates at 105% and 115%; while projections for 2050 set the net replacement rate still above 100%, and the gross replacement rate at 94% (European Commission, 2006a).

turnover") so as to eliminate distortion in favour of the self-employed and against dependent workers (and improve equity) have not so far been taken into account (ibid.).

2.1.3.3 Information services and debate

Policy documents touch upon the issue of how financial literacy and information services on old-age security across public (and private) institutions can be enhanced only marginally. A pilot project running since May 2007 at IKA and informing people about insured time covered and contributions paid could be a step towards promoting information services. There are no surveys or other sources regarding the level of knowledge/competency (and any changes) in respect of income security in old age (neither any information on differences by gender, age, educational level).

As to the involvement of main stakeholders in decision making, a process of public consultations with all relevant bodies (mainly political parties and social partners) preceded the enactment of the reform law. Undoubtedly, suggested amalgamations and attempts to equalise regulations stirred strong opposition on the part of vested interests (aligned with party-political stances). And indeed, in the case of some "noble funds" (e.g. the funds of persons employed in mass media[19]) the Government yielded to pressures. And instead of integrating the existing funds for employees and self-employed in the mass media with the newly created fund for the professions they proceeded with the establishment of a separate fund for this occupational group.[20] As debate waned after the passing of the reform law, crucial issues of effective implementation are swept out of sight. This is due to weak public-interest information channels through (more or less) independent think tanks and policy-oriented epistemic communities. This, in turn, accounts for a weak research environment and the absence of a systematic evidence base to inform and support the process of policy formation.

2.2 Health

2.2.1 Overview of the system's characteristics and reforms

Greece introduced a universalist national health system in the early 1980s. However, until present it hardly reached the state of a fully-fledged national health system (hereinafter referred to as NHS). 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, in particular some rural areas, it is the main provider of health care. Overall, however, primary and specialist care is characterised by a noticeably mixed system of service delivery by public, health insurance, and private providers. Employed citizens are enrolled in one of the sickness funds that are occupation-based.[21] The diversity of coverage in the social insurance funds, the NHS, and for some people in private medical insurance contributes to high

[19] … who benefit significantly from the so-called "social revenues" (in this case, specific charges levied by media for advertising).

[20] Trade unions of journalists and other occupational groups in media businesses and corporations used their political clout to get a better deal for their members. It is exactly such practices that in the past supported a high degree of social insurance fragmentation in Greece.

[21] In contrast to other countries with a health insurance system (e.g. Germany), employers (& employees) cannot choose among competing health insurance funds.

inequalities.[22] Multiplicity of funding also accounts for a lack of co-ordination 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.

Health care funding derives from payroll taxes, general tax revenue and out-of-pocket payments (including under the table payments to hospital doctors). The majority of primary care doctors are specialists. There are very few GPs in the country and a gate-keeping system is absent. Within the public sector, IKA operates primary health centres (about one hundred) for its insurees (including pensioners of OAEE). Primary care is also provided by the outpatient departments of hospitals, the about 1300 rural health posts and the 200 semi-urban and rural health centres (Petmesidou & Guillen, 2008, p. 114). It is estimated that about half of the number of physicians are directly employed mainly by IKA; these are salaried staff, but they can also pursue private practice. The rest are solely in private practice and a large number of them are contracted by sickness funds on a fee-for-service basis. Moreover, prevention practices of primary care remain extremely marginal.

Public hospital funding derives from two sources: Doctors' salaries and capital investment are provided by the Ministry of Health through general taxation, but services offered are paid on a per person, per diem basis by the sickness funds. Moreover, health care budgets are formed on a historical basis and no ceilings are applied either for sickness funds or hospital expenditure. Deficits incurred by both social insurance funds and hospitals are transferred to the state budget and are covered retrospectively by social subsidies.

Total health expenditure as a proportion of GDP grew steadily from 6.6 % in 1980 to 10% in 2005. Private health expenditure rose from 2.9% of GDP in 1980 to approximately 5.7% in 2005.[23] More importantly, private expenditure in Greece is primarily constituted by out-of-pocket payments (according to OECD data in mid-2000s out-of-pocket payments amounted to about 96% of total private health expenditure).[24] Extensive reliance on out-of-pocket payments and indirect taxation renders the system highly regressive. Furthermore, as widely discussed in the relevant literature, "equity, efficiency and cost-containment outcomes have persistently been poor in Greece" (see Mossialos et al., 2005; Davaki & Mossialos, 2006; Petmesidou & Guillen, 2008). This explains also why private health expenditure has been growing rapidly in recent years (for an estimation of the constitution and volume of private payments see Siskou et al., 2008, as well as Liaropoulos et al., 2008). As Table 2 shows, private health expenditure per head (in USD Purchasing Power Parities) in Greece is particularly high (highest among South European countries); between 2000 and 2005 it rose by 38% (at a much higher rate than public health expenditure per head).

Regarding the financing mix of the health system, in mid-2000s only a little over 20% of total health expenditure was financed by taxation (with indirect taxes accounting for a large part of it). Out-of-pocket expenses accounted for about 46% of total expenditure, while social insurance contributions covered about 30% of funding. Also, household expenditure data aptly illustrate the rapid increase of private expenditure on health care: from 5.7% of total household expenditure in 1993/94 it went up to 7.2% in 2004/05 (out of this, two-thirds concern direct payments to physicians and the rest drugs expenditure, including co-payments, and hospital care; data from the National Statistical Service).

[22] 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 in the social fund for the self-employed (OAEE, excluding the professions) amounted to EUR 344; the corresponding rates for IKA, OGA and some of the 'noble funds' for public utility employees, like those in telecommunications and electricity, were EUR 635, EUR 648, EUR 1040, and EUR 980 respectively)" (Petmesidou & Guillen, 2008, p. 115).

[23] For the profile of the private health sector in the mid 2000s see ICAP, 2006.

[24] Private health insurance has so far been of limited importance (roughly about 8% of Greeks have private insurance).

Table 2: Health expenditure trends

	2000		2005		2000		2005	
	Public expend-iture (% of total health exp.)	*Private expend-iture*	*Public expend-iture*	*Private expend-iture*	*Per capita public expend-iture (PPS USD)*	*Per capita private expenditure (PPS USD)*	*Per capita public expenditure (PPS USD)*	*Per capita private expenditure (PPS USD)*
Greece	44.2	55.8	42.8	57.2	869	1097	1266	1689
Italy	72.2	27.5	76.6	23.4	1489	564	1894	580
Spain	71.6	28.4	71.4	28.6	1100	436	1602	640
Portugal	72.5	27.5	72.3	27.7	1094	414	1472	564

Source: World Health Organisation, data retrieved from http://www.who.int/whosis/

There have been neither reductions regarding benefits over the past few years, neither any significant changes in co-payments. The latter were introduced in the early 1990s in an effort to contain pharmaceutical costs. On the other hand, a positive list of drugs, introduced at the end of the 1990s, was recently abandoned on the ground that no substantial cost reduction was achieved. Pharmaceutical expenditure has been growing fast and is a major cause of ongoing deficits of sickness funds (on trends in pharmaceutical expenditure see Yfantopoulos, 2008).

There are long waiting lists in public hospitals particularly in Athens and Thessaloniki. This is partly due to staff shortages (owing mostly to low pay rates for both nurses and doctors).[25] Waiting times are not systematically monitored. It is estimated that "there is a six-month waiting time for some surgeries and the wait period for appointments with specialists can be as long as 150 days" (Health Care Economist, 2008).

Concerning rehabilitation and geriatric care, these are largely covered by the private sector, given the fact that the NHS caters for only about one fourth of population needs (including primary care needs).

New legislation over the past few years concerned some minor administrative changes (e.g. the reduction in the number of Regional Management Health Care Agencies from 17 to 7), so as to improve administrative and organisational efficiency and enhance coordination at the central level (Law 3204 of 2004); the use of IT for monitoring and coordinating pharmaceuticals consumption and expenditure across the 30 health insurance funds, and secondary as well as tertiary level health care units (Law 3457 of 2006); c) [wo sind a und b?] changes in the procurement process of health care units (Law 3580 of 2007), with the aim to simplify the ordering procedure (a 15% reduction in the cost of procurement is expected by that (OECD 2007, p. 63)[26)]; d) the introduction of the private finance initiative (Greek

[25] It is estimated that just under one half of authorised medical positions are actually hold by the NHS (Health Care Economist, 2008).

[26] On the basis of this law a central procurement committee was formed in the Ministry of Health with the aim to control and coordinate the whole range of procurements by public health units. The mandate of this committee is to integrate the about 9,000 tenders announced annually by roughly 290 health units under the NHS, for the procurement of 500,000 medical equipment products and 11,000 types of pharmaceutical products, by 1,200 Greek and foreign firms. Particularly concerning pharmaceuticals, the Ministry expects to secure a 40% reduction of procurement costs when the central coordination will be in force, mainly because the new system will speed up payments to pharmaceutical firms and will thus avoid high interest imposed by firms because of payment arrears. Nevertheless, until late 2008 there has not been much progress in respect to central coordination. The new procurement body is still understaffed and poorly functioning, while required hospital supplies are largely purchased in small batches (as regulations allow large-scale purchases only under a centrally coordinated procurement process). Estimates indicate a 30%

acronym: SDIT) by Law 3389 of 2005 that is expected to boost private-public partnerships for funding construction, maintenance and operation of health and social care units (hospitals etc.).[27] Finally, after a protracted period of consultation between the Ministry and the trade unions of public hospital doctors, a new law was enacted in March 2009 that introduces changes in employment terms and conditions of hospital doctors. Regulations concern working time schedules (in accordance with the Directive 2000/34/EU), pay levels, appointment processes and advancement in career paths. Most importantly, the law introduces a new career structure for hospital doctors on the basis of the so-called "multi-director system" according to which after consecutive successful assessments doctors can attain the position of clinical director irrespective of whether such a post is available.[28]

Additionally, law 3697 of 2008 that concerns the "tidying up" of financial matters in local authorities, social insurance organisations, and public health and welfare units, enforces public units (including hospitals and social care organisations) to draft annual budgets, prepare operational plans and use a double-entry bookkeeping system for recording transactions.

2.2.2 Overview of debates/the political discourse

The need for enhancing quality and efficiency of health care has been repeatedly stressed in official reports (e.g. the section on health policy in the NSR 2008-2010) and academic debate. Yet no specific goals and policy mechanisms have been elaborated. In the above report reference is made primarily to the Health and Welfare Inspectorate in charge of periodically carrying out inspections in health and care units (the emphasis is primarily on physical amenities and operational aspects). The report announces, once more, the need for an integrated system for quality and safety issues in the provision of health services, with no specific details as to strategic goals and time frames though. The need for upgrading quality through accreditation processes, standardisation and evaluation procedures is briefly mentioned, but no further details are given of how this will be realised. It is simply stated that a draft bill (that deals with quality issues) is under preparation. Overall, what is presented under the heading of policy priorities for quality in health consists in vague statements on the need for quality assurance.

There is no national service regulation that specifies performance standards required across the whole range of health care providers (that could also supply a basis for uniform costing of services and providers' reimbursement). Inspection can yield only a snapshot of an organisation's activities and performance and produce limited reviews of mainly physical standards, and in itself cannot provide a comprehensive appraisal of quality (that could incorporate stakeholders' participation as well).

Concerning cost-containment, the law on rationalising the procurement process has extensively been advertised by the Ministry; yet, as stressed above, no significant developments have taken place so far in this respect. An attempt made by OECD to trace

increase of hospital expenditure on medical consumables in the second half of 2008. Additionally, the new law increased red-tape between health care units and the Ministry as all demands for supplies need to be endorsed by the central committee. Surely, for any gains to be realised, an effective and efficient planning, budgeting and procurement process is required.

27 Health care infrastructure to the amount of about EUR 800 billion has already been contracted under SDIT.

28 If assessment of a doctors' record is negative, they can apply for re-evaluation after two years; in case of a second negative assessment, the applicant remains in the same rank but gets the salary of the next higher rank and is re-evaluated within a 5-year period. Under this system almost all public hospital doctors will sooner or later reach the rank of director, yet not all of those promoted to this rank can be appointed as clinic directors.

future expenditure commitments produced two scenarios: under a scenario with no cost-containment measures, public spending on health and long-term care, as a share of GDP, from about 5% in 2005 could more than double by 2050; while under "an alternative cost-containment scenario" public expenditure on health and long-term care could reach 9% of GDP by 2050 (e.g. OECD, 2006).

Furthermore, no major developments took place in respect of tackling health inequalities. Given the fact also that there is complete absence of systematically collected (time-series) data on morbidity patterns (and health care needs) among different socio-occupational groups and geographical areas, the issue of health inequalities is only vaguely touched upon in public debate. Equally lacking are any projections as to future health care demand and expenditure (not to mention long-term care needs and expenditure).

Low quality of care in the public system, severe staff shortages (particularly of nurses), waiting lists, and particularly the high deficits of hospitals over the past year[29] constitute the major issues of public debate (in the media, between political parties, the social partners, etc.). In the past year, also employment conditions of hospital doctors were at the forefront of the debate (particularly working times, remuneration and career paths), given the fact that new legislation on this matter was being prepared by the Ministry of Health. Another crucial issue concerns the severe financial problems faced by some major sickness funds. For instance the deficit of IKA's sickness insurance branch amounted to about EUR 2 billion an the end of 2008, while the sickness fund for public employees (OPAD) is almost bankrupt and there are huge payment arrears to contracted doctors and pharmacists. Moreover, in the past year several hospitals ran out of medical consumables, as suppliers refused to supply them because the state had not settled invoices dating some years back.

The policy plans of the major opposition party (PASOK, the Panhellenic Socialist Party) acknowledge most of the above deficiencies of health care and exhibit an intention to improve administrative efficiency through decentralisation of decision making (establishment of local health committees with the participation of local authority and social partners' representatives). They also comprise reforms in hospital administration, establishment of a certification body controlling the quality of services, drafting of a code of good practice, integration of IKA hospitals with the NHS, enhancement of public health expenditure by 1% of GDP, and sufficient appointments so as to fill all authorised positions of medical staff. Overall, PASOK's programmatic commitments on "restoring the NHS" are rather vague, however. Costing measures, obstacles to reform by vested medical interests in the public and private sector, strong resistances to establishing a unified "health care purchasing authority" (that would pool resources from contributions and tax revenues), as well as the issue of how to curtail the expansionary trend of the private sector are not sufficiently tackled by PASOK's programmatic declarations.

2.2.3 Overview of impact assessment

Available studies (amongst others Davaki & Mossialos, 2005 & 2006; Mossialos et al., 2005; Petmesidou & Guillen, 2008) repeatedly stressed the regressive effects of funding and the inequity that results from the progressive shift to private health expenditure: significant regional inequalities in the quantity and quality of services provided are coupled by a diversity of coverage (and contribution rates) across funds and a highly fragmented financing system. Furthermore, available literature demonstrates that, historically, the main obstacles to building a truly national health system in Greece were a serious lack of support by major

[29] Estimated to be currently at about EUR 5 billion (Neta 2009).

social actors, conflicting interests within the medical community, discretionary privileges to particular social insurance funds, and complex ties between the public and private sector fostering corruption and waste of resources.

New legislation that cuts down the number of social insurance funds is a step forward in the elimination of huge discrepancies. Yet, the respective Ministries (of Health and Social Solidarity, and of Employment and Social Protection) have not so far produced any detailed policy document on how pension reform will affect health insurance.

Other issues extensively discussed by available studies are: the oversupply of specialists (but undersupply of nurses), mostly concentrated in the large urban centres; the resulting inequities of access to specialists; significant direct costs faced by patients in the private sector but also in the NHS (under-the-table payments); expensive inputs of the system (like heavy use of expensive medical technologies) contributing to inefficiency.

Academic debate on improving fiscal soundness and transparency in health care by introducing mechanisms for pooling resources, putting in place a uniform costing system based on diagnosis related groups (DRGs) and promoting techniques of measuring outcome, has not triggered so far any significant reforms. Regarding hospital performance monitoring, only very crude indicators of process outcomes are available (e.g. length of stay, occupancy rate and admission rate). Systematic information of the population's health condition is absent, and Greece rarely figures in relevant international statistics (Petmesidou & Guillen, 2008, pp. 118-9).

The annual review (for 2007) by the Health and Welfare Inspectorate – released in mid-2008 – points out many of the above discussed deficiencies: under-the-table payments to doctors and kickbacks for referrals to private hospitals and diagnostic centres, malpractice by doctors, administrative deficiencies and lack of transparency (in some cases absence of computerisation systems and defective inventories of supplies), environmental pollution by hospital waste and other problems. Overall the Health and Welfare Inspectorate carried out inspection in about 500 health and welfare units, issued 450 reports and of them fifty cases were brought to trial.

2.2.4 Critical assessment of reforms, discussions and research carried out

The comment made in the 2007 Joint Report of the European Commission that "the enhancement, integration, and better distribution of PHC services" is the main challenge ahead for Greece continues to be valid, as no significant developments can be recorded so far. Ongoing efforts to integrate and develop primary health care (PHC) have not been successful. Noticeably, in regard of primary health care the NSR 2008-2010 repeats exactly the commitments found in the NSR 2006-2008 (Ministry of Employment and Social Protection 2006), without however specifying any planning mechanisms and policy tools or a time frame for their realisation.

Concerning sustainability, official documents make reference to changes to be effected by legislation introducing a centrally controlled and coordinated procurement system for public health care units, and relevant legislation for the regulation of pharmaceuticals market and expenditure. Nevertheless, hospital deficits kept growing over 2008 and pharmaceutical expenditure rocketed (it reached EUR 8.5 billion in 2008, almost the double value of 2004, which was the last year before the abolition of a positive list for drugs).

Furthermore, sustainability is also linked to the introduction of IT in health care and of measures promoting electronic government. Official documents however provide scarce documentation regarding expected impacts on expenditure (of the relevant legislation) either

in the short term or in the medium term, and any detailed reference as to how cost-effectiveness will be realised is absent.

Similarly, health inequalities because of the diversity of provisions by the health insurance funds, inequalities in the geographical distribution of public primary, secondary and tertiary health units and personnel, as well as the inequalities and deficiencies of health care due to high out-of-pocket payments have repeatedly been acknowledged by the Ministry (see for instance NSR 2006-2008 & 2008-2010). However, in both of these reports no quantitative data are offered for geographical disparities in provision and access (not even any crude indicators of beds/health personnel per inhabitant by region or at any other level of geographical disaggregation). Equally absent are data on health inequalities associated with gender, occupation/working conditions, housing and living conditions. Such data are blatantly lacking in Greece, yet they are extremely important with respect to establishing an efficient and effective planning process in health and social care.

Health information systems are being introduced at a very slow pace and the inadequacy of available information is reflected in "incomplete medical records, absence of quality assessing techniques and reporting methods on resources and outcomes of care, as well as of measures for cost-effective prescribing" (Davaki & Mossialos, 2006, pp. 294-8). The development of an integrated information system (IASYS) for the NHS could be an important step. Meanwhile, however, discontinuity between ambulatory and secondary care persists due to the fragmented character of PHC resulting in flowed information transfer and poor medical records.

2.3 Long-term care

2.3.1 Overview of the system's characteristics and reforms

There has been an expansion of social care services over the past few years but it is noteworthy that provision took off from comparatively low levels. Intervention when problems are compounded often leads to institutionalisation with dubious results; not to mention the serious deficiencies in institutional settings due to lack of resources.[30] Particularly wanting is preventative work as well as fast response to crisis situations for supporting families, lone elderly people (as well as persons with long-term disabilities) in the community (Petmesidou, 2006; Guillen & Petmesidou, 2008).

The system is mixed including direct provision of services, social insurance coverage of care needs, tax exemptions and informal care services. There is also a great diversity of programmes (and modes of cooperation) across public and private for-profit and not-for-profit institutions. Furthermore, EU-wide policy orientations, such as the reconciliation of family and work and the encouragement of women to work, have guided most recent policy measures, largely funded under the CSFs (e.g. establishment of all-day schools and centres of creative activities for children during their off school hours, day care centres for frail elderly people, as well as centres for early diagnosis, counselling, support, education and training of disabled people; Petmesidou, 2006; Guillen & Petmesidou, 2008, pp. 73-7).

Social insurance funds exhibit high inequalities as to the range and quality of services (for long-term care) offered. Per diem costs are 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.

[30] As is for instance the poor progress in respect to the deinstitutionalisation of the mentally ill.

Systematic data on differences in access to care by gender, age, health status, ethnic minorities and geographical location are absent. In an appendix to the NSR 2008-2010 the number of care units by region is presented. Yet, no other indicators regarding, for instance, old-age population distribution and number of units / volume of services provided or other similar indices are offered by official documents (for a study on the geographical distribution of services in relationship to population needs see Petmesidou, 2006).

The interaction between health and long-term care does not constitute an area of significant policy concern. In official documents, as for instance in the NSRs 2006-2008 & 2008-2010 the link between these two care fields is very superficially touched upon, and it is evident that from the mid to late 2000s no major developments took place or are planned to be effected in the near future. Both of the above planning documents make reference to ongoing de-institutionalisation efforts. Yet, in the field of psychiatric medicine, reform grew with very low rates or even stagnated over the past couple of years due to a lack of financial resources (a new agreement between the Ministry of Health and the DG for Employment and Social Affairs was signed in April 2009, with the aim of giving a boost to the de-institutionalisation process of the mentally ill[31]). 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. The above mentioned official planning documents make reference to the further development of these specialised Centres for people with disabilities & centres for rehabilitation, as well as to other programmes like "Home Help" to the elderly and the handicapped (funded partly by national and partly by EU resources). The latter programme has persistently faced financial problems over the past few years. It extensively relies on personnel employed in short-term contracts and inability of the state to secure national resources (in addition to EU funding) often threatened its operation in various localities. Lately, the three ministries that are responsible for this programme (Ministry of Employment and Social Protection; Ministry of the Interior and the Ministry of Health and Social Solidarity) are considering the introduction of a voucher system for eligible persons who will use it for "buying home help services" from the publically run programmes (in local authorities), but also from voluntary and private providers. The voucher system has already been introduced for nursery services so that eligible families can have a choice of either public or private (for profit or not-for-profit) nurseries. Allegedly, the voucher system has increased efficiency by local-authority-run nurseries, and boosted competition with private units; however no studies have so far been conducted for providing empirical evidence on this.

Despite the growing need for long-term care due to rapid population ageing in the next decades, this policy area is rather neglected. There are no systematic data on existing needs and mode of coverage, neither any projections for future numbers of dependent elderly persons (prevalence rates and projections of dependency). Other issues that are highly relevant for planning long-term care are also hardly touched upon by official planning documents – they are the balance between formal and informal care, between residential and open care, past and projected care unit costs and other pertinent information in order to plan ahead how to meet a growing demand. To add here that such a documentation and analysis is notably absent also from "The National Programme for Social Cohesion and Solidarity" (2007) – that is the main planning document for social welfare for the period 2007-2013).

[31] The Greek Minister for Health assured the European Commission that this time the Greek authorities will provide the required financial resources so as to achieve considerable progress until 2015.

2.3.2 Overview of debates/political discourse and impact assessment

Long-term care is not a prevalent issue in public debate (and political discourse), and, generally, social care constitutes a chronically ailing and highly deficient policy area in Greece. The family and, particularly, women have traditionally been the main providers of social care. To the extent that statutory care developed it was geared towards institutional care, albeit falling far short of existing needs (and catering mainly for the most deprived). Personal social services (at the local/municipality level) have so far been minimal and patchy. Developments over the past decade or so (i.e. the expansion of the programme of domiciliary care for the elderly, the establishment of day care centres for frail elderly people, or of centres for early diagnosis of disability, counselling and vocational training to disabled citizens and other similar projects targeted at specific vulnerable groups) have extensively relied on EU initiatives and funding.[32]

A major issue stressed in the rather thin literature on this matter focuses on the changes to the "familialist" pattern in social care that traditionally characterised Greece. As the strains upon the family grow, due to the decline of traditional family and kin structures, and changing gender patterns, coupled with demographic trends, the family's capacity as care and welfare provider has been weakening significantly. This is further compounded by the fact that the social protection system in Greece is hardly geared towards protecting the family. Family benefits are comparatively low, statutory personal services remain patchy and no major foci of specialised care development, regulation and coordination are formed; while on the other hand a fast expanding informal market has been witnessed over the past decade. As a result, inequalities increased among social groups in terms of coverage of social care needs.

Growing demand for care services, due to changing family patterns and increasing female employment rates, combined with demographic ageing and a steadily increasing number of lone elderly people, is met by female migrant labour (either as co-residing or day care minders, Guillen & Petmesidou, 2008, p. 75). Thus a mode of informal privatisation in care arrangements is emerging, particularly among middle and higher income groups) where the family still plays a coordinating role but care tasks are undertaken by foreign minders (see also Cavounidis, 2006 and Lymberaki & Tinios, forthcoming).

The deficiencies of the system of statutory care are also reflected in the poor coordination of available programmes and institutions. Official documents have repeatedly announced the intention of the Ministry of Health to develop an "Atlas of Social Services" for mapping available services, pooling information and promoting coordination. Such a project was initially announced in the early 2000s – by the then Ministry of Health and Social Welfare – with little success though until recently. The intention to develop and update such a project that figures as an important priority in successive official documents (e.g. NSRs, CSFs & National Strategic Framework 2007-2013), is strikingly incongruent with the negligible action taken so far.

As in the case of health care, reference to issues of quality of long-term care in official documents is linked to the operation of the Health and Welfare Inspectorate (the comments made above hold for long-term care, too); as well as to accreditation of non-profit institutions providing long-term care services by the Social Protection and Solidarity Institute (under the auspices of the Ministry).

Quality issues are not a major concern in official reports, and this partly reflects the absence of a wider debate on mechanisms of quality appraisal and evaluation in social care, not to

[32] And often discontinuation of EU funding seriously threatens the operation of some of these comparatively recently established programmes.

speak of users' involvement in quality assessment. To mention here, that in the early 2000s, within the context of the establishment and operation of a number of social care centres (under the 2nd, and continued under the 3rd CSF) a couple of studies were carried out by the then Ministry of Health and Social Welfare on developing performance indicators for both residential care and open care programmes. Nevertheless, a coherent and efficient planning process (encompassing monitoring procedures, quality appraisal and overall performance evaluation, with the involvement of beneficiaries) has hardly developed so far.

2.3.3 Critical assessment of reforms, discussion and research carried out

Sustainability of long-term care is very poorly addressed in the most recent official planning documents (e.g. "The National Programme for Social Cohesion and Solidarity" 2007-2013, and the NSR 2008-2010). In a manner of "wishful thinking" the NSR 2008-2010 expresses the intention of relevant authorities to use efficiently all the available national resources as well as external ones (EU and other international resources) in order to meet demand. In addition, the private financial instrument (SDIT) introduced by legislation passed a couple of years ago is considered to contribute to the improvement and expansion of new care units.

Official documents on long-term care suffer from a paucity of data on expenditure trends, demographic changes and any short-term or medium-term projections of how to meet growing demand. Equally marginal is any concern with equitable financing (progressive taxation and contributions, risk pooling, etc.), coordination between medical and care services, and the many factors involved in measuring quality in social care (like measures of satisfaction and unmet need, support provided to family caregivers, consumer choice, the use of assistive technologies etc.).

Consequently, the main challenges stated by academic studies and EU reports for long-term care – namely to promote coordination and networking, improve information channels and research that generates empirical evidence, and create a comprehensive framework for evaluating the quality of services provided – continue to be of utmost importance for the future.

3 Impact of the Financial and Economic Crisis on Social Protection

In Greece GDP growth decelerated to 2.9% in 2008, while for 2009 a marginally positive growth rate or even slightly negative growth is anticipated by the European Commission (as well as the Bank of Greece; an even higher growth is forecasted by the Ministry of Economy and Finance, 1.1%). By the end of 2008, unemployment reached 8.9%, while in January 2009 it jumped to 9.4% (the number of unemployed amounts to about 450,000; 52% of them are long-term unemployed, not eligible for benefit).

Key sectors of the economy such as tourism, construction (and shipping) are particularly hard hit by the global financial and economic crisis due to falling domestic and foreign demand, while effects are held to be felt more widely and deeply in the months to come (predominantly in the tourist sector). Greece also records a considerably high fiscal deficit (according to recent data 5% of GDP in 2008), as well as a high public debt (over 95%). Thus, in terms of fiscal measures Greece faces severe challenges under conditions of an economic downturn, which, at the same time, also press for higher social spending.

Since autumn 2008, various recovery packages and specific measures have been decided by the Government. These do not constitute a comprehensive plan but target distinct fields:

a) Major emphasis has been given on enhancing liquidity in the funding market (e.g. with law 3723/9-12-2008 a EUR 28 billion stimulus plan was decided for the banking system so as to increase liquidity to the Greek economy).

b) Over the 2000s and until the onset of the present financial crisis bank credits to households (mortgage and consumption loans) increased considerably. However hiking interest rates at the onset of the crisis increased the likelihood for households to default on their payments and forced sales of property in auctions rose considerably. For protecting mortgage holders a bill was passed by Parliament that raised the ceiling under which property could be sold at auction, because of overdue loans, from EUR 10,000 to EUR 20,000.

c) Supporting SMEs[33] -and particularly preserving existing jobs in SMEs- is a major priority. The Credit Guarantee Fund for Small and Very Small Enterprises (TEMPME) facilitates access to financing by small enterprises (the Fund provides guarantees to credit institutions and subsidises interest rates). Also, recently, the duties on accommodation paid by hotels to local authorities have been abolished (though local authorities expressed disagreement with this measure because it affects negatively their revenues, and demanded counterbalancing policies).

d) In April 2009 a reduction of a special (registration) tax on the purchase of a new car was announced (to be in force until early August 2009), so as to boost the car market (and refrain car dealer businesses from sacking employees). This is however a dubious measure, given the fact that there are no car factories in Greece and gains will be exported to car-producing countries. Furthermore, reductions are significant in large cars that are addressed to middle and high income groups, who seem to benefit from this measure more than lower income groups.

e) A package of active labour market measures planned under the National Strategic Reference Framework 2007-2013 as well as under the NSR & NRP, are implemented by the Manpower Organisation (OAED):

These include subsidised employment schemes for young workers entering the labour market (and particularly women), for unemployed workers in regions severely hit by enterprise closures and economic restructuring, start-up funds to young professionals and various training programmes for the unemployed (including disabled persons and cultural and religious minorities).

Furthermore, a policy of converting the unemployment benefit into employment subsidy has recently been decided to be implemented both in the private and the public sector (including local authorities). It is estimated that in a time-span of three years this measure will benefit about 60,000 unemployed (subsidies by OAED will also cover social insurance contributions for up to 24 months). This policy measure is considered to enhance activation and increase choices in the labour market. However, the Confederation of Greek Labour (GSEE) and the Supreme Administration of Greek Civil Servants Trade Unions (ADEDY) expressed scepticism about eligibility criteria that have not been clearly specified so far. Also, local authorities expressed worries about their ability to cover the extra cost (i.e. the difference between the rate of unemployment benefit and the basic salary with which unemployed will be hired) for participating in this programme. There are good reasons for such a worry as a source of revenue for LAs from the tourist sector has been eliminated (as mentioned above).

[33] Roughly 98% of Greece's businesses employ up to 10 workers.

f) In late April, also, the Minister of Employment and Social Protection announced a support project for workers in enterprises that shifted (or intended to shift) to a 3-day or 4-day work week under the current crisis (including workers temporarily laid off). A subsidy for attending training programmes at the enterprise level will be provided to them that equals the loss of earnings resulting from the reduction of working days.

g) In respect of social assistance a major development is the launch of the operation of the National Social Cohesion Fund (ETKS, established by law in 2008 with the aim to design and implement income support schemes to vulnerable groups with incomes below the poverty line, and also provide documentation on income support needs and policy programmes). Initially, a budget of EUR 500 million was planned for 2008 for the fund, that would gradually increase to EUR 2 billion by 2010 (so that the fund could provide an income support of about EUR 1,000 to 2 million people falling below the poverty line, e.g. with incomes below 60% of the median equivalised income). Such policy objective, if realised, would be a significant step towards introducing a universal safety net that is still lacking in Greece. However, little progress has so far been made in bringing the fund to full operation. Its budget for 2009 amounted to only EUR 350 million. Out of this budget a one-off benefit payment to low-income pensioners, unemployed persons, disabled persons under the welfare benefit scheme and other low-income vulnerable groups was provided by the fund (amounting to EUR 230 million). The level of the benefits varied according to geographical area and ranged between EUR 100 and EUR 200.

Other specific income support measures include the provision by OAED of a double Christmas and Easter bonus to unemployment benefit recipients. Also a recently passed law (3576/16-2-2009) makes provision for a special one-off benefit amounting to up to EUR 1,000 to unemployed persons registered in OAED who face severe hardship. Yet, no further details about eligibility and other aspects of the programme implementation have been announced until now.

h) The recently decided income policy measures for the public sector constitute a response to the crisis. They reflect an attempt to curb public expenses and boost revenues as well as target support measures to low-income groups. Initially, a 2.5% increase of salaries of public employees was considered (on the basis of a forecast for 2-2.5% inflation rate for 2009). However, according to a recent bill voted by Parliament, salaries and pensions in the public sector will freeze. A one-off benefit (for the current year) to low-income employees and pensioners of the public sector has also been decided. This specific benefit is tax and contributions-exempt and amounts to EUR 500 for public employees with gross earnings up to EUR 1,500 (excluding the family benefit), or EUR 300 for those with gross earnings above EUR 1,500 and up to EUR 1,700 (for pensioners of the public sector the respective thresholds are: a gross pension up to EUR 800 for receiving a one-off benefit of EUR 500, and over EUR 800 up to EUR 1,100 for receiving a benefit of EUR 300). Additionally, the above bill introduced a specific tax (ranging from EUR 1,000 to EUR 5,000) to be charged on incomes over EUR 60,000.[34] If one also takes into consideration that thresholds for calculating income-tax rates have not been adjusted for inflation for some time, it is apparent that middle-income families will see their incomes significantly squeezed.

As to the private sector, according to the Collective Labour Agreement, wage/salary increases for 2009 were set at 5.5% (and 6.5% for public utility corporations).[35] However, it is highly likely that the salary freeze decided for the public sector will be a precedent for employers to avoid honouring this collective agreement provision (already a steel industry in Thessaloniki

[34] For the income bracket EUR 60,000 to EUR80,000 the charge will be EUR 1,000, while for higher incomes the charge is set at EUR 5,000.

[35] Increases refer to the minimum wage/salary.

has appealed to the Organisation of Mediation and Arbitration for disregarding the agreement obligation on wage raise).

i) There are multiple effects of the financial crisis on social security schemes too. First, the Funds assets have been severely hit by the financial crisis; their portfolio in stocks recorded significant losses (around 80%; to mention also the structured-bonds fiasco that erupted in 2007 which led to the devaluation of assets of about EUR 750 million invested in toxic bonds).[36] Second, contributions evasion has considerably increased and loss of revenue due to uninsured labour mounted over the last few months. According to the Institute of Labour (INE) of GSEE, arrears in contribution payments to IKA have increased by 25% since January 2005 (and uninsured labour is estimated to have increased by 15% in the same period). Third, rising unemployment and wage freeze will also impact negatively on the finances of social security funds. Under these conditions INE forecasts a severe strain on IKA's sustainability in the immediate future (as well as on most other funds).

A more optimistic approach is held by the Government that expects to offset any negative impacts by cost cutting initiatives to follow from the administrative reform of social security that is under way (amalgamation of funds stipulated by Law 3655 passed in 2008) and the new institutional framework for the management of assets (introduced by a law passed in 2007). However, such a forecast is hardly based upon solid (quantitative) evidence. On the contrary, IKA turns out to be burdened by the debts of the Funds of Public Utility Corporations and Banks (amalgamated into it), as stressed in Chapter 2; the Social Insurance Fund for Self-Employed Workers (OAEE) faces serious financial problems, while both the Welfare Fund of Public Sector Employees (TPDY) as well as the Organisation for the Health Insurance of Public Employees (OPAD) are almost bankrupt.

Finally, a measure for boosting the construction industry and promote the Workers' Housing Organisation (OEK) policy for addresssing housing needs of low-income families, is under consideration by the Government. This concerns a deal between OEK and construction businesses that have a stock of unsold new apartments (mainly in Athens), which will allow OEK to buy at affordable prices some of the available stock so as to cover the housing needs of households eligible for support under OEK's regulations.

[36] In late 2006 the Funds assets amounted to roughly about EUR 29 billion (information obtained from the Ministry of Employment and Social Protection); yet there are no available data on their present value.

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4 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.

[R1, R2 & R3 / L] GUILLEN, Ana and PETMESIDOU, Maria, "The public-private mix in Southern Europe: what changed in the last decade?", in Seeleib-Kaiser M. (ed.) "Welfare state transformations. Comparative perspectives". Houndmills, Basingstoke: Palgrave Macmillan, 2008.

This chapter reviews from a comparative perspective trends in financing, organisation and governance of welfare systems in Greece and Spain (remarks on Italy and Portugal are made too). The first part offers an overview of major reform challenges and interventions in the last few years; while the second and third part examine funding trends and modes of regulation and delivery in respect to four major social policy areas (social security, employment policy, health and social care). The authors are particularly interested in how far South European countries, that considerably differ from North-West Europe in regard to historical precedents in administrative capacities, and particularly in social planning practice and machinery, have responded to increasing pressures for new regulatory and financing structures in social welfare, which are prevalent across the EU (emergence of an enabling state and decentralisation of service management and delivery; encouragement of partnerships between public-private agents; and the rise of a contractual culture in the public sphere, in parallel with new modes of intervention from the centre through a host of arm's length regulators and auditors).

[R1 & R2] NEKTARIOS, Miltiades, "Ασφαλιστική Μεταρρύθμιση με Συναίνεση και Διαφάνεια", Athens: Papazisis, 2008.

"Pensions Reform on the Basis of Consensus and Transparency"

The author proposes a new pension system for Greece on the basis of the "Swedish Model". Starting from the premise that after 2015 social insurance funds and the state budget will not be able to honour the pension promise made to future pensioners, he foresees an abrupt disruption of social cohesion and eventually significant reductions in pension benefits. A way to avoid this impasse is to switch to a capitalisation system of supplementary pensions and promote coordination of regulations for both basic and auxiliary pensions, with the aim to reduce total macroeconomic cost. Capitalisation will require about 15 years for rendering results, and surely benefits would already have been felt, if such a change had been introduced much earlier. The author develops three different operation plans, on the basis of which the suggested reform can be accomplished in the four-year period from 2009 to 2012. The proposed new system will cover those insured since 1993 and it will be a variation of the "Swedish Model" that, according to the author, guarantees equal treatment of all insured persons and operates on the basis of "Individual Accounts".

[R] PAPARRIGOPOULOU-PEHLIVANIDI, Patrina, "Ο Νέος Ασφαλιστικός Νόμος", 3655/2008, Athens: Nomiki Bibliothiki, 2008.
"The New Law on Social Insurance"

The book provides a detailed presentation of the social insurance law enacted in 2008 (on the "Administrative and Organisation Reform of the Social Insurance System"). In the first part the main points of the legal reform are succinctly presented and the principal issues in respect to the implementation of the law are discussed. A detailed examination (from a legal perspective) of every clause of the law follows. An index, by Social Fund, of new regulations and adaptations of previous legislation is also included.

[R2] TINIOS,Platon, "Η οριοθέτηση της κοινωνικής πολιτικής και της επαγγελματικής ασφάλισης σε κατακερματισμένα συστήματα κοινωνικής προστασίας: η Ελληνική κοινωνική ασφάλιση 1992-2008", in Proceedings of the International Conference of the Hellenic Social Policy Association (on Social Reform and Changes in the Public-Private Welfare Mix), Athens: Ellinika Grammata (to be published in 2009).
"Drawing the boundaries of social policy and occupational insurance in fragmented social protection systems: social insurance in Greece, 1992-2008"
In fragmented social protection systems social insurance is provided by different funds organised along occupation, economic sector or enterprise. In these cases it is difficult to conceptually define what part of provisions derives from occupational insurance and what part constitutes social protection. This ambiguity is largely due to a confusion of roles undertaken by the state – as employer, as share-holder of public or semi-public corporations, as regulator and guarantor of social insurance. As the author stresses the need for clearly drawing the boundaries between these two components (namely, occupational and social protection provisions) is required on the following grounds: (a) equality of rights, (b) EU regulations that define occupational benefits as part of wage/salary while state funding in this case is considered to breach the competition law by favouring specific enterprises, and (c) the international accounting standards. Greece has been addressing this issue since the early 1990 in respect to public corporations (like public banks, DEH - the Public Electricity Corporation, and other utilities). Out of this emerged some new auxiliary funds for the above corporations and banks. The author critically examines the origins of the problem and solutions given so far with a view to future effects on the structure of social insurance in Greece.

[R1, R2 & R3] For a discussion of Law 3655 from a legal perspective see: (a) Επιθεώρηση Δικαίου Κοινωνικής Ασφαλίσεως - Review of Social Insurance Law, Vol. MI, 2008. And (b) The discussion forum on social insurance in Greece of: Ένωση για την Προάσπιση των Κοινωνικών Δικαιωμάτων" – Association for the Support of Human Rights (http://www.epkodi.gr).
The latter website comprises a number of short commentaries on Law 3655/2008 mostly written by lawyers.
Articles in these two sources lay emphasis primarily on legal issues and incompatibilities, e.g. between Law 3655/2008 and specific Constitutional clauses concerning the assurance and promotion of insurance protection, or incompatibilities with the European Code for Social Insurance, that also requires an actuarial study prior to a major structural reform which changes provisions and funding regulations. Furthermore, the principle of proportionality (as this is legally defined) is mentioned in this respect. Namely, as stipulated by constitutional law, when for a group of persons an unfavourable measure substitutes a favourable regulation, objective criteria should be used that account for this reform on the basis of public interest; while at the same time it should be indicated that in order to fulfil the pursued aim there was no other equally effective but less unfavourable measure that could be used.

Classification code: mostly discussions from a legal point of view.

[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

[H1 & H4] GUILLEN, Ana and PETMESIDOU, Maria, "The public-private mix in Southern Europe: what changed in the last decade?", in Seeleib-Kaiser M. (ed.) "Welfare state transformations. Comparative perspectives". Houndmills, Basingstoke: Palgrave Macmillan, 2008.

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[H1] LIAROPOULOS, Lycourgos, SISKOU, Olka, KAITELIDOU, Daphne, THEODOROU, Mamas and KATOSTARAS, Theofanis, "Informal payments in public hospitals in Greece", Health Policy, 87, 2008.

The paper examines the size and nature of informal payments to health personnel in public hospitals. Informal payments are made in order for patients to get quicker access to services and preferred providers. The authors used a randomised country wide sample of 1616 households (amounting to 4738 individuals, of them 336 reported treatment in public hospitals), and data were collected on the basis of telephone interviews (the questionnaire was supported by the software of Computer Assisted Telephone Interviewing). Out of the total number of those persons that had treatment in public hospitals about one third reported at least one informal payment to a doctor. About 40% of these stated that the payment was given because of fear of getting sub-standard care, while 20% reported that the doctor demanded such a payment. Surgical cases showed a comparatively high probability for extra payments (137% compared to non-surgical patients). The paper concludes that "despite near universal coverage of the population by public health insurance, informal payments are widespread and a major source of inequity and inefficiency in the Greek health care system".

[H1 & H4] PETMESIDOU, Maria and GUILLEN, Ana, "'Southern-style' national Health Services? Recent reforms in Spain and Greece", Social Policy and Administration, 42/2, 2008

This article analyses recent changes in the Greek and Spanish national health services. The aim is to assess how the period of austerity and further recovery during the 1990s and 2000s impacted on them in terms of equity and efficiency. This is of relevant interest because of the closeness in time between the universalising reform laws and the arrival of the conditions for economic convergence established in the Maastricht Treaty of the EU. The analysis is also attractive because it deals with the transformation of already mature health insurance systems into national health services, a transformation that is novel in European welfare history. The article addresses the questions of whether austerity has hindered full implementation of the reform laws enacted in the early-mid 1980s. With this purpose, the article examines reform trajectories and financing and expenditure trends. Furthermore, it considers the impact on access, understood in terms of population coverage, the array of services provided, waiting lists, and territorial inequalities. Finally, it discusses the introduction of new managerial formulas and attempts at enhancing efficiency. The concluding section states the fact that divergent trajectories have occurred, thus rendering the definition of a "Southern model of health care" difficult. It also provides explanations of the trajectories followed in both national cases and informs on prospects for the future.

[H1 & H3] SISKOU, Olga, KAITELIDOU, Daphne, PAPAKONSTANTINOU, Vasiliki and LIAROPOULOS, Lycourgos, "Private health expenditure in the Greek health care system", Health Policy, 88, 2008.

The authors attempt to throw light on the reasons of the high private expenditure in Greece despite the fact that there is almost near universal health insurance coverage. Greece today has the most "privatised" health care system among EU countries (they call this feature "the Greek paradox"). Data were collected from a randomised countrywide sample of 1616 households (it is the same sample as in publication number 2 above) and regression analysis was used for examining the extent to which some characteristics of households influence the size of payments for health services. The findings of the statistical analysis are the following: out of the total private health expenditure 66% concerns outpatient services, with the largest share covering dental services (31.1% or 1.5% of GDP). The rural population seeks private outpatient care more often, because of the deficient primary care facilities in rural areas. A little less that 15% of household private health expenditure concerns hospital care (and one-fifth of this consists in informal payments in public hospitals). The authors conclude that "the rise in private health expenditure and the development of the private sector during the last 20 years in Greece is associated with public under financing".

[H6] YFANTOPOULOS, John, "Pharmaceutical pricing and reimbursement reforms in Greece", European Journal of Health Economics, 9, 2008.

There is a centralised pharmaceutical price regulation in Greece, with the National Drug Organisation (EOF) being the main regulatory authority (under the auspices of the Ministry of Health and Social Solidarity). The paper examines the trends in pharmaceutical pricing in the country since 1998 when a positive list of drugs was introduced with the aim to contain costs. It uses econometric models to assess effectiveness of the positive list. The findings indicate that after a short-term reduction, pharmaceutical expenditure grew as fast as it did before the introduction of price control mechanisms (over the period 1998–2003 the average annual increase of pharmaceutical expenditure stood at 7.9%, a rate that is among the highest in the OECD countries). In 2006 new legislation was passed with the aim to increase access to medicines and promote efficiency in the utilisation of health resources and transparency in public management. The innovative characteristics of the recent reform are critically discussed. As the author stresses "the innovative aspect of the new legislation is the

abolition of the positive list and the establishment of a rebate system granting the National Insurance Funds a rebate rate paid by the pharmaceutical companies."

[L] Long-term care

[L] GUILLEN, Ana and PETMESIDOU, Maria, "The public-private mix in Southern Europe: what changed in the last decade?", in Seeleib-Kaiser M. (ed.) "Welfare state transformations. Comparative perspectives". Houndmills, Basingstoke: Palgrave Macmillan, 2008.

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[L] LYMBERAKI, Antigone and TINIOS, Platon, "Η προσφορά και η ζήτηση αλληλεγγύης στην πράξη: συγκριτική ανάλυση πρακτικών φροντίδας από και προς άτομα άνω των 50 ετών στην Ευρώπη", in Proceedings of the International Conference of the Hellenic Social Policy Association (on Social Reform and Changes in the Public-Private Welfare Mix), Athens: Ellinika Grammata (to be published in 2009).

"Supply and demand of solidarity in action: comparative analysis of care provision by and to persons 50 years and over in Europe"

The paper uses data on demand and supply of care services among people 50 years and over, collected in the context of the SHARE project that covers 12 European countries (including Greece). It focuses primarily on informal care and attempts to map demand and provision. It classifies care services according to need (personal care, social activities, health care etc.) and examines also gender differences (in demand and supply). Although it is not a detailed study on Greece, it offers valuable information. The main argument supported by the data is a differentiation between North-West European countries where statutory care is prevalent (and informal care supplementary), and South European countries where informal care is dominant. A major question asked is extent to which welfare state structures influence the supply and type of personal services.

5 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 (ΙΚΡΑ) – 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
Email: mtopali@ekke.gr
Adress: 14-18, Mesogeion Street, 115 27 Athens, Greece
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
Email:	politis@iobe.gr
Adress:	11, Tsami Karatassou Street, 11742 Athens, Greece
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
Email:	kepe@kepe.gr
Adress:	11, Amerikis Street, 106 72 Athens, Greece
Webpage:	http://www.kepe.gr

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/employment_social/progress/index_en.html