Country Document 2013

Pensions, health and long-term care

Greece

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On behalf of **European Social Policy Network (ESPN)**
DG Employment, Social Affairs and Inclusion

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1 Executive Summary

Since 2008 Greece has been in a deep and prolonged economic crisis and future forecasts remain grim. GDP will be contracting for a sixth consecutive year, while unemployment reached 27.6% in mid 2013 (and youth unemployment rocketed to 60%). The long-awaited return to growth is an issue of contention. Besides, forecasts by national and some international bodies for a return to positive growth next year (0% to 0.6%) do not allow much scope for optimism, as they continue to project a very anaemic trend over the longer term. The issue of a significant fiscal gap over 2015 and 2016 remains open, and fuels alternative scenarios about a protracted continuation of harsh austerity measures.

Fiscal consolidation under the bailout plans embraced successive rounds of cuts in wages/ salaries and pensions, increasing employment flexibility (and dismantling of labour rights), drastic reduction of public spending and rising direct and indirect taxes (including special levies). Pension and health care reform has been prominent in the context of structural adjustment. In these two major policy areas reforms are continuing and embrace a mix of structural changes, recalibration measures and rolling back of public provision.

The path-breaking pension reform introduced in 2010 is being phased-in (implementation of the multi-pillar system will come into force in 2015). From January 2013 pensionable age increased by two more years across social funds (from 65 to 67) and a new unified auxiliary pension fund was established, into which the major auxiliary funds of the private and public sector have been amalgamated. In addition, a new actuarial formula has been legislated that will strictly adjust benefits to available revenues. Further cuts to current retirees' incomes are in place since January 2012. Drastic downward pension adjustments for current and future retirees increase insecurity. System sustainability (even in the medium-term) is in danger too, mainly due to the fast decreasing revenues of social insurance funds in addition to the over 50% losses on their bond holdings that incurred in spring 2012 (because of their inclusion in the PSI – that is, the Private Sector Involvement in a complex bond-swap programme implemented as part of the rescue plan).

In health care major developments over the last few years embrace the amalgamations of health insurance fund into a unified organisation (EOPYY), the restructuring of the public hospitals map, higher control over medical prescriptions (through e-prescribing and e-diagnosis systems), the development of clinical protocols, new pricing rules for pharmaceuticals, changes in procurement processes and a greater penetration of generics. Other cost-affecting measures include cuts in health personnel salaries and overtime payments, freeze of appointments and increase of workload. Overall, in terms of cost-containment the electronic (outpatient) prescription system has been successful so far. Yet, rising user charges, rolling back of public provision, and rationing through increasing waiting times and other blockage mechanisms have serious negative effects on access, equity and service quality. The human cost of austerity may have not been highly visible yet, but an alarmingly rising number of uninsured and increasing unmet medical need (even among the insured population) makes a perilous future of a "humanitarian crisis" highly likely.

Finally, long-term care remains a little developed policy area. Austerity-stricken local authorities face great difficulty to continue delivering a number of social care programmes (home help, day-care centres etc.). Moreover, integration and consolidation of fragmented provision is not an issue of public debate under the auspices of local authorities (through public/ private networks, partnerships etc.).

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

Pensions are based on the public (first) pillar that constitutes a pay-as-you-go system. It provides basic and auxiliary pensions. Social insurance funds are self-governing bodies operating under the auspices of the Ministry of Labour, Social Insurance and Welfare and managed by representatives of employees, employers and the state. Public pillar pensions are defined-benefit. Law 3029 of 2002 introduced a second pillar provision (occupational pensions), but so far voluntary occupational pension plans (as well as private pension schemes) are of minor importance.

Until the late 2000s the system was characterised by a high degree of fragmentation across sectors of employment and occupational categories with great inequalities in terms of funding and the range and level of benefits. Law 3655 of 2008 drastically reduced the number of social insurance funds from approximately one hundred thirty to thirteen, in an attempt to improve administrative efficiency and create the conditions for progressively harmonising entitlements and provisions. Yet, changes almost remained on paper and the system's complex structure was kept more or less intact, as the numerous constituent units of the amalgamated funds retained their distinctive characteristics and regulations.

The need for rationalizing the pension system has been an issue of top priority in the context of Greece's bailout plan. Following the first "Memorandum of Understanding" (MoU) that Greece signed with its international lenders in May 2010, a "path-breaking" pensions overhaul was approved by Parliament in mid-2010 (laws 3863 and 3865 of 2010, concerning respectively the private and public sector). New legislation introduced a major a shift from a greatly fragmented, Bismarckian social insurance system (based primarily on the first pillar), to a unified, multi-tier system that distinguishes between a basic (quasi-universal) non-contributory and a contributory pension. Also the 13 social insurance funds were amalgamated into four major funds: (a) IKA, the social insurance organisation for private sector workers that – since January 2011- includes new entrants into the public sector as well, so as to become the fund for all wage and salary earners; (b) OAEE, the social insurance fund for self-employed workers (excluding professionals); (c) OGA, the farmers' retirement fund; and (d) ETAA the unified fund for independent professionals. The latter fund was set up by Law 3655/2008 providing the amalgamation of distinct schemes for various liberal professions (lawyers, engineers, medical doctors and others).[1]

The pension system continues to be reformed. With law 4093/2012 that went into force in January 2013 retirement age increased from 65 to 67 years (and with 40 years of work from 60 to 62 years). Due to great delays in the administrative processing of retirement applications,[2] law 3996/2011 and 4151/2013 made a partial payment of pension benefits

[1] For a brief review of the 2010 reform see Annual Reports on Greece for 2011 and 2012. See also Matsaganis 2011 and Petmesidou 2013a and 2013b). For the stalemate over a comprehensive pension reform in the previous decade and how this contributed to the crisis see Lymberaki and Tinios 2012; also Tinios 2012 and 2013.

[2] In certain cases, a year or more (depending on the social insurance fund and whether the retiree has "sequential insurance", that is, during his/her working career had been successively covered by different insurance schemes).

possible. This applies for benefits amounting up to 80% of the basic pension to which the retiree is entitled (in the case of private sector retirees), or to 50% of the last (basic) salary of the retiree (in the case of public sector retirees). Also, the latter law made the carrying out of a census of public sector pensioners mandatory every five years.

Most importantly, law 4052/2012 revised the auxiliary pensions system and lump sum benefits. It established a single auxiliary pensions fund (ETEA) which started operating in early 2013 through the merging of most of the existing auxiliary pension schemes (ETEAM, the auxiliary pension scheme of IKA; TEADY, the auxiliary pension fund for public employees; TAYETEKO, the respective fund for employees in public utility organisations, and some others).3 The law also defined a new formula for calculating auxiliary pensions and the lump sum benefit entitlement that will come into effect in 2014.

With article 101 of a recently approved omnibus law (4172/2013) a social insurance debt collection centre is established. Initially it will deal with contributions arrears in the four major social insurance organisations (IKA, OAEE, OGA and ETAA); while by the end of 2016 the required preparatory work will have to be accomplished for a unified system of tax and contributions collection.

Moreover, since 2010, successive legislative acts (laws 3968/2011, 4024/2011, 4052/2012 & 4093/2012), following the stipulations of the MoU, have provided for significant in present day retirees incomes (see section 2.2.1 below).

2.1.2 System characteristics

Laws 3863 & 3865 of 2010 significantly changed the structure of the pension system, accrual rates, years of paid contributions required for standard or early retirement, and pensionable income. The new multi-tier system distinguishes between a basic (quasi-universal) non-contributory (flat rate) pension, and a contributory pension. In addition, a third and fourth pillar of occupational pension schemes and private insurance respectively could be added. The amount of the basic pension is set at 360 euros (but may be reduced if economic performance deteriorates), and the contributory part is linked to paid contributions. The basic pension is granted to old-aged uninsured persons (including people who paid contributions for less than 15 years) provided they fulfil certain requirements.

New arrangements will take effect from 2015 onwards in a phased way. Namely, for the period prior to 2011 pensions will be calculated on the basis of pre-reform regulations, while from 2011 there will be two constituent parts, a basic pension and a contributory one. Accrual rates will range from 0.8% (for up to 15 years of work) to 1.5% (for 40 years of work) of pensionable income that is based on the entire working career (instead of the last five years of work according to previous legislation). Retirement age was set at 65 years across all schemes. But in late 2012, a further increase to 67 years was legislated, as mentioned earlier. The 2010 pension reform laws embrace also the provision that the statutory retirement age for men and women will be revised from 2021 onwards (and every three years) so as to reflect changes in longevity.[4]

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[3] A number of auxiliary pension funds (for instance, the fund for employees in the food trade sector and the fund for employees in insurance firms) opted to remain independent with the view to be transformed into occupational funds. Yet, already auxiliary pensions in the above mentioned funds were cut by 30% from March 2013 due to serious funding problems.

[4] When this will be first implemented, the change over the period 2013-2020 will be taken into account.

Auxiliary pensions have so far been part of the public (first) pillar and were defined-benefit schemes. Currently, less than 50% of pensioners receive an auxiliary pension (according to data released by "HELIOS", the newly established unified control system of pension payments). Law 3655/2008 stipulated a 20% ceiling for auxiliary pension replacement rate across schemes by 2013. However, this regulation has been superseded by more recent legislation (mainly Law 4052/2012, and legal enactments for successive cuts in auxiliary pension benefits).

According to Law 4052/2012, the old defined-benefit system (of auxiliary pensions) turned into a "notional defined contributions" version (that will operate on the basis of individualized pension accounts). This will be topped up by a "sustainability factor" that will revise existing and future pensions through an indexation formula that takes into account the amount of revenues through paid contributions, as well as demographic characteristics. Given the fact that under the new system from 2015 onwards public involvement in pensions will cover only the basic (flat rate) pension, the contributory (main) schemes and auxiliary schemes should not incur any deficits (as any transfer from the national budget is precluded). Hence the need for an actuarial formula that periodically adjusts benefits to available revenues. Similar considerations underlie the new formula for calculating future lump sum entitlements. In the coming months strong efforts are required to implement the reform, in particular the organisational aspects of ETEA and the setting up of individualised pension accounts.5

Additionally, the reform laws of 2010 provide for an annual adjustment of pensions (from 2014 onwards) on the basis of a coefficient drawing on GDP fluctuations, the consumer price index and the financial situation of pension funds.

Under the MoU it is required that by the end of 2013 the government will provide a plan for the reduction of the employers' contribution by 5 percentage points. A reduction of 1.1% has been facilitated by the abolition of a 0.75% contribution for the Workers Housing Organisation and 0.35% for the Workers Welfare and Recreation Organisation. An alternative proposal by the government for a further, gradual reduction of contributions over the next three years by 3.9 percentage points is currently under negotiation with the "troika" (the three international creditors, EC, ECB and IMF). Regarding public utility organisations and banks, actuarial studies are under way for reducing their comparatively higher contribution rates to the level of contributions in IKA.

2.1.3 Details on recent reforms

The reform laws of 2011 and legislation that has followed since then signposts a decisive change in the structure of the pension system, with the introduction of a multi-tier system, the amalgamation of social insurance funds into larger entities (IKA, OAEE, OGA & ETAA), the establishment of a new single auxiliary pension fund, the introduction of new formulas for the calculation of benefits and other related changes (as the above brief reference to a range of new legal acts indicates).

Yet, despite extensive merging, there is still a considerably high number of pension schemes (particularly as regards auxiliary pension plans). The above mentioned new control system of pension payment ("HELIOS") located about 93 pension funds in mid-2013. It was put in place as soon as a first census of pensioners was carried out across all the existing pension

[5] Currently ETEA covers 2.5 million (actively) insured persons in the private and public sector and 1,025,000 pensioners.

schemes, with the main aim to weed out false claimants and systematically monitor payments. It operates in close connection with the recently introduced "ARIADNI" system in order to track demographic changes and feed information into the centralized control system of pension payment.

A reassessment of all recipients of disability pensions is also in progress with the aim to locate fraudulent claimants and control the total amount of disability pensions so that they do not exceed 10% of total pension expenditure (and with a view to reach less than 8% in 2020).

In September 2011 a single centre for certification of disability replaced a large number of previously existing committees. This was accompanied by an updated definition of disability and the use of an electronic registry of the beneficiaries.

Stricter income requirements were introduced for EKAS (the social solidarity benefit for low-income pensioners) too. In 2014 EKAS will be suspended for pensioners below 65 years of age (EKAS will be abolished in 2015, with the launching of the new multi-tier system).

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

High unemployment (27.6% in July 2013), as well as the inability to pay contributions by a large number of self-employed has significantly increased the number of uninsured population (it is reported by OAEE that four in ten self-employed stopped paying contributions because of economic hardship). In addition, undeclared work is estimated to be around 30% (IOBE 2012). These conditions seriously affect coverage of the system.

As stressed above, the reform laws of 2010 and recent legislation for auxiliary pensions introduced significant changes in pensionable income and replacement rates. The combination of shrinking pensionable income and a lower replacement rate will lead to significant reductions of pensions. As the new regulations will progressively come into force from 2015 onwards, the replacement rate (for both the contributory and basic pension and a full working career) is estimated to fall to about 50% (Institute of Labour 2010, p 315).

Under the bailout plan, drastic cuts in current pensions (including the introduction of a special levy) significantly reduced present day retirees' pension-income (by about 40% to 50% for certain pension income brackets).[6]

- In August 2010, a special (intergenerational solidarity) levy was introduced. Initially it ranged from 3% to 10% of gross monthly (basic) pension income, but was raised up to 14% in early 2012 (and the income threshold for it was reduced to 800 euros). It was meant to contribute to a contingency fund for social insurance organisations (the so-called LAFKA, Solidarity Account for Social Insurance) administered by the Insurance Fund for Inter-generational Solidarity (AKAGE) that was established by the reform Law 3655 of 2008. Recent legislation however, allows for the use of part of it to "plug" other public funding gaps, like for instance the "Home Help" programme run by local authorities, with service provision on strictly means-tested though. A levy to auxiliary pensions over 300 euros monthly (ranging from 3% to 4%) was introduced in September 2011 too.

[6] For the current average rates of old-age, survivors and disability pensions see tables below.

- With law 3986/2011, basic pensions over 1200 euros were cut by 20% (while for pensioners younger than 55 years with pension-incomes over 1000 euros, they were reduced by 40%).
- Also, from November 2011 the auxiliary pensions under the ETEAM (IKA) scheme were reduced by 30% and those of the auxiliary schemes for public utility organisations (the Public Power Corporation, the Hellenic Telecommunications Organisation and others) were reduced by 15%.
- Law 4051/2012 introduced a further cut by 12% to basic pensions over 1300 euros and of auxiliary pensions by 10% (between 200 and 25 euros), 15% (between 251 and 300 euros) and 20% (for over 300 euros monthly).
- Law 4093/2012 abolished the already drastically-reduced Christmas, Easter and summer bonuses for pensioners. It also introduced further cuts to total pension-incomes in excess of 1000 euros per month ranging from 5% to 20%.
- Moreover, the new formula for auxiliary pensions (to be in force form 2014) is expected to lead to further cuts in auxiliary pensions that may turn into a meagre social assistance benefit.

Table 1 shows the total number of pensioners by pension category, gender and mean pension-income. In August 2013 there were 2,707,727 pensioners (about 47% men and 53% women, on the basis of the censuses completed during 2013). It has to be mentioned that the economically active population decreased significantly between 2010 and 2013 and the ratio of the economically active to the inactive population fell from about 1:1 to 0.78:1, while the corresponding rate of the economically active population to pensioners is 1.3:1.

Table 1: Pensioners by gender and pension category, and mean-pension income

	Number of pensioners			**Mean pension-income (monthly, in euros)****		
	(A)* **Total**	**(B) Men**	**(C) Women**	**(D) Total**	**(E) Men**	**(F) Women**
Old-age	2,033,842	1,088,051 (85%)	939,734 (73%)	921.19	1,075.56	767.43
Survivors	376,264	23,601 (2%)	348,563 (27%)	679.40	483.08	694.06
Disability	233,253	144,714 (11%)	88,415 (7%)	610.12	672.08	507.21
Social pension (by OGA)	40,161	13,209 (1%)	26,952 (2%)	361.96	361.76	362.06
Not classified	24,207	9,705 (1%)	14,398 (1%)	719.69	658.69	658.69
Total	*2,707,727*	*1,279,280*	*1,418,062*	-	-	

Source (for Tables 1, 2 & 3): The "Helios" system, retrieved on 25 August 2013 at http://www.idika.gr/files/ΤΡΙΤΗ_ΕΚΘΕΣΗ_ΗΛΙΟΣ_Αύγουστος_2013.pdf

* Column (A) depicts the sum of columns (B) and (C) plus about 10,000 pensioners for whom there are no data on gender. Also column (D) refers to the mean income in each pension-category for the total sum of pensioners (including those for whom gender details are missing).

** Monthly pension benefits before income tax and health care contributions

73% of women pensioners received an old-age pension (compared to 85% of men), a little less than a third received a survivor's pension, and 7% received a disability pension

(compared to 11% of men). Mean-pension income for women pensioners amounted to about 70% of that of men as regards old-age and disability pensions. The mean (gross) monthly pension-income of women pensioners receiving the survivor's pension was about 690,000 euros. Also, the number of women receiving only the social pension (of 360 euros) was double that of men.

Table 2: Pensioners by pension category and income group, and respective mean-pension income (basic pensions)

	Old age		**Survivors**		**Disability**	
	Percentage of pensioners	**Mean pension-income***	**Percentage of pensioners**	**Mean pension-income***	**Percentage of pensioners**	**Mean pension-income***
€0-500	*25.1*	362.98	*24,6*	304,21	*43,5*	383.06
€500.01-1000	*36.8*	707.26	*61,5*	700,01	*47,5*	682.37
€1000.01-1500	*22.5*	1257.87	*12,1*	1186.61	*7,3*	1203.37
€1500.01-2000	*13.6*	1689.14	*1,6*	1658.60	*1,5*	1683.17
€2000.01-2500	*1.6*	2166.69	*0,2*	2183.83	*0,2*	2181.64
€2500.01 and over	*0.4*	2786.07	*0,0*	2854.32	*0,1*	2909.63
Total	*100*		*100*		*100*	

Source (for Tables 1, 2 & 3): The "Helios" system, retrieved on 25 August 2013 at http://www.idika.gr/files/ΤΡΙΤΗ_ΕΚΘΕΣΗ_ΗΛΙΟΣ_Αύγουστος_2013.pdf

* Monthly pension benefits before income tax and health care contributions

Table 2 exhibits the distribution of pensioners by pension category and mean income in each of the six income groups considered. In the category of old age pensions, a quarter of pensioners are in the lowest income group (with a mean pension at the level of the social pension, 360 euros (gross) monthly); a little over a third receive a monthly pension of about 700 euros; about a fifth receive a mean pension of 1200 euros and only about 15% are classified in the income categories of 1500 euros and over (gross income). In the case of survivor's pensions, about 85% of pensioners (mostly women) belong to the two lowest income groups (25% receive a mean monthly pension even below the rate of the social pension, and 61% a mean monthly pension of 700 euros). As regards disability pensions, 43% of the beneficiaries belong to the lowest income group (with a mean monthly pension at about the level of the social pension) and 47% to the second lowest income category (with a mean monthly pension of about 680 euros).

A little over 50% of all pensioners receive only one pension, which means that auxiliary pension coverage is not very high. Also, about 99% of auxiliary pensions across the three categories of pension benefits (old-age, survivors and disability) belong to the lowest income category (up to 500 euros): 99% of old-age recipients get a mean (gross) monthly auxiliary pension-benefit of about 187 euros, 99.8% of survivors pension recipients get a mean (gross) monthly auxiliary pension-benefit of 130 euros, and 99.6% of disability pensions recipients get a mean (gross) monthly auxiliary pension of 157 euros(see Table 3 below).

Table 3: Pensioners by pension category and income group, and respective mean-pension income (auxiliary pensions)

	Old age		Survivors		Disability	
	Percentage of pensioners	**Mean pension-income***	**Percentage of pensioners**	**Mean pension-income***	**Percentage of pensioners**	**Mean pension-income***
€0-500	*99.22*	187.82	*99.87*	130.55	*99.63*	157.64
€500.01-1000	*0.76*	529.42	*0.13*	602.51	*0,36*	603.33
€1000.01-1500	*0.02*	1170.14	*0.0 [only 3 persons]*	1162.14	*0.01 [only 8 persons]*	1136.56
€1500.01-2000	*0.002% [only 21 persons]*	1600.24	*0.0 [only 3 persons]*	1731.95	*0*	0
€2000.01-2500	*0*	0	*0*	0	*0*	0
€2500.01 and over	*0*	0	*0*	0	*0*	0
Total	*100*		*100*		*100*	

Source (for Tables 1, 2 & 3): The "Helios" system, retrieved on 25 August 2013 at http://www.idika.gr/files/ΤΡΙΤΗ_ΕΚΘΕΣΗ_ΗΛΙΟΣ_Αύγουστος_2013.pdf

* Monthly pension benefits before income tax and health care contributions

The most recent available data on poverty refer to 2010 incomes (EU-SILC data for 2011). Thus, they do not fully capture the effects of harsh austerity measures in the following years.

The aggregate poverty rate rose from 20.1% in 2008 to 21.4% in 2011 (respective EU-27 average rates 16.3% and 16.9%); while the poverty rate for people 65 years or over rose, accordingly, from 22% to 24% (respective EU-27 averages 19% and 15.9%). Alarmingly, the combined at-risk-of-poverty and/ or social exclusion aggregate rate reached 31% (affecting 3.5 million people in Greece; EU-27 average rate 24.2%). It stood at about 34% among old-aged people (75 years or over; 36% among old-aged women).

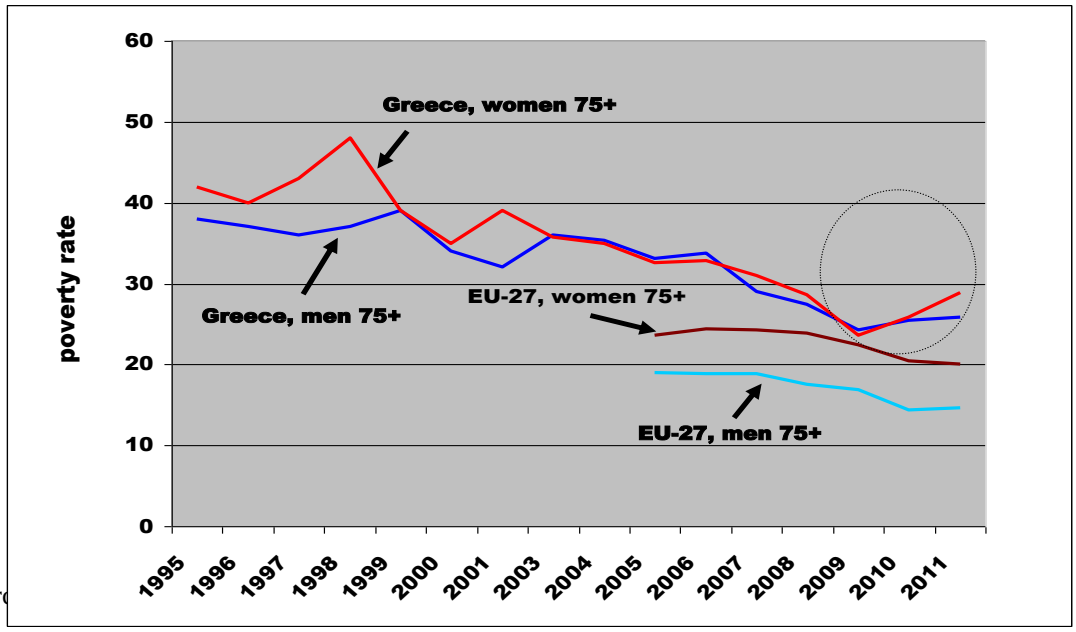
Table 4 presents indicators of poverty and social exclusion among the elderly. The poverty rate is particularly high among elderly women (65+ and 75+), while the gap with regard to the respective EU averages (for both men and women) has significantly increased between the two years included in the Table. The relative median income ratio between the over and less than 65 years also increased for both men and women. The S80/S20 income quintile ratio for people 65 years and over has persistently been higher in Greece (compared to respective rate for EU-27), while the rates of elderly men and women experiencing severe deprivation in Greece have persistently been double the (average) rates for EU-27.

Table 4: Poverty, income inequality and social exclusion among the elderly

	2008 (Greece / EU-27)			**2011 (Greece / EU-27)**		
	Total)	***Men***	***Women***	***Total***	***Men***	***Women***
At-risk-of poverty (65+)	**22.3 (19.0)**	20.8 (15.7)	23.6 (21.4)	**23.6 (15.9)**	21.7 (13.2)	25.2 (18.0)
At-risk-of-poverty (75+)	**28.0 (21.7)**	27.4 (17.6)	28.6 (24.3)	**27.5 (17.9)**	25.8 (14.7)	28.9 (20.0)
At risk of poverty of pensioners (65+)	**22.9 (17.6)**	20.1 (15.7)	26.3 (19.2)	**22.4 (14.8)**	22.1 (13.0)	22.8 (16.3)
At-risk-of-poverty and social exclusion (65+)	**28.1 (23.2)**	24.6 (19.5)	30.9 (26.2)	**29.3 (20.4)**	26.5 (17.0)	31.5 (23.1)
Relative median income ratio (65+ to 65-)	**0.86 (0.85)**	0.89 (0.88)	0.84 (0.83)	**0.81 (0.89)**	0.84 (0.92)	0.80 (0.87)
Severe material deprivation (60+)	**14.1 (7.3)**	10.9 (6.1)	16.8 (8.4)	**12.9 (7.3)**	11.3 (6.0)	14.2 (8.3)
Relative median at-risk-of-poverty gap (65+)	**20.8 (17.2)**	-	-	**21.1 (16.7)**	-	-
Inequality of income distribution: S80/S20 income quintile ratio (65+)	**4.5 (4.1)**	-	-	**4.5 (4.1)**	-	-

Source: Eurostat data accessed on 10 October 2013 at http://epp.eurostat.ec.europa.eu/portal/page/portal/income_social_inclusion_living_conditions/data/database

Figure 1: Poverty trends among men and women 75 years and over



Sour

It is highly alarming that a trend of significantly decreasing poverty among the elderly, clearly evident from the mid-1990s until the eve of the crisis, has been reversed since 2009 (see Figure 1).

2.2.2 Sustainability

There are significant challenges in terms of both medium and long-term sustainability. However, as argued bellow, the stipulations of the bailout agreement guiding policy reform have been subject to a lot of controversy.

Pension expenditure stood at about 13% of GDP in 2010 and (without any reform) it was projected to almost double in 2060, as demographic ageing is forecasted to exert significant pressure on social insurance. According to the projections by the EPC Working Group on Ageing Populations, elderly population (65 years and over) from 19% in 2010 will increase to 31% in 2060 (and the dependency ratio 65+/(15-64) will accordingly rise by about 28 percentage points – from 28.6 in 2010 to 56.5 in 2060). Also the very elderly population (80 years and over) is projected to almost triple between 2010 and 2060 (from 4.6% to 13.3%). The demographic factor has the most important influence on an upward trend in public pension expenditure. A set of measures take centre stage in the on-going negotiations of reform with the "troika", as they are considered to lower down the pressure of the demographic factor on public pension expenditure. These include diminishing coverage (particularly through restriction of early retirement schemes and increase of retirement age and effective exit from the labour market), rising employment rates (in the long-term), and drastic reductions in the generosity of benefits.

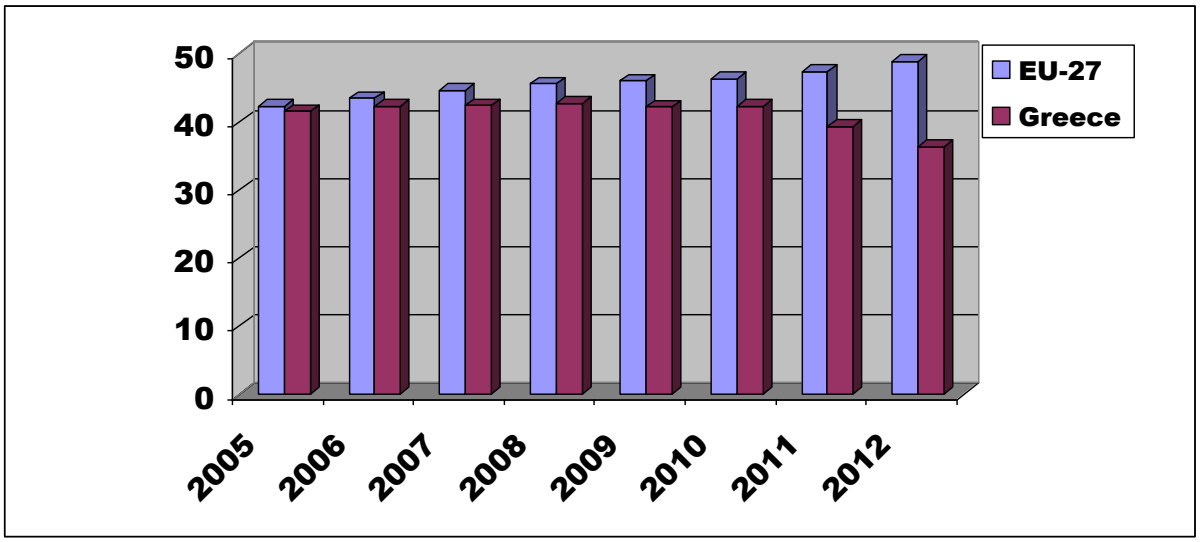
Over the last three years, reforms more or less embraced these issues. But there are significant adverse effects due to the crisis; while in addition some measures seem to be rather controversial on sustainability accounts, not to mention adequacy of benefits.

Effective labour market exit stood at about 61.4 years in the late 2000s. Retirement age increased so as to reach 67 years from January 2013 on and measures were taken for equalizing pensionable age across social insurance funds and between men and women (also – as mentioned above- provisions have been made for linking retirement age to longevity from 2021 onwards).[7]

However, due to rapidly rising unemployment over the last three years, the employment rate among older workers (55 to 64 years) has declined in Greece (see Figure 2). From 43% in 2008, it dropped to 36% in 2012 (corresponding figures for EU-27 46% and 49%). This is primarily the effect of a fast declining employment rate among male workers of this age group (from 59% in 2008 to 48% in 2012); while on the other hand the employment rate of women 55 to 64 years, which was rather low even before the crisis (28% in 2008) dropped to a lesser extent (to 26% in 2012 – contrary to the EU-27 average that increased from 34% and 40%).

Although the stated aim of the on-going reform is to put the brake on early retirement, governmental decisions have facilitated early exit in the short- and medium-term for specific groups (e.g. through the provision of "notional time" to parents with under age children, the possibility to "buy" additional years by some categories of workers, and other similar measures). Also in the attempt to fulfil the MoU stipulation for "slimming down" the public sector through the so-called "suspension programme" for civil servants, the government is keen to encourage early exit of older workers.

Figure 2: Employment rate among older workers (55 to 64 years)



Source: Eurostat data, accessed on 5 September at http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do

As mentioned above, the reform laws over the last three years significantly reduced pension benefits of current pensioners and provided for a drastic cut of replacement rates for future retirees (according to the EU Ageing Report accrual rates are forecasted to fall by 41.7%,

[7] According to the projections by the EPC Working Group on Ageing Populations, on-going reforms are expected to increase average age of exit from the labour market for both men and women to about 64 years in 2060; EU-27 average, 64.5 years.

between 2010 and 2060). Furthermore, with the aim to further bolster financial sustainability, from 2014 onwards pensions will be annually adjusted on the basis of a coefficient drawing on GDP fluctuations, on the consumer price index and the financial situation of pension funds, as mentioned earlier.[8] Also, for auxiliary pensions (and the lump sum benefit) an actuarially neutral formula has been devised, along with the formation of individualized contributions accounts topped by a "sustainability factor" that will periodically adjust the size of the benefits in accordance with demographic changes and the level of revenues by the auxiliary pension funds.

The above-mentioned measures aim to respond to the bailout stipulation that the contribution of the state budget to pension expenditure should not surpass an increase by about 2 to 2.5 percentage points of GDP through 2060. Yet, it is highly unlikely that this premise can be satisfied, as the baby-boomer generation will be retiring over the coming decades, unless steep decreases of pension income will take place (further to the cuts already imposed) throwing even larger numbers of elderly people into poverty.

Social insurance funds are currently at a great strain. Their reserves have drastically been reduced by the over 50% haircut of their bondholding (in the context of the PSI – the Private Sector Involvement is a complex bond-swap programme implemented in March 2012). Their revenues have steeply plunged due to high unemployment and inability by small firms and the self-employed to pay contributions (while in parallel contributions evasion continues to be high). In mid-2013 the deficit of social insurance funds reached 2.5 billion euros (as indicated in a report by the Panhellenic Federation of Employees in Social Welfare Organisations). Revenues of IKA, the largest social insurance fund, dropped by 14% this year. Loss of revenue because of undeclared work remains high (estimated at 6.5 billion euros annually), while contribution arrears by businesses amount to 8 billion (half of it is owed by businesses that went bankrupt or closed down, and hence it is highly unlikely that arrears will be paid off).

On the other hand, in the case of OAEE (the social insurance fund for the self-employed) from the roughly 780,000 insured persons, close to half of them face great difficulties in paying contributions (and about 200,000 discontinued their insurance). Currently OAEE's deficit amounts to 600 million euros. Equally in OGA accumulated arrears reached about 700 million euros in mid-2013.

A further reduction in employers' contributions, as advocated by the "troika", will augment the financial strains of social insurance funds. Interestingly, at the same time the "troika" exerts pressure for the introduction of a special levy of the range of 0.1% to 0.2% on the turnover of businesses in order to cover the rising deficit of OAEE.

Such a worsening outlook of social insurance runs counter to the viability estimates of the 2010 reform plans.[9] If from 2015 onwards public sector involvement in the pension system will be limited to the provision of the basic pension, the only way to address the problems of sustainability is through further substantial decrease of pension benefits.

In a nutshell, the recession, extensive contributions evasion, undeclared labour and demographic ageing constitute a perilous mix that puts at stake the system's viability. Sooner or later this will trigger a shake-up of the system that can deal a serious blow to the living

[8] The mean of GDP and CPI growth will be taken into account in calculating the adjustment coefficient; the latter should not exceed the CPI rate, a condition that will reduce the real value of pension income if inflation rises faster than GDP.

[9] On this issue see also Tinios 2013.

standards of retirees, particularly also as the third and fourth pillar (of occupational and private pensions) have little developed so far.

2.2.3 Private pensions

Participation in second- and third pillar schemes has been negligible. Particularly as regards private insurance, the crisis renders participation difficult even among middle income groups due to rapidly diminishing incomes under the crisis. Moreover, the very few occupational (and private schemes) are rather young and will have an effect on pension payment to future retirees. No projections are available by the relevant authorities for pension expenditure in occupational and private pensions, as these schemes are held to be non-relevant in Greece.

2.2.4 Summary

On-going reforms focus primarily on strengthening the financial sustainability of pensions systems by decreasing coverage and benefits. Yet, the above analysis has shown that, despite the reforms already introduced, the system's viability is on shaky grounds, among others due to the adverse effects of the crisis on the revenue of social insurance funds. Successive cuts of pension incomes of current retirees impact negatively on adequacy. It is difficult to gauge adequacy of pensions in the future, given that a number of parameters of social insurance depend upon major economic factors. According to the EPC Working Group on Ageing Populations, Greece is projected to exhibit a rather substantial decline in the public pension benefit ratio over the period 2010 to 2060, from 36% in 2010 to 28% in 2060; EU27 rates: 45% and 36% respectively). This indicates a significant fall (even below a minimum threshold) particularly if no other sources of pension entitlement and assistance will be available.

2.3 Reform debates

Further system rationalisation is considered through the full (financial and administrative) merging of social insurance funds, as despite the amalgamation that has taken place so far, constituent units retained their distinct status and distinct bureaucracies. As stated earlier, even after the merging of both primary and auxiliary schemes, the "Helios" monitoring system located 90 distinct schemes (mostly for auxiliary pensions).

The new single auxiliary fund (ETEA) is already in the red (its deficit is expected to be in the range of 200 million euros by the end of 2013).[10] The government is even considering the case of abolishing auxiliary pensions by incorporating them into the main pension component (the contributory component).

The introduction of a unified mode of calculation of contributions is also currently being considered, as well as unification of the pre-2010 reform rules concerning pensionable income. Although these rules will be gradually phased out from 2015 onwards, they will continue to be in force for some time for the calculation of that part of the pension that refers

[10] This is mostly due to depletion of the reserves of ETEAM (the former auxiliary fund of IKA, which is the core constituent unit of ETEA) through extensive and continuous borrowing by IKA (in order to pay basic pensions), without, however, so far paying back these loans to ETEAM. Law 3655/2008 set the debt of IKA to ETEAM at 2.5 billion euros at that time (without taking into account any interest rate).

to the working time prior to the 2010-reform. Further merging and unification of regulations will embrace also a range of benefits to the insured (like "kindergarten" benefits, maternity allowances etc.)

Reduction of employers contributions (by 3.9 percentage points at least), on top of the 1.1% reduction, as mentioned above) figures also high on the reform agenda. Strikingly, also the introduction of an extra 0.1% to 0.2% taxation on turnover is an issue debated with the "troika".

Another major reform that has already been decided and is currently coming into force is the establishment of a unified "Centre for the Collection of Contributions Debts" (KEAO). It initially is in charge of collecting contribution arrears for IKA and OAEE, while from January 2014, it will expand its services to ETEA and OGA. Its action plan embraces the following stages: the immediate unification of the debt collection process in the four major social insurance funds (and the strengthening of the collection capacity) by mid-2014; the coordination of the recovery of contributions arrears with the debt collection process of the tax authorities by mid-2016; and finally the full integration of both of these debt collection mechanisms by mid-2017. This is supported by the creation of a "debtors register", the adoption of modern practices for tracing and informing debtors, and the staffing of KEAO with qualified personnel on legal/ financial matters and in matters of risk analysis and information systems.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

A universal health system (ESY) was introduced in the early 1980s. However, four decades after its establishment, the system hardly reached the state of a fully-fledged national health service. Both in terms of funding and service delivery a mixed system continued to operate until recently: a highly fragmented, occupation-based health insurance system was combined with a national health service, while, in parallel, private provision expanded rapidly until the eruption of the crisis (total health expenditure stood at about 9% for much of the second half of the 2000s, and roughly about 40% of it was private spending – mostly out-of-pocket payments, as private insurance remained limited).

ESY comprises primary and secondary care. It also employs some general practitioners and particularly in some rural areas it is the main provider of care. Overall, however, primary and specialist care is characterized by a noticeably mixed system of service delivery by public providers – the outpatient departments of public hospitals, health insurance (e.g. the former health centres of IKA that have come under EOPYY since 2012), and private providers (either under contract by health insurance organisations or paid out-of-pocket by the patients).

Until the 2011 reform, the employed population was enrolled in one of the large number of occupation based health insurance funds. Diversity of coverage by the social insurance funds, by ESY, and for some people by private medical insurance has persistently contributed to significant inequalities. Multiplicity of funding and system fragmentation accounted also for lack of coordination of purchasing policies, soaring ESY deficits, rapidly rising pharmaceutical expenditure and other inefficiencies. Piecemeal reforms over the 1990s and 2000s hardly tackled the system's major predicaments.

The bursting of the public debt bubble made system rationalisation a key priority and a major requirement of the rescue deal. The merging of most health insurance funds into a unified health fund, EOPYY ("the National Health Services Organisation") with law 3918 of 2011 (and subsequent legislation) constitutes a major development in health insurance with the aim to equalise health care provision across occupational groups. This was accompanied by increases in co-payments and fees and a significant rolling back of provisions. In parallel, a reorganisation of ESY is under way that will redraw the map of hospitals and cut down/rearrange the number of clinics and functional beds with the aim to contain cost and rationalize structure and administration Other major developments embrace higher control over medical prescriptions (e-prescribing and e-diagnosis systems), the development of clinical protocols, new pricing rules for pharmaceuticals, changes in procurement processes, and a greater penetration of generics.

3.1.2 System characteristics

Poor coordination between primary and secondary care is a major predicament of health care in Greece. A gate keeping/referral system is lacking. The amalgamation of most health insurance funds under a single organisation (EOPYY) constitutes a significant step towards improving primary care organisation and provision. However, it is highly problematic how out of some "ailing" health insurance funds, and with diminishing resources, quality of service provision by the unified primary health care system can be secured. Another major predicament concerns diminishing contributions due to exceptionally high unemployment.[11] All these lead to EOPYY being seriously underfunded. Moreover, the creation of one more national health organisation, EOPYY (in parallel to ESY), with a hybrid form - namely a funding agency (for both primary and hospital care) but also a provider of primary care services, as well as a contractor of services to and buyer of services from private providers - raises problems for system rationalisation.

Access to EOPYY primary health care facilities (and to physicians under contract by EOPYY, examining patients in their office) does not involve a user charge. Yet, EOPYY runs few health units and some of them are understaffed, while the number of private physicians under contract by EOPYY has been declining. What is more, there is an upper limit of 150 to 200 visits per month for which each physician can be reimbursed. If this limit is surpassed, then a charge of 10 to 20 euros is claimed from the patient.

Cost-containment in the hospital sector is a major stipulation of the bailout plan. As referred to below, this is sought through a mix of measures aiming to reduce waste of resources, promote economies of scale, rationalize administration, costing and payments methods, and redeploy human resources. The redrawing of the hospital map is currently under way. It aims at the amalgamation of clinics and hospitals, the closing down of some health care facilities or the change of their function.[12] Administrative staff shortages are intensifying, also due to the policy of layoffs and recruitment freeze with the aim to considerably shrink the public sector

[11] Also health-related contributions are still being collected by the different social insurance funds and transferred to EOPYY. Delaying transfer (or withholding contributions) creates serious problems in EOPYY funding. Allocation of the necessary administrative staff from the existing individual funds to EOPYY is pending too.

[12] Out of the 137 public hospitals merging led to 83 entities. Also from a total of 1950 clinics in public hospitals 330 were merged (and 40 were transferred between hospitals). The number of functional beds was cut down from about 36,000 to 32,000, and of them 550 beds were allocated to private practice. Changes are forecasted to save about €150 million in the context of the medium-term plan (data obtained from the Ministry of Health).

in the coming years, as mentioned above. Recently the health care personnel has also been included in the "suspension"/reallocation programme of the public sector. Most importantly, the shortage of nursing staff seriously affects service delivery (in some of the main hospitals in Athens cutbacks have left one nurse to look after 20 or more patients).[13] Also about 25% of the intensive care beds are not in operation due to staff shortages.

Drastic containment of pharmaceuticals expenditure has been a top priority in the context of the bailout plan (given the fact that drugs expenditure increased exceptionally fast during the 2000s).[14] Significant cost-savings have so far been achieved through the introduction of e-prescribing and e-referral systems (initially on a pilot basis, but made progressively compulsory for all outpatient medical acts under ESY and EOPYY – including drugs, referrals and diagnostics).[15] Accompanying measures include: compulsory prescription guidelines and therapeutic protocols, incentives and obligations (for medical staff) to use generics, the regular revision of drugs' prices, the reduction of the profit margin for pharmacies, and the automatic clawback mechanism (every six months, on pharmaceutical producers). Also, the "positive list" of drugs is periodically revised. Co-payments (for pharmaceuticals, diagnostic tests and use of private clinics) increased too, while exemptions have been drastically reduced.

3.1.3 Details on recent reforms

Further to the establishment of EOPYY and the reorganisation of the hospital sector, legal changes enacted over the last few years provide for the all-day operation of hospitals and health centres and the charging of fees per visit in the afternoon shift to outpatients (covered only partly by social insurance).

Measures for lowering prices and volumes of pharmaceuticals embrace interventions: (a) on drugs pricing and profit margins of pharmacies and pharmaceutical industries, in parallel with administratively forced reduction of prices for specific drugs; and (b) on doctors prescribing patterns.

A new pricing and regulation system was introduced in 2010. The price of drugs is set on the basis of the average price of the three lowest-priced markets in the EU (22 EU countries are reference countries). A drug-pricing observatory was established for this purpose and about 12,000 pharmaceutical products started being re-priced on the basis of the new system (a price list is set three times yearly). A number of drugs were also eliminated from the "positive list" of drugs. Yet the pricing mechanism still requires adjustments so as to become more transparent and to reduce the number of complaints and potential confusion caused by several revisions of the same list.[16]

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[13] See Skroubelos et al. 2012b for an analysis of the profile of nursing personnel in Greece.

[14] In 2009 outpatient pharmaceuticals expenditure amounted to about 5.2 billion euros (that is, roughly about 40% of total public health spending).

[15] E-prescription coverage for medicines is well over 90% but for the other medical acts (compulsory from April 2013) it reached 84% in late spring (a new deadline for achieving almost full coverage was set for autumn 2013).

[16] A ban on exports of pharmaceuticals was announced by the National Organisation of Medicines (EOF) in October 2012, as a drugs shortage became an increasing problem (due to much lower prices for certain medicines in the Greek market compared to Western Europe).

Regarding user charges, a 15% co-payment for clinical tests was introduced for all insured in EOPYY, in tandem with 25% co-payment for a range of prosthetic devices, orthopaedic materials and respiratory devices,[17] and a ceiling on consumables, such as diabetic test strips, injection needles etc. An entrance fee of 3 euros for all (regular) outpatient services was introduced in 2010 that was raised to 5 euros in January 2011. Moreover, from 2014, a fee of 25 euros will be charged for every hospital admission,[18] as well as an extra fee of one euro per prescription (on top of the 25% co-payment). User charges for treatment in private clinics (if required) have also increased (the rates differ among major health insurance funds, ranging from 15% to 50% in the case of farmers).[19] At the same time existing exemptions from user charges for some groups were lifted (e.g. for the chronically ill persons exemptions are strictly related to their chronic illness, even though some of their ailments maybe an "indirect" consequence of their health conditions).

Increasing the market share of generics and regulating their prices are also major objectives stipulated by the MoUs. E-prescription and prescription by active substance (INN - International Non-proprietary Name) are now compulsory.[20] The pharmacist is obliged to dispense the generic with the lowest price. If the patient chooses the branded name instead, s/he has to pay 50% of the difference between the reference price and the actual price of the branded medicine (while lately the Ministry of Health raised this charge to the full price difference).

The market penetration of generics remains limited (they cover about 25% of the dispensed drugs in terms of volume and about 18% in terms of value). Despite the observed progress in pharmaceuticals expenditure, in a recent review by the "troika" it is emphatically stated that "further monitoring and fine-tuning of policies is needed in the containment of pharmaceuticals expenditure, to ensure the necessary savings for 2013 to achieve the EUR 2.37 billion target" (European Commission 2013, p. 34). Combining electronic prescription with compulsory use of prescription guidelines/protocols for physicians drawing upon the IDC10 (International Statistical Classification of Diseases and Related Health Problems) is another component of the on-going reform.[21] This is attempted initially for the expensive medicines and those most widely used.

Interestingly, pharmaceuticals cost-containment occurred only in ambulatory care, while hospital drug expenditure has been rising (mostly due to the transfer of dispensing of expensive drugs to hospital pharmacies). In parallel, centralised tenders and international e-auction procedures for hospital procurements were launched.[22]

The shift from retrospective reimbursement based on the patient cost per specialty to a case-mix based payment took place in 2011, but still the process is at an incipient stage. So far

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[17] As for instance oxygen tanks for people suffering from chronic pulmonary fibrosis.

[18] The Ministry of Health estimates for this measure to yield up to 114 million euros per year; it remains to be seen, however, whether this is a realistic goal.

[19] Also, in January 2013 the government decided a "haircut" of 20% on debts owed by EOPYY to hospitals, pharmacies and suppliers (for pharmaceuticals the "haircut" was 8%, as a clawback provision is also imposed on this sector). For a review and forecast regarding pharmaceuticals in Greece see BMI 2013.

[20] An automatic blockage mechanism is in place and is activated when branded prescriptions by a doctor surpass 15%.

[21] ICD-10 constitutes a medical classification list of diseases by the World Health Organisation. Therapeutic protocols should be posted on EOF's (National Organisation for Medicines) website.

[22] So far centralized procurement covers about 25% of all hospital buys and according to Ministry authorities has produced substantial savings.

there are strong reservations (Skroubelos et al. 2012a) with regard to the way the Greek version of DRGs has been coded and priced, as it tends towards higher pricing. Furthermore, piloting of DRGs is not accompanied by a system of prospectively agreed global budgets for hospitals in Greece.

Salaries of health personnel almost halved since the eruption of the crisis and significant cutbacks in overtime were enforced. The latter are a hotly debated issue lately, as the budget for hospital doctors' overtime has been drastically trimmed (by about 40% between 2011 and 2013). Hospital managers reschedule (regular) overtime into "on-call" work that is less expensive. But often they cannot fully cover needs for required overtime even under such an arrangement. Also, there are great delays in overtime payment (of three or more months; this being often one of the causes of doctors' mobilisations).

3.2 Assessment of strengths and weaknesses

A comprehensive reform of the health care system that started in 2010 is still in progress, with the aim to improve system integration and governance and reduce health care spending at or below 6% of GDP. The establishment of a unified health care organisation with the merging of the largest health insurance funds aims to reduce fragmentation and inequalities in coverage, rationalize administration and costing of hospital services, and drastically control pharmaceutical spending (through changes in pricing, prescribing and reimbursement, with an emphasis on the promotion of the use of generic medicines). Also co-payments were reviewed upwards and fees for diagnostic services increased, as mentioned earlier. The reorganisation of ESY has been underway over the last couple of years too with the aim to contain hospital operating costs and monitor performance. Public health expenditure has been drastically reduced from 2009 to 2012 by about 2.9 billion euros and further cuts (of about 2 billion euros) are budgeted for 2013 and 2014. What is lacking, however, is any monitoring of the serious effects of the cuts on the quality and range of public care services provided, and on access to services (particularly as the number of uninsured people rose sharply over the last few years).

3.2.1 Coverage and access to services

Austerity-driven reforms highly weaken the principle of "universalism" that, however, did not fully apply to the case of Greece even before the eruption of the crisis and the launching of structural reforms. Two things should be stressed. First, equalization of provision across social insurance funds was accompanied by a significant review of the range of public provision (leading towards a low common denominator). And, second, the crisis conditions brought to the fore the serious problem of a rapidly increasing number of uninsured people. As the head of EOPYY recently stated, there are over 2,000,000 people[23] that have no health care coverage (because of being unemployed- themselves or the household head on who they depend-, because of the bankruptcy of their business, or because even though still in employment they discontinued paying contributions due to severe economic hardship). Increased co-payments and fees also function as rationing measures creating barriers to access. Rationing through long waiting times (e.g. in certain prefectures the quicker appointment you can get for seeing a pathologist or a cardiologist in EOPYY could be in two

[23] Yet, he clearly stated that EOPYY is not in a position to give a precise number of the uninsured as the records of the amalgamated social insurance funds are defective.

or more weeks, while in the national hospitals network might take even longer) is further compounded by blockage mechanisms (as for instance discontinuity by EOPYY in the procurement of vital medical supplies for the performance of diagnostic tests in its health centres).[24] Barriers to access to public provision in a time of crisis and the inability to get medical treatment in the private sector (because this is unaffordable for people in economic hardship) seriously increase unmet needs for medical care.[25]

Table 5: Self-reported unmet need for medical examination

	Self-reported unmet need for medical examination (%)								
	Reason: "Too expensive"		**Reasons: "Too expensive, too far to travel, waiting lists", 2011**			**Reason: "Too expensive" 2011**			
			Total population			**Persons 16 to 64 years of age**			**Persons 85 years and over**
	2004 Total population *Males/ Females*	**2011 Total population** *Males/ Females*	*1st* income quintile*	*2nd income quintile*	*3rd income quintile*	*1st* income quintile* Males/ Females	*2nd income quintile* Males/ Females	*3rd income quintile* Males/ Females	*3rd income quintile* Males/ Females
EU-27	n.a.	4.0/4.7	6	4	3	8.3/9.4	5.5/6.0	3.6/4.0	2/3
Greece	4.1/4.2	6.5/7.1	12	10	8	10.4/9.4	7.0/8.0	8.9/7.9	7 /10

Source (for Tables 5 & 6): Eurostat data accessed on 20 September 2013 at http://epp.eurostat.ec.europa.eu/portal/page/portal/employment_social_policy_equality/social_protection_social_inclusion/indicators/health_long_term_care

According to EU-SILC data, self-reported unmet need for medical examination (because "it is too expensive") significantly increased from the mid-2000s to 2011 (the percentage almost doubled for females and increased by a third for males; see Table 5). Unmet need is most frequently reported among people in the first income quintile. However, strikingly, the percentages of people with unmet needs in the second and third income quintiles are also high compared to EU-27 averages. In the case of the "oldest-old" unmet need for medical examination (because it is "too expensive") is particularly high even among middle-income people.

[24] These conditions reduced visits to EOPYY health centres, in certain localities, even by half over the last two years (research in progress at the Observatory of Economic and Social Developments, of the Institute of Labour/General Confederation of Greek Trade Unions, on "Health and long-term care in Greece" co-ordinated by M. Petmesidou).

[25] According to a survey undertaken by the Public Health Scholl of Athens 6 out of 10 people interviewed about two years ago stated that they limited their use of health services due to high costs.

Table 6: Self-perceived general health and limitations in daily activities

	Self-perceived general health ("bad" & "very bad"), 2011			**Self-perceived limitations in daily activities ("severe limitations"), 2011**		
	1st income quintile* Males/ Females	*2nd income quintile* Males/ Females	*3rd income quintile* Males/ Females	*1st* income quintile* Males/ Females	*2nd income quintile* Males/ Females	*3rd income quintile* Males/ Females
EU-27	12.7/15.0	11.4/13.9	8.6/10.7	11.4/11.8	10.2/11.4	7.8/9.2
Greece	11.1/14.0	12.5/14.4	9.0/10.8	10.6/12.1	12.3/13.5	9.3/10.1

Source (for Tables 5 & 6): Eurostat data accessed on 20 September 2013 at http://epp.eurostat.ec.europa.eu/portal/page/portal/employment_social_policy_equality/social_protection_social_inclusion/indicators/health_long_term_care

In the lowest income quintile, the percentages of males and females that reported "very bad or bad" health status are close to the EU-27 average (Table 6). In the 2nd and 3rd income quintiles respective rates for Greece are higher than EU-27 averages. Data for Greece show that in a range of income groups from the bottom to the middle of the income hierarchy self-reported health problems are found almost to the same extent. This indicates a worsening of health conditions for lower and middle-income groups; a trend that is also evident in respect to the self-perceived limitations in daily activities (see also Vandoros et al. 2013 and Zavras et al. 2013).

The effects of the crisis on a rising number of people (including people considered themselves "middle class" before being severely hit by the crisis) is also reflected in the increasing use of free access clinics run by NGOs (e.g. Médecins du Monde). Until recently, people turning to NGOs were mostly immigrants. Only 3% to 4% of Greeks sought "street medical care" before the crisis. Yet, recent estimates indicate that about a third of the Greek population turn to such clinics or seek support from NGOs for covering their health care bills.

A programme recently launched by the government ("Health Voucher for Free Access to Primary Care") for 2013 and 2014 (with a budget of 46 million euros) aims to provide (on a means-tested basis) to about 100,000 people per year -who lost health coverage due to unemployment or inability to pay health care contributions - vouchers that allow them to visit doctors. Vouchers will cover a period of only four months and up to three visits for medical examination and diagnostic tests.[26] Eligible are persons who before losing their health insurance coverage, where insured in one of the funds that merged into EOPYY (people formerly insured in the funds that have not joined EOPYY are excluded). This is a positive measure, but falls short of covering need, given the staggering number of over 2 million uninsured. Moreover, duration of coverage is small, and most importantly, it does not cover hospital care (if needed by the uninsured) which is most expensive.[27] Hence, a structural long term solution is required.

[26] For pregnant women the duration of coverage is up to nine months.

[27] Anecdotal evidence, through the media, about incidences of uninsured destitute people thrown out of public hospitals by security forces because of inability to pay is rather worrying.

In terms of birth related health indicators, we observe an increase in infant mortality rate in Greece between 2008 and 2010 (from 2.7 deaths of children under one year of age per 1,000 live births to 3.8 deaths). Equally, the low birth weight babies rate increased by 1.6% in the same period. Life expectancy at the age of 65 years increased for both men and women between 2004 and 2010 (from 18.9 years to 20.2 years for women and from 16.9 to 17.9 years for men). However, healthy life years at the age of 65 decreased from 9.5 to 8 for women and from 9.5 to 8.8 for men. As the crisis conditions and structural reforms create barriers to access, morbidity problems in the future may seriously diminish healthy life expectancy both at birth and at the age of 65 years. And an eruption of expensive morbidity in the future is likely to have a "boomerang" effect on health care costs.

There is also evidence of an increasing suicide rate (by about 40% between 2009 and mid-2012).[28] Cardiovascular diseases, mental disorders and some infectious diseases (like malaria) are on the increase, as are also "unhealthy practices" (like alcohol and drug abuse). Equally, HIV cases by injecting drug-users increased ten-fold between 2004 and late 2011 (see Kentikelenis et al. 2011, 2012a and 2012b; Karamanoli 2012; Karanikolos et al. 2013; Kondilis et al. 2013).

3.2.2 Quality and performance indicators

Undoubtedly significant efficiency improvements in health care have been achieved, as this is reflected in the drastic cost-containment (public health spending has been cut by half between 2009 and 2013). To a large extent this is due to drastic cost-containment in outpatient drugs expenditure. Savings stem also from the reduction of exemptions in user charges (as well as from increasing their rates), the rolling back of public provision (under EOPYY), an improved accounting system in hospitals (allowing them "to produce balance sheets on an accrual basis"), and centralized procurement (including e-procurement).[29] In contrast, the introduction of DRGs has not been proven cost-effective so far, but this new method of costing is still at an incipient stage.

The Ministry of Health produces an annual report comparing hospitals performance on the basis of a set of benchmarking indicators (staff and beds, operating costs, average length of stay, bed occupancy rates, use of generics and others). Available data published on the website of ESY show significant differences between hospitals in terms of the indicators used.[30]

Prescription patterns by EOPYY doctors are closely monitored through the web-based application used for e-prescription and e-diagnosis. Hence, real time information is available on a basis on which detailed auditing on pharmaceutical prescription and expenditure is carried out (on volume and value, use of generics and off-patient drugs, on rebate etc.). Individual prescription behaviour, in comparison to peers, is also monitored and assessed (every month), and in the case of non-compliance with guidelines, penalties are imposed on

[28] For a debate on whether the crisis has increased suicidality in Greece see Economou et al. 2012; Fountoulakis et al. 2012a and 2012b; and Fountoulakis et al. 2013).

[29] It is planned that by November 2013 analytical cost accounting will have been introduced in all hospitals, in parallel with the allocation of internal controllers. For an assessment of the cost-effectiveness of new regulatory and policy mechanisms in respect to public procurement of health technologies see Kastanioti et al. 2013.

[30] See Polyzos 2012. For a review of logistics in Greek hospitals see Kafetzidakis and Mihiotis 2012.

physicians.[31] Nevertheless, despite these significant innovations, major stumbling blocks remain in performance terms. For instance, the web-application for e-prescription and e-referral is collapsing every little and while. This creates a backlog for doctors, and patients have to visit their doctors time and again to finally receive their prescription. Moreover, the e-system is not very "clever" and patients can be prescribed the same diagnostic tests within a very short period of time by different doctors. Thus, doctors have been ordered, in parallel to e-prescribing, to use the old-fashioned way of handwriting the prescription into the so-called "patient's booklet" which the patient must carry with him/her every time s/he visits a doctor. This is stress testing doctors (particularly those employed by the health centres of EOPYY) who are "ordered" not to spent more than 10 minutes with every patient.

It is more or less evident that cost-containment and efficiency improved at the cost of worsening performance in terms of equity, equality and responsiveness to users (and medical workers), and any efficiency gains that have been achieved, have not so far been used for improving universal access. Strikingly, quality indicators for service provision are lacking in the set of benchmarking indicators used. Measures do not embrace a long term view for improving effectiveness (e.g. the duplication of ESY through the establishment of EOPYY and the indecision and inertia about how to reorganize provision and funding in primary and secondary care, and most importantly, the indecision about how to better coordinate primary, specialist and secondary care testify to this).[32]

Fiscal sustainability overrides any other goal, and health outcome indicators already manifest a deteriorating trend, as we briefly mentioned above. Concern for health inequalities is absent from the policy context shaped by austerity measures and by the more specific bailout stipulations. The human cost of austerity may still not be fully visible but a perilous future of a "humanitarian crisis" is highly likely. The majority of hospital medicines on which savings are being made are mostly expensive, lifesaving drugs (e.g. for cancer and HIV/AIDS). Cancer treatment, mental health services, as well as services for prevention of drug use and therapy for substance dependence have been badly hit by spending cuts, while decisions about licensing and pricing new drugs particularly for serious illnesses are greatly delayed.

3.2.3 Sustainability

The cost-containment measures taken so far aim at improving system sustainability. However, drastic cuts in public resources allocated to health care spending and significantly reduced revenue (through contributions) of the unified health insurance fund (EOPYY) - due to galloping unemployment, and increased economic hardship that forces people (particularly the self-employed and small firms) to stop paying contributions - makes sustainability a contentious issue.

The financial situation of EOPYY remains rather grim. So far EOPYY has not settled "old arrears" to health care service and pharmaceutical providers that where transferred to this new unified health fund by the health insurance organisations that merged into EOPYY (paying off about 1.6 billion of these old arrears is still pending). In addition EOPYY created new arrears, and its growing deficit is estimated to reach about 1.2 billion by the end of 2013. This is primarily due to lower revenues than expected. Also expenditure overruns occurred for

[31] The system allows also full control of pharmacies.

[32] For some critical remarks on primary care see Fragkoulis 2012.

diagnostics and private health clinics during the first half of 2013.[33] In the face of these developments the government adopted as contingency measure the imposition of a clawback mechanism for private clinics and diagnostic health units (similar to that in force for pharmaceutical providers). An annual target has been set and any bills that overrun it will not be reimbursed by EOPYY. Whether private providers will incur the extra cost or shift it to the patient remains to be seen.

Moreover, a vicious cycle is perpetuated, where payments to hospitals by EOPYY take place with great delays. This impacts negatively on the ability of hospitals to pay suppliers on time, and generates arrears on the hospital side. Outstanding debts to suppliers often cause severe disruptions of service delivery, as suppliers refuse to provide medicines and other medical goods.[34] This, in turn, harms quality of service and access criteria (as waiting lists become longer).

3.2.4 Summary

Assessed on account of economic goals (efficiency and sustainability), health care reforms in Greece have been quite effective. Innovations in managing and monitoring drugs prescription and dispensing and the referral systems have largely contributed to the drastic cost-containment effort. Together with a number of accompanying measures - briefly reviewed above - cost savings in pharmaceuticals account for close to two thirds of the reduction of public health spending. Obviously, e-prescribing and e-diagnosis are positive developments that increase transparency and significantly reduce fraudulent behaviour.

However, what should be at stake in the field of health care in Greece is not only to control public expenditure but also to use efficiency gains in order to improve universal access, equity and service quality. On the latter accounts the country performed rather bad even before the eruption of the crisis (and this is reflected in the very low degree of satisfaction of the population by public health care services in Greece, see Eurobarometer 2007).

Yet, reforms prioritize drastic cuts both in spending and in the scope of publicly provided services shifting the financial burden to the patients (due to rising fees and co-payments, drastic limitation of exemptions – particularly for the chronically ill). Highly alarming is also the increasing number of the uninsured. All this has negative impacts on access and equity, not to mention service quality which is rarely alluded to in public documents. Seemingly a drift towards rolling back public provision and levelling down quality has begun, though it is an open question whether this will irreversibly lead to residual protection.

3.3 Reform debates

Reforming the newly established (but ailing) unified health fund (EOPYY) is at the forefront of the public debate. Recently a report was handed in to the Ministry of Health by an experts committee that was assigned the task to develop a proposal for reforming primary care (Souliotis et al. 2013). The committee proposes the unification of all (public) primary health care providers - currently operating under ESY, EOPYY and some Local Authorities - under

[33] Evidently through an induced demand so as to offset the reduction of price rates.

[34] Such a "vicious cycle" lies also at the root of rapid rising public health care spending for medical supplies over the previous decade (as suppliers expected payment with very long delays they increased prices, and successive rounds of this tactic ballooned expenditure).

the management and control of the Health Region Administrations (YPE). EOPYY will be a funding organisation for the insured population and will administer the financing for both primary and secondary care. A reorganisation of the network of primary health care provision will take place through the formation of health care units providing primary and specialist care. Family doctors will be the "gate" to the system and the coordinators of the medical acts required. However, the proposal allows for flexibility in access, as patients will be able to directly visit doctors of other specialities. GPs, pathologists, paediatricians and gynaecologists will constitute the core specialities of the local health care units. These will be decentralized, autonomously operating networks funded on the basis of prospective, global budgets that take into account demographic criteria and health care needs in the various regions.[35] A thorny issue concerns the doctors' employment status, in the case where ESY and EOPYY primary health care units will be amalgamated (ESY doctors are employed full time and cannot run a private practice, while EOPYY doctors are under contract[36] but carry out private practice too).

On the other hand, the Head of EOPYY proposes that the unification of primary health care services will take place under the management of EOPYY that will continue to have a service provision and a funding branch. Such a proposal draws upon the Health Management Organisations operating in the US (the funding branch of EOPYY will contract providers from the public and private sector).[37]

In the short-term, the Ministry of Health is considering measures on (further) rationing of health care provision and containing supplier-induced demand (for diagnostics), in order to reduce (or even avoid) reliance on the clawback mechanism that spurred strong opposition from private clinics.

High on the reform agenda is also a next step in the e-prescription process, namely the introduction of compulsory prescription protocols for some therapeutic groups and the establishment of monitoring mechanisms ensuring that the compulsory use of ICD-10 coding is respected.

The hospital network reorganisation constitutes an on-going process (on the basis of Law 4052 of March 2012) involving staff reallocation, changes in the function of several ESY health care facilities so as to achieve economies of scale and scope, redistribution of heavy equipment across hospitals, and revision of emergency and on-call duty.

Reforms in progress embrace also the further development of DRGs (with technical assistance from other EU member states). Putting in place a modern hospital costing system is a top reform priority. A DRG Management Institute is planned to be established soon, and steps are taken to incorporate a detailed personnel cost assessment in the new costing system. [38]

Finally, the cost-effectiveness of the reduction of profit margins of pharmacies is currently being assessed. Taking additional measures for further reducing it is still on the agenda, with a new deadline set for January 2014.

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[35] It is suggested that family doctors will be remunerated by capitation and along criteria of performance, health promotion initiatives and management of complex medical problems; while specialists will be remunerated on the basis of the volume of services provided. For a different view supporting the integration of primary care into ESY, "as the only realistic way to move forward" see Kondilis et al. 2012.

[36] Contracts are of varying duration though.

[37] A more or less similar proposal has been made also by the National School of Public Health; see also Niakas 2013.

[38] On the implementation of the DRG system see Polyzos et al. 2013.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

As stressed in the previous ASISP Annual Reports, social services (to children, the elderly, the disabled and other vulnerable groups) have developed slowly and in a fragmented way, while informal care within the family (in relation to privately financed care services provided mostly by legal and/or illegal migrant women, either as co-residing or day-care minders) has persistently played a crucial role in covering needs. Widespread and uniform provision of first-stop services addressed to all the population is lacking, while systematic data on care needs and differences in access to services by gender, age, health status, ethnic minorities and geographical location are absent.

Particularly regarding long-term care for the elderly, there is a mix of services provided: (a) by social insurance schemes (mainly nursing care in private clinics for chronically ill elderly people, though the extent and level of coverage significantly differ among social insurance funds); (b) by "new units" for elderly care – home help, day-care for frail elderly people- operated under the auspices of local authority agencies; and (c) by the family, as informal (unpaid or paid) care. Most of the "new units" have for a long time operated as distinct programmes (funded by EU sources) under the management of local agencies. Initially it was considered that the new units would be integrated in unified local authority social services, but this has hardly been achieved until the eruption of the crisis. Over the last few years debt-stricken local authorities have been even more unable to integrate programmes such as "Home Help" in their main functions; to a large extent employment in the "new units" is on a temporary basis, and due to sparse national funding service provision is often discontinued.

4.1.2 System characteristics

There is no universal statutory scheme for long-term care. Social insurance funds provide disability pensions and allowances. Other (non-contributory) disability benefits (in cash and in kind) are provided by social welfare institutions to persons who are in need of care because of a specific chronic illness or incapacity. According to 2011 administrative data (referred to in OECD 2013), about 60% of disability benefit recipients (either insurance or assistance-based) were above 50 years. Dependent on invalidity levels (of 50%, 67% or 80%) and kind of chronic illness, recipients are entitled to different levels of care provision. The degree of incapacity is evaluated by the Centres for Certifying Incapacity (KEPA).

The state provides residential care to indigent, lonely aged people in need of care through the 25 Chronic Illness Nursing Homes. Yet only three of them (two in Northern Greece and one in Crete) have a geriatric section. In 2009, there were roughly about 1900 people (of all ages) in residential care and 80 people in open care in these Chronic Illness Nursing Homes (total employment in them amounted to about 1400 personnel).[39]

[39] Data obtained from ELSTAT. Some beds are also provided by private elderly care units contracted by the Ministry of Labour, Social Security and Welfare for indigent elderly (due to insufficiency of beds in state run institutions), but there is no information about their total number.

Public nursing homes for the chronically ill are financed by the state budget and by per diem fees paid by social insurance organisations. In addition, according to recent legislation, 40% to 80% of the pension income of the chronically ill in state residential care (including psychiatric hospitals) is withheld by social insurance organisations for funding care expenses. After the recent reorganisation of the public-hospitals sector there are about 2000 beds in psychiatric hospitals (that can be counted as long-term care beds), while in all other hospitals out of the about 35,000 beds it is estimated that about 1000 may be used for long-term care.[40]

A number of private clinics under contract with EOPYY provide long-term care (mostly to terminally ill). Long-term care to frail, incapacitated (mostly lonely and indigent) elderly people is also provided by about 100 non-profit residential care homes. The majority of them are run by the Church of Greece, and the rest are run by specific endowments and some local authorities. There are also about 100 for profit residential homes for the elderly. In total, non-profit and for-profit residential care homes for the elderly have a capacity of about 15,000 beds. The former are partly subsidized by the state, and partly funded by donations (and per diem fees paid by social insurance organisation for those entitled to social insurance). For-profit residential homes are privately paid by the persons in care and their families. Interestingly over the last few years occupancy has significantly fallen from 100% to about 80%. Due to the crisis and economic hardship families opt to look after the elderly at home as pension benefits are a major source of income particularly among households with low work intensity.[41]

Semi-residential, day-care to the elderly is provided by the 68 Day Care Centres for the Elderly (KIFI).[42] They undertake the day care of old-aged people who cannot care for themselves, have serious economic and health problems and their family members cannot look after them because of their work. In the majority of cases they are operated by municipal enterprises or joint municipal enterprise partnerships, and cooperate with local social and health services. Since their establishment they have been funded mostly by EU resources. Presently they accommodate about 1500 old-aged people (and have a staff of about 270 employees).

As with the centres of day care, the "Home Help" programme (introduced in 1998) has so far been operated by municipal enterprises and has been mostly funded by EU resources. Presently there are about 879 "Home Help" schemes, providing services to about 76,000 beneficiaries. Employment amounts to about 3680 people (social workers, nurses, physiotherapists and home helps), the majority of whom are on a term-contract basis.[43] The schemes provide nursing care, social care services and domestic assistance to elderly (and/or disabled) people who live alone and face severe limitations in their everyday activities.

There are also three groups of rehabilitation centres providing outpatient services (Centres for Further Therapy and Rehabilitation of the Disabled, Centres for Physical and Medical Rehabilitation; and the so-called KEKYKAMEA - Centres for Education, Training and Social Support to Disabled Persons).[44] With Law 4025 of 2011 they came under the management of

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40 Data obtained from the Ministry of Health.

41 Information obtained from representatives of the Greek Health Care Homes Association.

42 There are also Open Protection Centres for the Elderly (KAPI) operated by municipal enterprises and non-profit entities. However, these have primarily a recreational function (prevention and medical care services provided are of a limited range).

43 Information on KIFI and "Home Help" programmes obtained from the Central Union of Municipalities of Greece (KEDE). According to KEDE, payment is pending for over nine months for long-term care workers in "Home Help" municipal schemes.

44 Rehabilitation is also provided in private centres. There is variation among social insurance funds as to the extent to which they cover costs in private rehabilitation centres.

ESY hospitals and, thus, control has been transferred from the Directorate of Social Welfare of the Ministry of Labour, Social Security and Welfare to the Ministry of Health).

4.1.3 Details on recent reforms in the past 2-3 years

In 2010, an overhaul of the national mode of governance (the so-called Kallikratis plan) transferred social care and social welfare responsibilities to local authorities. However crisis-stricken local authorities have been unable so far to integrate existing "fragmented" welfare structures. As mentioned earlier, schemes like "Home Help" and day care relied extensively on EU funding and temporary appointed personnel. These conditions in tandem with precarious employment for much of the staff negatively affect service provision.

Another legal reform took place with Law 4025 of 2011 that redrew the map of welfare organisations stipulating the administrative or functional amalgamation of a number of centres for child care, child camps, chronic disease institutions and others.[45]

Bringing long-term care under social insurance could be a structural solution for tackling future need. However such a plan runs counter to the bailout stipulation of reducing contribution rates. Instead, with the above mentioned law, the government made possible the use of resources of the so-called AKAGE (the Insurance Fund for Intergenerational Solidarity, established in 2008 as a reserve fund for meeting the future funding needs of social insurance) for plugging holes in the local authorities budgets (e.g. in respect to the "home Help" schemes). Moreover, Law 4052 of 2012 made explicit reference to the use of AKAGE resources for the "Home Help" programme, as an additional purpose to AKAGE's main function of covering future pension deficit. The resources devoted to "Home Help" will be transferred from AKAGE to IKA that will be responsible for the programme management. The "new" programme will be strictly means-tested and addressed to lonely indigent elderly people (or couples) 78 years and over, as well as to disabled pensioners (with a disability level of 67% and over) independent of age, who meet the required income criteria (the threshold is set at the level of 7715 euros per year).[46]

Competition among providers is encouraged, as apart from the schemes operated by municipal enterprises, other non-profit as well as for-profit "Home Help" units can submit bids for being included in the registry of certified schemes administered by IKA, from which beneficiaries can choose a provider. State funding to municipal "Home Help" schemes will be discontinued. The option offered to those working in municipal schemes is to form "social cooperatives" and bid for becoming accredited providers under the new, competitive system.

Due to strong opposition by local authorities and the association of social workers, legislation passed in early October 2013 postponed the full implementation of the above regulations and allowed for the renewal of the schemes run by local authorities for one more year (under programmatic agreements to be signed between the Ministry of Labour, IKA and EETAA (the Hellenic Agency for Local Development and Local Government).

[45] Among other provisions this law stipulated the compilation of an electronic data base of all recipients of welfare benefits.

[46] "Home Help" schemes that have been operated so far by local authorities have not strictly used means-testing criteria, as the decision taken by social workers have been based on individual judgment of needs.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

Admissions to state operated care centres for the chronically ill (that, however, hardly cover the needs among deprived elderly people) and to contracted non-profit and for-profit clinics are subject to referral by the social services of local authorities, of "regional units" (ex-prefecture level social welfare directorates), and of the NHS hospitals. Existing legislation does not define a specific income threshold. It rather stresses that economic hardship is a crucial criterion, but other factors defining the severity of need should be taken into account too in the evaluation of each specific case.[47]

Prevention measures and promotion of independent living among the elderly are a rather neglected policy area (as is also public health and health promotion). Moreover, over the last few years the combined effect of cuts to benefits and rapid increases in co-payments for medical devices and materials of vital importance for the chronically ill (as for instance, the 25% co-payment for oxygen tanks that people suffering from chronic pulmonary fibrosis require) place a heavy burden on low-income pensioners.[48] Such conditions not only run counter to independent living but put at risk the lives of older people suffering from severe chronic impairment.

4.2.2 Quality and performance indicators

Accreditation of (for-profit and non-profit) institutions providing care to elderly chronically ill and incapacitated persons is carried out by the Directorate of Welfare of the Ministry of Labour, Social Insurance and Welfare. Regular inspections of both state and non-state institutions also take place by the health inspectorate services of the Ministry of Health.[49] So far, no systematic quality assessment of residential care and care at home schemes has been introduced. As referred to by Kagialaris et al. 2010 (p. 31) the Greek Care Homes Association (PEMFI) has drafted a quality standard guide for elderly care homes that can voluntarily be adopted.

4.2.3 Sustainability

Statutory long-term care provision is insufficient, as nearly two thirds of people (15 years and over) needing care because of chronic impairment and reduced degree of independence in activities of daily living either receive informal care or no care at all. Fragmentation, discontinuity and precarious conditions of work characterize a number of schemes introduced in the late 1990s and early 2000s mostly on the basis of EU funding. Hence in many localities, social programmes have been beset with sustainability problems since their introduction.

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[47] According to data by the EU Commission, in 2010, 12% of persons 15 years and above in need of long-term care were in institutional care, 28% in home care, and 60% either had no access to care or were looked after by informal carers.

[48] E.g., monthly oxygen tanks bills exceed monthly pension income for many low-income pensioners in need of this.

[49] Currently, in collaboration with the Technical University of Athens (TEI) a pilot project for implementing a systematic preventive approach to food safety (a so-called HACCP system (funded under the National Strategic Reference Programme 2007-13) is under way in three state operated care centres for the chronically ill.

Under the harsh fiscal adjustment measures improving governance of the fragmented, rudimentary provision could be a solution for maintaining operation of the above mentioned schemes and improving efficiency. As also stated in the 2012 Annual Report, local authorities could play a coordination role in promoting the formation of networks of various providers (public, private, NGOs) targeted to elderly care. The establishment of one-stop agencies at the local level as single entry points into the social care and welfare system could further contribute to this. Moreover, partnership building could take the form of pooled budgets between cooperating institutions so as to better use resources for developing integrated care packages for elderly people in need, link up health care provision to social care and facilitate the introduction of regulatory mechanisms across the whole range of providers.

4.2.4 Summary

In a nutshell, there are no comprehensive formal long-term care services guaranteeing universal coverage. Existing services are addressed to the neediest, indigent people. Care for the chronically ill (either in state residential units or contracted non-profit and for-profit care centres and clinics) hardly covers demand due to insufficiency of the number of beds, the low rates paid by social insurance organisations, and a rapidly shrinking public budget. Private insurance for long-term care is negligible and the cost of private residential care, by those who can afford it, is met by out-of-pocket payments.

4.3 Reform debates

The option of social insurance coverage for long-term care needs could offer a solution for the future in view of rapid demographic ageing. Yet it is seldom considered in public debate. Social insurance contributions are held to be rather high and any increase is precluded. Under fiscal adjustment, it runs counter to the conditionalities of the MoU that links any prospects for improving competitiveness with a decrease of contributions (in tandem with the decrease of wages).

Promotion of independent living is prominent in terms of rhetoric, but relevant schemes and programmes remain fragmented and targeted to the neediest elderly people. Moreover, blurring the lines between social assistance and social insurance (e.g. by using the resources of the AKAGE fund for a strictly and narrowly targeted "Home Help" scheme) distorts equity and redistribution.

Old-age dependency ratios, particularly regarding the "oldest old" will rise steeply over the coming decades, pushing up demand for formal care. It is also highly likely that harsh cuts in public health spending and the rolling back of provision, in parallel with increasing hardship among households, will seriously limit access to health care (and to required treatment in case of medical need). As stressed earlier, this could lead to increased morbidity in the future that may spur a boomerang effect in terms of costs.

The alarming shortage in nursing and (formal) care personnel is another major issue. In addition to the fact that low prestige and low pay make such jobs not a labour option, the freezing of appointments of health personnel (and the threat of dismissals through the "suspension" programme currently underway) exacerbate shortages. At the same time, increasing emigration of skilled health personnel mostly to North European countries constitutes a significant drain of human resources.[50]

[50] See Malone 2012. On the need to improve motivation in Greek nurses see Gaki et al. 2013.

As the severe economic crisis leaves little room for an expansion of public provision, it is imperative to seek efficiency gains that can have a net positive impact on equity and coverage - through better coordination of existing provisions in cash and in kind, strengthening the interface between formal and informal care and developing support for carers.

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SKROUBELOS, ANASTASSIOS, DAGLAS, ARIS, SKOUTELIS, DIMITRIOS and KYRIOPOULOS JOHN (2012b), Nursing staff in Greece: current situation and challenges, Athens, National School for Public Health (in Greek).

SOULIOTIS, KYRIAKOS, THIRAIOS, ELEFTHERIOS, KAITELIDOU, DAPHNE, PAPADAKI, MARIA, TSANTILAS, PETROS, TSIRONI, MARIA and PSALTOPOULOU, THEODORA (2013), Main points of the proposal for primary health care reform, retrieved on 8 October at http://www.care.gr/post/7924/i-protasi-tis-task-force-gia-ton-eopyy.

TINIOS, PLATON (2012), Greece: extreme crisis in a monolithic unreformed pension system, Global Social Policy, 12(3), pp. 332-344.

TINIOS, PLATON (2013), Pensions and the economy after the Memorandum: towards a strategy of risk-spreading, ELIAMEP, Research Paper No 1 (in Greek).

VANDOROS, SOTIRIS, HESSEL, PHILIPP, LEONE, TIZIANA, and AVENDANO, MAURICIO (2013), Have health trends worsened in Greece as a result of the financial crisis? A quasi-experimental approach, European Journal of Public Health, 23(5), pp. 727-731.

ZAVRAS, DIMITRIS, TSIANTOU, VASILIKI, PAVI, ELPIDA, MYLONA, KATERINA, and KYRIOPOULOS, JOHN (2013), Impact of economic crisis and other demographic and socio-economic factors on self-rated health in Greece, European Journal of Public Health, 23(2), pp. 206-210.

Annex – Key publications

[Pensions]

LYBERAKI, Antigone, and TINIOS, Platon, Labour and pensions in the Greek crisis: The microfoundations of disaster, *Sudosteuropa*, 60(3), 363-386, 2012.

The paper focuses on pensions and the labour market in Greece that are called "the micro-foundations of disaster" by the authors. Critical points discussed are: policy inertia in respect to pension and labour market reform since the early 1990s (due to political expediency); and avoidance of quantification and sound forecasting mechanisms. This created a disjunction between appearance and reality, accompanied by a disjunction in perceptions between domestic and external commentators. The 2010 reform appeared as imposed by outside forces, though it was a lagged attempt at tackling long-lasting problems in the country. The authors stress that even under the current reforms no systematic process has emerged for defining problems, formulating proposals, implementing solutions and assessing impact. This indicates that major governance shortcomings remain, creating obstacles to Greece's recovery.

PETMESIDOU, Maria, Is social protection in Greece at a crossroads? *European Societies*, 15(4), 597-616, 2013, retrieved on 10 October at http://www.tandfonline.com/toc/reus20/current.

This paper examines social protection reforms under the combined effect of conflicts and impasses of the welfare system in Greece prior to the crisis and of an intractable sovereign debt crisis (largely due to accumulated deadlocks) that has engulfed the country since the late-2000s. Current welfare reforms on pensions, health and long-term care are critically reviewed with the aim to foreshadow the direction of impending change; and, particularly, to trace any indications of whether reforms can bolster universal access, equity and redistribution; or instead it triggers the drastic rolling back of public provision.

TINIOS, Platon, Greece: Extreme crisis in a monolithic unreformed pension system, *Global Social Policy*, 12(3), 332-344, 2012.

The author discusses the role that pensions played in the Greek sovereign debt crisis. He argues that an unreformed pay-as-you-go, defined-benefit pension system functioned as a key mechanism in the 'micro foundations of disaster'. The logic of fiscal stabilization applied to a public pay-as-you-go system led to major downward pension adjustments and increased pensioner insecurity.

TINIOS, Platon, Συντάξεις και οικονομία μετά το Μνημόνιο: προς μια στρατηγική διασποράς του κινδύνου, ΕΛΙΑΜΕΠ, Ερευνητικό Κείμενο, No 1, Μάρτιος 2013.

"Pensions and the economy after the Memorandum: Towards a strategy of risk-spreading"

This paper focuses on the role of pensions in the crisis and argues in favour of 'public-private partnerships' in the field of social insurance. According to the author, the key objective of pension reform in Greece should be the development of complementary and not mutually undermining relations between State and private (occupational and individual) responsibility for pensions, namely a reform towards the consolidation of a multipillar system.

[Health care]

ANAGNOSTOPOULOS, Dimitris C., and SOUMAKI, Eugenia, The state of child and adolescent psychiatry in Greece during the international financial crisis: a brief report, *European Child & Adolescent Psychiatry*, 22(2), 131-134, 2013.

This short article refers to the imminent backtracking of child and adolescent mental health in Greece. The authors stress the advocacy role of academic and professional organisations of child and adolescent psychiatrists in respect to dealing with the causes of this problem.

ATHANASAKIS, Kostas, SOULIOTIS, Kyriakos, KYRIOPOULOS E.-J. LOUKIDOU, Evangelia, KRITIKOU, Persefoni, and KYRIOPOULOS, John, Inequalities in access to cancer treatment: an analysis of cross-regional patient mobility in Greece, *Supportive Care in Cancer*, 20(3), 455-460, 2012.

The article presents and discusses the findings of a survey that assesses patient geographic mobility to access services for the prevention and treatment of neoplasmatic diseases in Greece. Their main conclusion stresses the misallocation of oncology-specific resources in the country that creates "two-tier" cancer patients based on ability to pay for travelling/accommodation.

ATHANASOPOULOS, Charalampos, PITYCHOUTIS, Pothitos M., MESSARI, Ioanna, LIONIS, Christos, and PAPADOPOULOU-DAIFOTI, Zeta, Is drug utilization in Greece sex dependent? A population-based study, *Basic & Clinical Pharmacology & Toxicology*, 112(1), 55-62, 2013.

The article investigates whether sex may have an impact on medication trends of the Greek population. It uses data from a survey conducted under the auspices of the National Centre for Social Research. Information was collected from a sample of 2499 inhabitants of Athens. The statistical analysis carried out proves that sex is a differentiating factor influencing the use of a range of drugs. Women consume more drugs and present different medication patterns, as compared to men, though other factors are involved too in influencing drug consumption patterns (like education, employment, socio-economic status).

BAGAVOS, Christos, Η κατάσταση υγείας του πληθυσμού στην Ελλάδα: Προσδόκιμο επιβίωσης και προσδόκιμο υγείας, Αθήνα, Παρατηρητήριο Οικονομικών και Κοινωνικών Εξελίξεων, ΙΝΕ-ΓΣΕΕ, 2012, retrieved on June 2013 from http://www.ineobservatory.gr/dhmosieuseis/meletes/i-katastasi-ygeias-toy-plithysmoy-stin-ellada-prosdokimo-epibiosis-kai-prosdokimo-ygeias/

"The health status of the Greek population: life expectancy and healthy life years"

This is a study of the health profile of the Greek population in 2009 on the basis of data provided by the Hellenic Statistical Authority. The emphasis is primarily on how to calculate life expectancy indicators. Life expectancy and healthy life years are examined with respect to gender, geographical area and employment status (with a focus on employee-status). The findings for Greece are compared with those of other EU member countries.

BMI 2013f: Greece Pharmaceuticals & Healthcare Report, Q3 (July), Business Monitor International, London, 2013.

This is a review of market trends in pharmaceuticals in Greece. It briefly presents and discusses major developments in health expenditure in relationship to the country's financial outlook, and traces key trends and developments in respect to payment of hospital arrears,

clawback taxes, and ability of EOPYY to pay drug makers in timely manner. It further assesses the risks to the pharmaceuticals industry in the medium term under the current crisis conditions.

BOUDIONI, Markella, MCLAREN, Susan Margaret, and LISTER, Graham, Cross-national diagnostic analysis of patient empowerment in England and Greece, *International Journal of Caring Sciences*, 5(3), 246-263, 2012.

This article compares patient empowerment policies in the context of the English NHS and the national health system in Greece. It aims to assess potential and actual barriers and facilitators to the application of national empowerment policies in each country. It is based on a network analysis of national voluntary and governmental organisations. Information was collected from semi-structured interviews with key representatives of the above-mentioned organisations. A documentary analysis is also carried out. A strong influence of the voluntary sector and well-developed policies facilitate patient empowerment in England, while low degree of knowledge and awareness characterizes patients in Greece.

BOUTSIOLI, Zoe, A simple descriptive analysis of hospital admissions' progress: a case study of the Greatest Public General Hospital, Athens, Greece, *Journal of Hospital Administration*, 1(1), 36-41, 2012.

This paper examines the progress of hospital admissions over the time period 1995-2005 for the largest Greek general public hospital. The findings indicate great seasonality for hospital admissions. Patterns are examined for both emergency and elective admissions.

DARVIRI, Christina, FOUKA, Georgia, GNARDELLIS, Charalambos, ARTEMIADIS, Artemios K., TIGANI, Xanthi, and ALEXOPOULOS, Evangelos C., Determinants of self-rated health in a representative sample of a rural population: A cross-sectional study in Greece, *International Journal of Environmental Research and Public Health*, 9(3), 943-954, 2012.

This is a cross-sectional study on self-rated health conducted in rural communities in Greece between 2001 and 2003. It corroborates previous findings indicating that people following a more proactive lifestyle pattern tend to rate their health better. The authors also discuss the stress-related neuro-endocrinologic mechanisms on self-reported health and health status in general.

DRAKOPOULOS, Stavros, ECONOMOU, Athina, and GRIMANI, Katerina, A survey of safety and health at work in Greece, *International Journal of Workplace Health Management*, 5(1), 56-70, 2012.

On the basis of an extensive literature review the authors examine the current state of occupational safety and health in Greece. While the number of working accidents has decreased over time, the severity seems to be increasing. Accidents are more frequent among males who are more exposed to negative working conditions.

ECONOMOU, Marina, MADIANOS, Michael, PEPPOU, Lily E., THELERITIS, Christos, and STEFANIS, Costas N., Suicidality and the economic crisis in Greece, *The Lancet*, 380(9839), 337, 2012 (authors' reply 337).

This short article focuses on the relationships between economic hardship and suicidality and argues about the rigorousness of the findings that confirm this association (it is a reply to critical comments by Fountoulakis and colleagues).

FOUNTOULAKIS, Konstantinos N., GRAMMATIKOPOULOS, Ilias A., KOUPIDIS, Sotirios A., SIAMOULI, Melina, and THEODORAKIS, Pavlos N., Health and the financial crisis in Greece, *The Lancet*, 379(9820), 1001-1002, 17-23 March 2012.

On the basis of the available empirical data on suicide rates in Greece, the authors examine the negative cycle of poverty and mental ill health, given the fact that conditions of poverty can increase the risk of mental illness. Also, people with mental health problems are more likely to experience poverty through increased health costs, loss of employment, reduced work hours, and stigma. However, it is argued that so far in Greece data do not support a causal link between economic hardship and increase of the suicide rate. A longer time span is required for arriving at conclusive evidence.

FOUNTOULAKIS, Konstantinos N., SAVOPOULOS, Christos, SIAMOULI, Melina, ZAGGELIDOU, Eleni, MAGEIRIA, Stamatia, IACOVIDES, Apostolos, and HATZITOLIOS, Apostolos I., Trends in suicidality amid the economic crisis in Greece, *European Archives of Psychiatry and Clinical Neuroscience*, 263(5), 441-444, 2013.

As in the previous publication, the authors focus on whether any conclusive data have been available so far for confirming the association between economic hardship and increased suicidality in Greece. They advocate measures so that there will be no increase in completed suicides in the near future, since historically, periods of socioeconomic instability might be related to increased suicidality.

FOUNTOULAKIS, Konstantinos N., SIAMOULI, Melina, GRAMMATIKOPOULOS, Ilias A., KOUPIDIS, Sotirios A., and THEODORAKIS, Pavlos N., Suicidality and the economic crisis in Greece – authors' reply, *The Lancet*, 380(9839), 337-338, 2012.

This short note is a response to the work by Economou and colleagues on the increasing suicidality in Greece. The authors stress that any conclusions on increasing suicide rates in Greece are immature, because Greece experienced extreme indices of crisis (e.g, unemployment rate above 17%) only after late 2011. Thus a longer time span is needed for conclusive evidence.

FRAGKOULIS Evangelos, Economic crisis and primary healthcare in Greece: 'disaster' or 'blessing'? *Clinical Medicine*, 12(6), 607, 2012.

The author expresses a warning that budget cuts without major reforms will lead to a Greek 'health tragedy'. He stresses that the crisis presents an opportunity for reengineering health service, so as to deal with the inefficiencies of the past, and improve access to quality healthcare, while keeping the cost in check.

GAKI, Eleni, KONTODIMOPOULOS, Nick, and NIAKAS, Dimitris, Investigating demographic, work-related and job satisfaction variables as predictors of motivation in Greek nurses, *Journal of Nursing Management*, 21(3), 483-490, 2013.

This article examines whether demographic variables and work-related factors predict work motivation in Greek nurses. Information was collected from a sample of 200 nurses from every sector and registration level in a University Hospital in Greece (the response rate was 76%). A previously developed and validated questionnaire was used that addresses four work-related motivators (job attributes, remuneration, co-workers and achievements) on a five-point Likert scale. Their findings show a highest score for "achievements" as the most important motivator. Job satisfaction, work sector and age were statistically significantly related to motivational factors too.

HYPHANTIS, Thomas, The "depression" of mental health care in general hospitals in Greece in the era of recession, *Journal of psychosomatic research*, 74/6, 530-532, 2013.

This author argues that the optimistic view that the crisis might be an opportunity for the Greek public health to tackle major deficiencies is not supported by the limited current evidence. Insteadm measures introduced so far indicate a deterioration of service quality and diminishing access.

KAFETZIDAKIS, Ioannis, and MIHIOTIS, Athanassios, Logistics in the health care system: the case of Greek hospitals, *International Journal of Business Administration*, 3(5), 23-32, 2012.

This paper attempts to identify the level of awareness of logistics in Greek hospitals, in view of the fact that the majority of the larger Greek hospitals face serious deficiencies in medical supplies due to their insolvency. The authors examine the distribution process of supplies, the amount or the volume of distributed medicines and the degree of partnerships between Greek hospitals and their suppliers. In the cases where logistics departments exist, they attempt to monitor and assess the extent of responsibility given to them with respect to purchasing, inventory management, internal distribution to medical departments and management information systems.

KAITELIDOU, Daphne Ch., TSIRONA, Christina S., GALANIS, Petros A., SISKOU, Olga Ch., MLADOVSKY, Philipa, KOULI, Eugenia G., PREZERAKOS, Panagiotis E., THEODOROU, Mamas, SOURTZI, Panagiota A., and LIAROPOULOS, Lykourgos L., Informal payments for maternity health services in public hospitals in Greece, *Health policy* (Amsterdam, Netherlands), 109(1), 23-30, 2013.

The authors attempt to estimate the size of the black economy in the field of obstetric services in Greece. Information was collected (through questionnaires) from a sample of 160 women who had recently given birth in three provincial general hospitals and one general hospital in Athens. Their findings show that 74.4% of women who used public maternity services had to pay under-the-table payments. These amounted to approximately the net salary of an intern physician. The authors conclude that there is a need for the state to adopt effective strategies to crack down on informal payments.

KARAMITRI, Ioanna, BELLALI, Thalia, GALANIS, Petros, and KAITELIDOU, Daphne, The accessibility of vulnerable groups to health services in Greece: a Delphi study on the perceptions of health professionals, *The International Journal of Health Planning & Management*, 28(1), 35-47, 2013.

The paper focuses on the issue of limited accessibility to healthcare services by certain population groups, such as poor and unemployed people, migrants and minorities. Limited access has negative impact on the health of these population groups. The issue is investigated from the perspective of health professionals. The authors conclude on empirically informed suggestions to address these problems.

KARATZANIS, Alexander D., SYMVOULAKIS, Emmanouil K., NIKOLAOU, Vasilios, and VELEGRAKIS, George A., Potential impact of the financial crisis on outpatient hospital visits due to otorhinolaryngologic disorders in Crete, Greece, *International Journal of Medical Sciences*, 9(2), 126-128, 2012.

On the basis of the outpatient database records of a large hospital in Crete, the authors explore the occurrence of a series of otorhinolaryngologic disorders which may be potentially attributed to increased levels of socioeconomic stress under the severe economic crisis. Their findings revealed that although the total number of visits for otorhinolaryngologic morbidity in the two periods examined - before and after the beginning of the financial crisis in Greece –

was comparable, a significant increase in the diagnosis of two disorders, namely vertigo and tinnitus, occurred after the eruption of the crisis.

KASTANIOTI, Catherine, KONTODIMOPOULOS, Nick, STASINOPOULOS, Dionysis, KAPETANEAS, Nikolaos and POLYZOS, Nikolaos, Public procurement of health technologies in Greece in an era of economic crisis. *Health Policy*, 109(1), 7-13, 2013.

This paper examines recent efforts by the government to reduce procurement costs of medical devices and pharmaceuticals, speed-up payment to suppliers, make uniform medical requests by providers, transfer redundant materials from one hospital to another and improve management of expired products. A state Health Procurement Committee (EPY) was re-established in order to prepare a plan for promoting efforts with regard to the above-mentioned goals. The authors review very briefly procurement practices and policies implemented so far and discuss their cost-saving impact.

KENTIKELENIS, Alexander, KARANIKOLOS, Marina, PAPANICOLAS, Irene, BASU, Sanjay, MCKEE, Martin, and STUCKLER, David, Health effects of financial crisis: omens of a Greek tragedy, *The Lancet*, 378(9801), 1457-1458, 22-28 October 2011.

The article briefly presents and discusses the negative health effects of the economic crisis in Greece. The emphasis is on diminishing access to care and preventive services, increasing risks of HIV and sexually transmitted diseases, and on conditions that in the worst cases threaten people's lives. The authors conclude that greater attention to health and health-care access is needed to ensure that the on-going severe crisis does not undermine the ultimate source of the country's wealth, namely its people.

KENTIKELENIS, Alexander, and PAPANICOLAS, Irene, Economic crisis, austerity and the Greek public health system, *The European Journal of Public Health*, 22(1), 4-5, 2012.

This is a short note on the impact of the crisis on public health. The emphasis is on the imbalance between reduced resources and increased demand and the wide-ranging changes required for addressing structural problems that the health care system has been accumulating for over a decade.

KENTIKELENIS, Alexander, KARANIKOLOS, Marina, PAPANICOLAS, Irene, BASU, Sanjay, McKEE, Martin and STUCKLER, David, Health and the financial crisis in Greece – Authors' reply. *The Lancet*, 379(9820), 1002, 17-23 March 2012.

This is a short note that replies to critical comments (published in *The Lancet*) to a previous article of the authors on the epidemiological effects of the current economic crisis in Greece.

KONDILIS, Elias, GIANNAKOPOULOS, Stathis, GAVANA, Magda, IERODIAKONOU, Ioanna, WAITZKIN, Howard, and BENOS, Alexis, Economic crisis, restrictive policies, and the population's health and health care: the Greek case, *American Journal of Public Health*, 103(6), 973-980, 2013.

This short paper attempts to show how rising health care needs and increasing demand for public services collide with austerity and privatization policies, exposing Greece's population to serious health care risks.

KONDILIS, Elias, SMYRNAKIS, Emmanouil, GAVANA, Magda, GIANNAKOPOULOS, Stathis, ZDOUKOS, Theodoros, ILIFFE, Steve and BENOS, Alexis, Economic crisis and primary care reform in Greece: driving the wrong way? *The British Journal of General Practice: the Journal of the Royal College of General Practitioners*, 62(598), 264-265, May 2012.

This is a short note on the politics of primary care reform in Greece. The authors argue that the economic crisis may offer an opportunity for the reorganisation of the health system, with primary health care reform being high on the agenda. Yet there are crucial questions as to the intended direction of restructuring.

KOURAKOS, Michael J., KAFKIA, Theodora V., THANASA, Georgia P., KILOUDIS, Panagiotis G., STATHAROU, Aggeliki K., REKLITI, Maria D., and SARIDI, Maria I., Εθνικό Σύστημα Υγείας (ΕΣΥ): Διερεύνηση αντιλαμβανόμενου άγχους στο νοσηλευτικό προσωπικό, *Το Βήμα του Ασκληπιού*, 11(4), 563-576, Οκτώβριος – Δεκέμβριος 2012.

"Greek National Health System (NHS): a study of perceived stress in nursing personnel"

The paper investigates the level of stress of the nursing personnel in Greece. Information was obtained through interviews with a sample of 102 nursing staff in the pathology clinics of four public hospitals in Attica. The findings show that despite an increasing workload, the nursing staff works with great zeal and care. Nevertheless, improving work conditions and pay levels, and providing adequate training on how to handle stressful conditions should be high on the policy agenda.

LOUKIDOU, Evangelia, MASTROYANNAKIS, Anastasios, POWER, Tracey, THORNICROFT, Graham, CRAIG, Tom, and BOURAS, Nick, Evaluation of Greek psychiatric reforms: methodological issues, *International Journal of Mental Health Systems*, 7(1), 11, 2013.

The authors briefly comment upon the efforts in Greece to modernize the outdated mental health system over the last 20 years, by developing community-based mental health care (including supported living facilities, community mental health centres and employment opportunities). The emphasis is on the methodology used for the evaluation of the Psychargos programme of the mental health reforms.

MALONE, Jasmine, Greek nurses reach crisis point: austerity measures imposed in Greece are wreaking havoc on health care and the nursing profession, *Nursing Standard*, 26(37), 18, 2012.

The author briefly discusses the serious effects on working conditions of nursing staff in public hospitals in Greece that the austerity measures have had so far.

PAPPA, Evelina, KONTODIMOPOULOS, Nick, PAPADOPOULOS, Angelos, TOUNTAS, Yannis, and NIAKAS, Dimitris, Investigating unmet health needs in primary health care services in a representative sample of the Greek population, *International Journal of Environmental Research and Public Health*, 10(5), 2017-2027, 2013.

This study aims to examine the prevalence of unmet needs and to identify the socioeconomic and health status factors that are associated with inability to satisfy medical needs. Information was collected in the context of cross-sectional study conducted in Greece in 2010 and involved data from 1000 consenting subjects (over 18 years of age). Multiple binary logistic regression analysis was applied to investigate the predictors of unmet needs and to determine the relation between the socio-demographic characteristics and the accessibility, availability and acceptability barriers.

PETMESIDOU, MARIA (2013a), Is the crisis a watershed moment for the Greek welfare state? The chances for modernization amidst an ambivalent EU record in 'Social Europe', in TRIANDAFYLLIDOU, Anna, GROPAS, Ruby and KOUKI, Hara, eds, The Greek crisis and European modernity, Houndmills, Basingstoke, Palgrave, pp. 178-207.

Structural changes and drastic social spending cuts in Greece (particularly in health and pensions), over the last two years, are framed and assessed in terms of EU-wide policy choices. Stringent European austerity and protracted recession will dismantle Social Europe. This does not augur well for the reform of the Greek welfare state, as it is highly probable that under a deficit-cutting "frenzy" the modernisation path will lead to a hotchpotch of residual, stigmatizing programmes for the most needy. On the other hand, an alternative scenario drawing upon a re-conceptualisation of the European Social Model as a "social buffer" and "economic stabilizer" at a time of crisis could provide fertile ground for an "upward convergence" of social protection systems; and hence encourage a modernisation path in Greece favouring a balanced mix of solidaristic elements, redistribution principles and market choice.

POLYZOS, Nicolaos, A three-year performance evaluation of the NHS hospitals in Greece, *Hippokratia*, 16(4), 350-355, 2012.

This paper assesses the performance of 117 Greek National Health System hospitals for the year 2011. The findings are compared with the results from similar studies of the previous years (2009 and 2010), so as to highlight changes during the last three years of financial crisis. On the basis of the data available on the web-based facility, ESY.net, three indicators were measured, namely technical, pure technical and scale efficiency indicators. The input variables were the number of physicians, the number of nurses and other personnel, the number of beds and expenditures of every hospital. The output variables were the number of inpatient and outpatient visits. Hospitals were classified into three size groups. The analysis concludes by indicating best practices in these three different groups of hospitals.

POLYZOS, Nikolaos, KARANIKAS, Haralampos, THIREOS, Eleftherios, KASTANIOTI, Catherine, and KONTODIMOPOULOS, Nick, Reforming reimbursement of public hospitals in Greece during the economic crisis: implementation of a DRG system, *Health Policy*, 109, 14-22, 2013.

The paper examines the introduction of DRGs in Greek public hospitals (the adoption of a patient classification system from abroad and its adaption for use in the Greek national health system). Overall, the authors discern an increasing adaptability by the hospitals and consider the measure as contributing to cost savings. Nevertheless, they admit that further corrective actions are needed.

SBAROUNI, V., TSIMTSIOU, Z., SYMVOULAKIS, E., KAMEKIS, A., PETELOS, E., SARIDAKI, A., PAPADAKIS, N. and LIONIS, C., Perceptions of primary care professionals on quality of services in rural Greece: a qualitative study, *Rural and Remote Health*, 12(2156), 1-14, 2012.

The paper focuses on the main barriers to providing high-quality primary care services. These embrace primary care service shortages in workforce and equipment; inadequate GP and paramedic training; the absence of position/job descriptions or duty statements for GPs and other primary care personnel; and limited public awareness about the role of GPs. The authors provide suggestions for remodelling the current primary care. They emphasize the need for the introduction of new technologies; GP empowerment; leadership reforms; and mechanisms for evaluating service quality.

SKROUBELOS, Anastassios, KAPAKI, Vasso, ATHANASAKIS, Kostas, SOULIOTIS, Kyriakos and KYRIOPOULOS, John, Ανασυγκρότηση και χρηματοδότηση της ασφάλισης υγείας. Το εγχείρημα του ΕΟΠΥΥ, Αθήνα, Εθνική Σχολή Δημόσιας Υγείας, 2012.

"Restructuring and funding of health insurance. The EOPYY project"

EOPYY is an intermediary agent for "collecting revenues" and "paying off bills to health providers" (albeit inefficiently). The authors argue that EOPYY as an organisation has not the capacity to develop health insurance policy satisfying the criteria of medical effectiveness, economic efficiency and equity. On the basis of an examination of EOPYY's organisational features and performance, the authors put forward a reform proposal that includes the integration of existing primary and specialized care units into primary care networks; and the adoption of a prospective payment system based on global budgets (payment of GPs and other frontline physicians per capitation and specialties on a fee-for-service basis). Multiple sources of funding are considered (state subsidy, health insurance contributions, user charges –with few exemptions- and EOPYY's own resources). Furthermore, they discuss the following elements, considered as crucial for a health insurance policy: provisions designed on the basis of evidence-based medicine; the financial burden that falls to users to be inversely proportional to need; management methods subject to the criteria of efficiency, effectiveness and equity; and comprehensive monitoring and evaluation processes.

SKROUBELOS, Anastassios, DAGLAS, Aris, SKOUTELIS, Dimitrios and KYRIOPOULOS John, Το νοσηλευτικό προσωπικό στην Ελλάδα: παρούσα κατάσταση και τρέχουσες προκλήσεις, Αθήνα, Εθνική Σχολή Δημόσιας Υγείας, 2012.

"Nursing staff in Greece: current situation and challenges"

This study examines the profile of nursing staff in the Greek health care system. The "expert panel" method was used for data collection from 32 distinguished health professionals. After a detailed analysis of the experts' answers to a broad range of questions the authors conclude on the serious problem of severe shortage of nursing staff in Greece.

SOULIOTIS, Kyriakos, THIRAIOS, Eleftherios, KAITELIDOU, Daphne, PAPADAKI, Maria, TSANTILAS, Petros, TSIRONI, Maria and PSALTOPOULOU, Theodora, Βασικά σημεία πρότασης για τη μεταρρύθμιση της πρωτοβάθμιας φροντίδας υγείας, Αθήνα, retrieved on 8 October at http://www.care.gr/post/7924/i-protasi-tis-task-force-gia-ton-eopyy.

"Main points of the proposal for primary health care reform"

This report summarizes the main reform proposals of a committee formed by the Ministry of Health. The main points of the proposal include: the unification of all (public) primary health care providers - currently operating under ESY, EOPYY and some Local Authorities - under the management and control of the Health Region Administrations (YPE). EOPYY will be a funding organisation for the insured population and will administer the financing for both primary and secondary care. A reorganisation of the network of primary health care provision will take place through the formation of health care units providing primary and specialist care. Family doctors will be the "gate" to the system and the coordinators of the medical acts required. However, the proposal allows for flexibility in access, as patients will be able to directly visit doctors of other specialities. GPs, pathologists, paediatricians and gynaecologists will constitute the core specialities of the local health care units. These will be decentralized, autonomously operating networks funded on the basis of prospective, global budgets that take into account demographic criteria and health care needs in the various regions.

VANDOROS, Sotiris, HESSEL, Philipp, LEONE, Tiziana, and AVENDANO, Mauricio, Have health trends worsened in Greece as a result of the financial crisis? A quasi-experimental approach, *European Journal of Public Health*, 23(5), 727-731, 2013.

This article examines the impact of the recent financial crisis on health in Greece on the basis of a quasi-experimental approach. The European Union Statistics on Income and Living Conditions survey for the years 2006–09 are used. The authors applied a difference-in-

differences approach that compares health trends before and after the financial crisis in Greece with trends in a chosen control population (Poland, which did not experience a recession but had health trends comparable with Greece before the crisis). Logistic regression was used for examining the impact of the financial crisis on poor self-rated health, controlling for demographic variables. The findings provide strong evidence of a statistically significant negative effect of the financial crisis on health trends.

ZAVRAS, Dimitris, TSIANTOU, Vasiliki, PAVI, Elpida, MYLONA, Katerina, and KYRIOPOULOS, John, Impact of economic crisis and other demographic and socio-economic factors on self-rated health in Greece, *European Journal of Public Health*, 23(2), 206-210, 2013.

This paper also focuses on the determinants of self-rated health in Greece. Data were collected through two national cross-sectional surveys, conducted in 2006 and 2011. In both surveys the samples used were random and stratified (by gender, age, degree of urbanization and geographic region). Logistic regression analysis was applied to determine the impact of several factors on self-rated health. The findings confirm the association of self-rated health with economic crisis and certain demographic and socio-economic factors.

[Long term care]

CARAYANNI, Vilelmine, STYLIANOPOULOU, Christina, KOULIERAKIS, George, BABATSIKOU, Fotoula, and KOUTIS, Charilaos, Sex differences in depression among older adults: are older women more vulnerable than men in social risk factors? The case of open care centers for older people in Greece, *European Journal of Ageing*, 9(2), 177-186, 2012.

The paper aims to estimate the prevalence of depression among older people in an urban Greek population. It examines the covariates of depression symptoms prevalence by gender. Information was collected from a sample of 360 individuals, 218 women and 142 men, aged 60 years or older, members of four open care centres for older people in Greece. The findings confirm the relationship between depression symptoms and gender and the importance of social and medical factors in the prevalence of depression symptoms, in both gender groups. However, women exhibit greater vulnerability to some social factors.

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