Greece

Health Care & Long-Term Care Systems

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Health care systems

1.12. GREECE

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

In 2013, Greece had a GDP per capita of 20,173 PPS, below the EU average of 27,900. Greece continues to suffer the economic effects of the crisis, but there are signs that the economy may be improving. The recession in 2015 now appears to have been less severe than expected and economic growth is expected positive in the second half of 2016. Compliance with the conditionality of the third adjustment programme, easing of capital controls and confidence in the markets, is expected to lead to GDP growth of 2.7% in 2017 ([109]).

Population was estimated at 11 million in 2013. According to Eurostat 2013 projections, total population in Greece is projected to decrease to 8.6 million in 2060, with a 22.5% decrease, which goes in the opposite direction of the EU as a whole, projected to increase on average by 3.1%.

Total and public expenditure on health as % of GDP

Total expenditure ([110]) on health as a percentage of GDP (9.8% in 2013) is just slightly below the EU average ([111]) of 10.1%. Public expenditure, at 6.8% of GDP (2013), shows a wider gap from the EU average of 7.8%.

When expressed in per capita terms, total spending on health, at 1751 PPS in Greece is below the EU average of 2988 in 2013, having increased steadily from 1588 in 2003 until a peak of 2410 in 2008. Public spending on health care was 1217 PPS vs. an EU average of 2208 PPS in 2013, having increased from 915 in 2003 to 1480 in 2009.

Expenditure projections and fiscal sustainability([112])

As a consequence of demographic changes, health care expenditure is projected to increase by 1.3 pps of GDP, above the average growth expected for the EU (0.9) ([113]) according to the Reference Scenario. When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 2.1 pps of GDP from now until 2060 (EU1.6). ([114])

Health status

Life expectancy at birth (84 years for women and 78.7 years for men in 2013) is above the respective EU averages (83.3 and 77.8 years of life expectancy) ([115]) and has increased slightly since the beginning of the crisis. Healthy life years, at 65.1 years for women and 64.7 for men are above the EU averages of 61.5 and 61.4 in 2013, but have fallen slightly since 2006. The infant mortality rate of 3.7‰ is below the EU average of 3.9‰ in 2013, having fallen since 2003. Amenable mortality was in 2011 163, well above the EU average of 128.4.

As for the lifestyle of the Greek population, the proportion of regular smokers at 38.9% of the population was above the EU average of 23.2% ([116]) and the highest recorded in the EU. Alcohol consumption, at 7.4 litres per capita, was lower than the EU average of 10 in 2009.

([109]) European Commission (2016), European Economic Forecast - Winter 2016.

([110]) Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under the System of Health Accounts and include HC.1-HC.9 + HC.R.1.

([111]) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU average for each year is based on all the available information in each year.

([112]) Greece is implementing the third adjustment programme monitored by the EU, the IMF and the ECB. The macroeconomic and budgetary prospects for Greece are assessed more frequently than for the other Member States. The time horizon covered by the forecasts for Greece is also different than for the other Member States and assume full implementation of the adjustment programme. Projections based on the fiscal sustainability indicators S1 and S2 are therefore not included here.

([113]) I.e. considering the "reference scenario" of the projections (see The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

([114]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

([115]) Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database. Data on life-styles is taken from OECD health data and Eurostat database.

([116]) The EU average value is recorded for 2009.

System characteristics

System financing, revenue collection, population coverage and role of private insurance and out-of-pocket payments

A mixed system in terms of funding and service delivery operates in Greece. A national health service funded by taxation goes hand in hand with a social health insurance system. A universal health system (ESY) financed on the basis of taxation was introduced in the early 1980s. The mandate of ESY is to provide both primary and secondary care. However, the actual provision of services was characterised by an underdeveloped primary care which resulted in exposing the population to high private expenditure. In terms of provision, public provision via ESY facilities goes in parallel with private provision with a very large number and type of private providers contracted by EOPYY. 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).

Four decades after its establishment, the system had not developed into a typical fully-fledged national health service despite the legal reforms introduced over the 1990s and 2000s. Until the end of 2011, a highly fragmented (multiple funds), occupation-based health insurance system purchased goods and services in parallel and in supplement to the National Health Service.

Until the 2011 reform, when EOPYY ("the National Health Services Organisation") initiated its activity, the employed population was enrolled in one of the large number of occupation based health insurance funds (the four biggest being IKA (employees), OGA (farmers), OPAD (civil servants) and OAEE (self-employed) and comprising about 80% of the population). Contribution rates varied across funds and each fund provided its own package of health services and goods. There was no risk-adjustment mechanism across funds to account for socio-economic differences and differences in health conditions of each fund's members. The multiplicity of funding and the fragmentation in the system did not contribute to ensuring good care coordination or defining effective care paths and referral systems, and were instead a significant challenge to equity, efficiency and effectiveness (unequal access to services, unnecessary use of specialists and rapidly rising pharmaceutical expenditure). This was reflected in a diversity of service coverage by social insurance funds enhanced by the different ability of funds to access private services.

The crisis showed that the coverage available to the unemployed for health care benefits offered by social security funds was uneven across funds and largely temporary in the case of some professions. While some groups continued to have coverage two years after becoming unemployed (e.g. those insured with IKA), certain groups lost coverage immediately (e.g. many of the self-employed professions). The coverage for those who became uninsured or those who could not afford their health insurance fees was limited to very low incomes (only those whose family income was below EUR 6,000 and held the so-called poverty booklet had access to the whole range of health care services for free).

Many Greek citizens lost their employment status and therefore the insurance status, losing their access to medicines, diagnostic tests and non-emergency primary and secondary care. Preventive care such as vaccination, emergency care and care to chronic diseases was instead declared provided to everyone. Whether in practice access was provided to uninsured persons anyway, notably in terms of primary and hospital care under ESY, is unclear. ([117])

The economic and sovereign crisis made health system reform a key priority and a major requirement of the rescue programme. The merging of all public health insurance funds into a unified health fund (EOPYY), initiated with law 3918 of 2011 (and subsequent legislation), constitutes a major development in health insurance with the aim to equalise contribution rates and health care benefits across occupational groups, for those employed and their dependents. EOPYY became the fully-fledge purchaser of health and services, while ESY and private

([117]) According to several reports, the uninsured did continue to receive care unofficially from different health care providers especially NHS (ESY) providers, but this was left to the discretionary decision of providers and not necessarily done in a systematic manner.

providers provide the necessary health goods and services. While the implementation of EOPYY has been an improvement so far, some challenges remain, notably the effective allocation of assets to EOPYY, the persistence of arrears in their payments to public and private providers and the collection of contributions and the lack of a proper primary care network and service. Indeed, in parallel to the social health insurance reform, a reorganisation of ESY was adopted that has moved the primary care centres under EOPYY into the ESY structure and redrew the national map of primary care centres and hospitals and cut down/rearranged the number of clinics and functional beds with the aim to contain cost and rationalise structure and administration. However, the primary care network remains underdeveloped, as signalled by a density of GPs that is lower than half that of the EU average([118]). In addition the authorities are currently developing policies to ensure a coherent and universal coverage of all residents and citizens independent or their occupational status, despite a recent set of measures aimed at establishing universal access to health care for Greek citizens.

The Greek government have recently passed several Ministerial Decrees to grant access to the uninsured to Primary Health Care (December 2013), Secondary care and diagnostics (July 2014) as well as pharmaceuticals (July 2014).

These laws have been adopted, but, based on information from the authorities it seems as though the government has not proceeded with full implementation. Reportedly, there are over 2,000,000 people that are estimated to have no health care coverage due to unemployment (of the individual or of the household head upon whom they depend) or due to discontinued payment of contributions. Whereas it seems that uninsured did receive free hospital care, although not full, free access to pharmaceutical care was never implemented. However, it is extremely difficult to estimate the real level of access ([119]). Recently passed legislation, the "Social Bill" of February 2016, tackles the issue of universal coverage, addressing the existing shortcomings ([120]) and extends coverage to refugees and other vulnerable groups in response to recent migration flows.

The share of private expenditure on health in total health expenditure (30.5% in 2013) is far higher than the EU average of 22.6%. Most is out-of-pocket for private care or for private providers with a contract with EOPYY. Out-of-pocket expenditure constitutes about 26.4% of total health expenditure, far above the EU average (14.1% in 2013). It has decreased since 2009 (37.9%), with a particular sharp drop from 2008 to 2009 (down to 28.4%). To a large extent, this is due to overconsumption and to higher than average prices of healthcare goods and services. To tackle the first issue, co-payments were revised upwards. Hospital care is delivered free of charge in public hospitals of the National Health System (ESY). As for contracted private clinics the amount patients contribute depends on the financing system ([121]): For private clinics not contracted by EOPYY, full charges apply.

A 15% co-payment for clinical tests when using private providers contracted by EOPYY, in tandem with 25% co-payment for a range of prosthetic devices, orthopaedic materials and respiratory devices, and a ceiling on consumables, such as diabetic test strips, injection needles etc. Cost-sharing also applies to pharmaceuticals (a share of the price of either 0%, 10% or 25%) depending on severity of condition.

At the same time existing exemptions from user charges for some groups have been made stricter (e.g. for the chronically ill persons exemptions are strictly related to their chronic illness).

Despite the increase registered in co-payment rates, parallel measures adopted to lower prices of goods, such as pharmaceuticals ([122]), and services,

([118]) See section "Coverage of services, types of providers, referral systems and patient choice".

([119]) Recent figures provided by the OECD report a level of coverage of 79% in 2013.

([120]) For instance removing the obligation for a committee to assess eligibility, which was reportedly hindering implementation in many cases.

([121]) When Diagnosis-related Groups (DRGs) (Κλειστό Ενοποιημένο Νοσήλειο- KEN) apply, insured pay a 30% contribution. When daily fees apply, they pay a 10% contribution. (http://www.missoc.org/MISSOC/INFORMATIONBASE/COMPARATIVETABLES/MISSOCDATABASE/comparativeTablesSearchResultTree.jsp, accessed 8 March 2016).

([122]) See section "Coverage of services, types of providers, referral systems and patient choice".

have lowered the basis on which the patients participation is calculated. However for policies to realise the full potential in terms of containing costs for patients, the joint effort of all stakeholders is essential.

Administrative organisation and revenue collection mechanism

The Ministry of Health develops the national health policy strategy, defining public health and policy priorities, specifying the regulatory framework, defining the system organigram and providing the overall management of the health care system as a whole. The Ministry of Health through ESY provides goods and services to residents and citizens of Greece.

EOPYY, the National Health Services Organisation purchases the goods and services for its insurees. At the moment the Social Security Funds continue to collect health-related contributions from those insured and submit them to EOPYY. EOPYY then commissions providers of health care, both public and private.

EOPYY and ESY are also funded form the State general budget. The budget for ESY is defined annually in Parliament when the general Budget is approved. In recent years, authorities have tightened the monitoring over the budget execution of both ESY and EOPYY. The information system has been strengthened and financial flows are regularly followed up on both an accrual and cash basis.

There are also seven Regional Health Authorities and their role vis-à-vis the administrative regions is under evaluation. Nevertheless, decision-making remains highly centralised (which may actually have helped with the implementation of cost containment policies in recent times).

EPY is the centralised purchasing agency for the Ministry of Health and tenders for and purchases centrally medicines and medical devices. The National Agency for Pharmaceuticals (EOF) is in charge of developing and implementing pricing and reimbursement policies, clinical and economic evaluation. IDIKA, the IT agency for the Ministry of Labour maintains the eHealth prescription system and monitoring prescription together with EOPYY who receives the data on a daily basis.

Coverage of services, types of providers, referral systems and patient choice

ESY comprises primary and secondary specialist and hospital care through a network of public facilities. In some rural areas it is the main provider of care. In Greece a mixed system of service delivery by public and private providers exists and there are a range of public and private care providers. Public providers include the ESY health centres plus the former health centres of IKA that have come under EOPYY and that have now been moved under ESY and the outpatient and inpatient departments of public hospitals and public laboratories. Private providers either under a contract with EOPYY or paid out-of-pocket by the patients include a large variety of laboratories, diagnostic centres and hospitals from small to very large companies. EOPYY defines the services included in the statutory provision. The services provided by ESY are not necessary explicitly defined.

However, there is not a very clear distinction between primary and specialist care (what constitutes primary care is not explicitly defined) and a gate keeping/referral system is still lacking. Residents do not have to register with a family doctor and first visit this prior to being referred specialist. Poor coordination between primary and secondary care is therefore a major predicament of health care in Greece. Addressing this shortcoming is a current policy priority. The re-modelling of the primary health care system and of EOPYY aims to help set up an effective referral/gate keeping system. The amalgamation of most health insurance funds under a single organisation (EOPYY) also constitutes a significant step towards improving primary care organisation and provision. Similarly, the transformation of EOPYY into a commissioner of health care rather than a provider means that its former hybrid form as 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 – has been rationalised. In 2014, all primary health care centres of public nature have been grouped under the common label of PEDY (National Primary Healthcare Network). De facto, primary care provision has remained inadequate as PEDY provided primary care was not sufficient to cover the population's needs. This led to access to

primary care through EOPYY's contracted private providers, for those who could afford it and to low-quality service and long waiting lists for vulnerable groups.

The total number of practising physicians per 100,000 inhabitants (629 in 2013) is the highest in the EU and well above the EU average (344 in 2013) and has continuously increased since 2003 (474), both before and after the crisis. Data on the physician skill-mix indicates that the number of GPs per 100,000 inhabitants (32 in 2013) is below the EU average (78.3) although it registered an increase since 2005 (26) as part of the authorities' effort to improve primary care provision. The number of nurses (390 in 2013) per 100,000 inhabitants is far below the EU average (837 in 2013). The reported figures point at an oversupply of doctors and undersupply of nurses, which is indicative of an inefficient allocation of resources.

Greece had 399 acute care hospital beds per 100,000 inhabitants in 2011 (up from 382 in 2003), above the EU average of 360 for the same year. In addition, Greece displays higher than average rates of MRI units (2.42 vs EU 1.0), angiography units (1.1 vs EU 0.8) and CTS scanners (3.5 vs EU 1.6) per 100,000 inhabitants.

Purchasing, contracting and remuneration mechanisms

Remuneration is defined by the government. All ESY doctors in primary or secondary care are paid on a salary basis and directly by the Ministry of Finance. Hospitals are allocated resources setting the budget on the basis of historical and prospective costs, but the authorities are developing a Diagnosis-Related Group (DRG)([123]) system to be used for hospital remuneration. In addition to the transfers from the Government, hospitals generate their own revenue, though a very limited share of the total ([124]), through special services (e.g. individual private rooms) and from privately insured patients in the so-called afternoon practice.

There has also been progress in establishing a DRG-based hospital payment system in order to ensure effective reimbursement of hospitals. The first step was to develop KEN-DRGs, to define standard patient cases and calculate the respective hospital costs and use these to bill SSFs, private insurance companies and private patients. Work is still on-going but progress is currently uncertain.

Doctors in private practices are paid a fee for service in the case of most diagnostics and outpatient consultations and on the basis of a "DRG-KEN" costing structure in the case of private hospitals.

The market for pharmaceutical products, the use of Health Technology Assessment and cost-benefit analysis

Major developments in this area embrace higher control over medical prescriptions (e-prescribing and e-diagnosis systems), the development of clinical protocols, new pricing rules for pharmaceuticals and changes in procurement processes.

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. 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 two times yearly). A number of drugs were also eliminated from the “positive list” of drugs (reimbursed 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.

Increasing the market share of generics and regulating their prices are also major objectives of past and current Greek governments. E-prescription and prescription by active substance (INN - International Non-proprietary Name) are now compulsory. The pharmacist is obliged to dispense the generic with the lowest price, but, according to evidence, this is not happening. 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). Very recently, a further MD amended this mechanism to limit the patients' participation to 20 euros.

([123]) Κλειστά Ενοποιημένα Νοσήλια (KEN) in Greek.
([124]) The share is estimated not to exceed 10%.

The market penetration of generics remains limited. ([125]) 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. 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, but remain limited.

Containment of pharmaceuticals expenditure has been a top priority and has been carried out successfully to large extent in recent years plan (given the fact that drugs expenditure increased exceptionally fast during the 2000s). 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). 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, which has preserved prices and volumes from otherwise stricter necessary downwards revisions. 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.

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 could be imposed on physicians. Nevertheless, despite these significant innovations, major stumbling blocks remain in performance terms, due to resistance from main stakeholders, in particular doctors and pharmacists.

([125]) The Role of Generic Medicines in Sustaining Healthcare Systems: A European Perspective, IMS (2015).

eHealth (e-prescription, e-medical records) and information and reporting mechanisms

Greece has an e-prescription system, run by HDIKA that includes prescription for pharmaceuticals, referrals and diagnostics. This prescriptions' processing unit collects all the data of prescribing, both the electronic prescriptions and handwritten and scanned ones and has developed a Business Intelligence system producing both fixed reports as well as reports generated ad-hoc.

In addition, a personal health insurance file is being developed, containing data for all hospitalisations, health services, materials and diagnoses of a patient. The data are computerised and the coverage is national. This will be further enhanced by adding information on laboratory exams recorder by diagnostic centres. Lastly, 3 registries of medicinal products have developed (hepatitis C, chronic myeloid leukaemia and multiple sclerosis) and an additional one is expected during 2016.

These tools can help improving monitoring and control of prescription and consumption of services and goods and will render a future referral system and care coordination more effective, reducing the use of unnecessary pharmaceutical, specialist and hospital emergency care.

Health promotion and disease prevention policies

in 2013, public and total expenditure on prevention and public health services as a % of GDP were lower than the EU average (0.10% and 0.10% vs. 0.24% and 0.19% in 2013), which also characterised recent years. Public and total expenditure on prevention and public health services as a % of current health expenditure (public and total, respectively) are, similarly, both

below the EU average (1.1% vs. 2.5% and 1.7% vs. 2.5% in 2013).

Transparency and corruption

In past years, there have been reports of corruption in the system ([126]), in the form of bribery in medical service delivery (informal payments to obtain better services or to jump queues), procurement corruption (favouring of specific providers and putting obstacles to competition) and misuse of (high) level position. It is important to assess to what extent the measures addressing public procurement adopted so far have positive effects in this field and to design further improvements to completely eliminate corruption.

Furthermore, although there has been important progress in safeguarding the independence of hospital managers the last years, the system has not fully succeeded in isolating political interventions from decision making.

Recently legislated and/or planned policy reforms

In recent years, the authorities have taken several steps to improve health care delivery in Greece.

The creation of EOPYY was an important step in improving equity in financing and access to care. With EOPYY, contribution rates across professions and population groups were harmonised considerably (only those previously in OGA continued paying a lower amount and had access to a more limited set of benefits). The programme also included the introduction of centralised tendering of specific hospital supplies, which has led to significant savings, as the differences in prices paid by different hospitals have been eroded. However, the proportion of purchasing that is conducted through centralised tendering is still relatively low, indicating there is still scope to achieve further increases in efficiency.

These measures have also helped reduce fraud and waste. Improved budgeting and transparency, regular monitoring and e-prescription have made it easier to detect irregular behaviour. More reforms can be undertaken in this direction, such as electronic queuing systems for referrals to secondary care or, as mentioned in the paragraph above, increases in centralised tendering.

Under the programmes, the Greek government has undertaken measures yielding substantial savings on pharmaceuticals in line with best international practice:

- Setting up of an electronic prescription system to enable control and monitoring of prescription behaviour, as well as the implementation of electronic prescription guidelines.
- Pricing based on the three-lowest EU prices.
- Establishment of an evidence-based positive list of drugs that are reimbursed by EOPYY.
- Promotion of generic medicines and reduction of over-prescription and fraud by INN prescribing.
- Establishment of an annual expenditure ceiling and claw back system to enable control of pharmaceutical expenditure.
- Establishment of pharmaceutical co-payments from 25% to 10%, while setting up a list of exemptions to ensure access.

As a result, public reimbursed expenditure on pharmaceuticals has gone from above 5bn at the start of the programme to a budgetary cost of about 2bn in 2014 and is legislated to remain at this level until 2017.

Until recently, public hospitals faced significant deficits. These deficits were addressed periodically through ad-hoc state subsidies derived from taxation revenues and often resulted in payment arrears to providers. The reasons were manifold and included delays in payment by SSFs combined with low statutory fees paid by SSFs for hospital services, in comparison to actual per diem costs, but also poor IT systems, poor budgeting and accounting systems combined with poor monitoring which led to a lack in transparency of financial and care activities carried by hospitals. In addition, an inefficient procurement of

([126]) European Commission (2013), "Study on Corruption in the Healthcare Sector", Directorate-General Home Affairs.

pharmaceuticals and medical supplies led to high prices and large variations in the prices paid by different hospitals. More generally, a proper incentive structure to deliver cost-effective services and stay within their budgets was absent. Such incentives common in other Member States include a mix payment system and performance assessment mechanisms. More recently, improved IT and modern accounting systems have been established (accrual accounting has been introduced in addition to cash accounting), with balance sheets for all hospitals, unpublished for several years, now regularly published online. Hospital funding and funding flows from various sources are now transparent and monitored on a regular basis and arrears have been significantly reduced.

Centralised purchasing has improved even if at slow speed with important savings, sometimes reaching more than 50% in price reduction paid for some medicines and medical supplies. Performance indicators have been introduced in order to assess the performance of hospitals and identify specific challenges.

Greece is currently implementing the third adjustment programme monitored by the EU, the IMF and the ECB. Several commitments have been formulated by the authorities and policies are being developed accordingly to meet the targets within the agreement.

In parallel, the authorities have formulated a plan to improve the system contained in the 100 Actions' Plan document. The document addresses several areas that need reforming based on three axes:

AXIS 1: ensuring universal access to quality care,

AXIS 2: transparent, inclusive and modernised health governance through an efficient and effective public administration

AXIS 3: fair and sustainable financing.

The proposed plan aims at the modernisation of the system and at improving quality and access while ensuring sustainability.

Recently, legislation was passed to update the existing legislation on the coverage of uninsured Greek citizens to accommodate the incoming flows of migrants. This legislation contained other measures to improve the functioning of the healthcare sector, such as a human resource strategy to increase staff and re-qualify the existing one to support the development of a primary health care network over the territory.

In general, policies are being developed which should support the goals of greater generics penetration, more rational prescribing patterns, rationalisation of healthcare expenditure, promotion of higher transparency in the system, elimination of waste, greater transparency and elimination of corruption. In practice though, progress is slow and uncertain in these areas.

Challenges

The analysis above shows that several reforms have been implemented in Greece over the last five years. However, the current incentives present in the system are not necessarily conducive to the use of cost-effective interventions, while individuals pay a significant share of expenditure directly out of their own pockets. On the basis of the analysis the main challenges for the Greek health care system are as follows:

- To continue increasing the efficiency of health care spending, promoting quality and integrated care as well as a focusing on costs, to tackle the impact on spending due to population ageing and non-demographic factors. To this end, rationalise health care expenditure by discouraging the overuse of products and services. In addition to encourage the use of generics, to improve hospital management, to strengthen public procurement and to further the efforts in the development of protocols for treatment.

- To improve the basis for more sustainable and efficient financing of health care in the future, aiming at a better balance between resources and spending. This can reduce the size of private payments through enhanced coverage and reduce inequalities in the access and quality of care and its distribution between population groups and regional areas. To tackle the issue of arrears in payments by EOPYY.

- Despite the observed progress in pharmaceuticals expenditure, more efforts are needed to ensure that spending stays within the envelope and that spending targets are not achieved just due to the implementation of established cost-containment mechanisms (clawbacks), for instance, increasing the penetration of generics and the application of therapeutic protocols.

- To reduce the excessive use of secondary specialist and hospital care. To promote greater efficiency in the hospital setting, including by rationalising the use of resources to ensure all capacity within public hospitals is utilised. To this end, consider whether there is scope to regulate the flows of patients towards private providers by linking this possibility to a threshold in terms of waiting time/local capacity. In addition, consider adjusting the existing reimbursement schemes to increase efficiency and productivity in the delivery of hospital services.

- To implement a comprehensive strategy for primary health care over the territory, for it to act as a gatekeeper. To adjust staff training and the staff skill mix towards having more primary care doctors and nurses, correcting the current inefficient allocation of resources that sees an oversupply of doctors and an undersupply of nurses. It should be complemented with financial and non-financial incentives including the extent of cost-sharing to encourage the use of primary care versus specialist care. Relatedly, authorities should improve follow-up care so as to reduce the unnecessary use of acute care settings for long-term care patients. To this end, to make use of the existing eHealth tools.

- To improve governance (general coherence and management) of the health care sector for instance by clearer definition of strategic, evidence-based objectives and by strengthening technical expertise. To tackle the issue of corruption and to eliminate waste.

- To enhance and continue data collection and monitoring of inputs, processes, outputs and outcomes so that regular performance assessment can be conducted and used to continuously improve access, quality and sustainability of care. This includes efforts to assess and publish evaluations of the quality of care provided for example.

- To make more use of cost-effectiveness information in determining the basket of goods and the extent of cost-sharing to induce cost-effective behaviour.

- To enhance health promotion and disease prevention activities i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (diet, smoking, lack of exercise, obesity).

- To ensure access to primary and secondary health care of the vulnerable groups, particularly the uninsured. In that respect, close monitoring of the respective costs will be necessary, particularly those related to the health needs of the refugee/migration flows in order to disentangle the relevant budgetary effects and seek for the appropriate EU funding.

Table 1.12.1: **Statistical Annex – Greece**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	179	194	199	218	233	242	238	226	207	191	180	9289	9800	9934
GDP per capita PPS (thousands)	24.4	25.2	24.5	25.6	25.6	25.1	23.2	22.1	19.9	19.6	20.2	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	5.6	4.0	1.9	5.2	3.2	-0.4	-3.1	-4.7	-6.9	-6.7	:	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	3.6	1.1	13.4	6.2	3.8	2.8	-2.5	-11.3	-3.9	-11.7	:	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	8.9	8.7	9.7	9.8	9.8	10.1	10.2	9.5	9.8	9.3	9.8	10.4	10.1	10.1
Total current as % of GDP	8.2	8.0	9.0	9.0	9.1	9.8	10.0	9.3	9.7	9.2	9.2	9.8	9.6	9.7
Total capital investment as % of GDP	0.7	0.7	0.7	0.8	0.8	0.4	0.2	0.1	0.1	0.1	0.7	0.6	0.5	0.5
Total per capita PPS	1588	1671	1908	2099	2249	2410	2372	2096	1981	1739	1751	2828	2911	2995
Public as % of GDP	:	:	:	:	:	:	7.0	6.3	6.6	6.2	6.8	8.1	7.8	7.8
Public current as % of GDP	5.1	4.8	5.6	5.7	5.6	5.8	7.0	6.3	6.6	6.2	6.0	7.9	7.7	7.7
Public per capita PPS	915	945	1111	1247	1302	1392	1480	1353	1336	1167	1217	2079	2218	2208
Public capital investment as % of GDP	:	:	:	:	:	:	0.0	0.0	0.0	0.0	0.8	0.2	0.2	0.1
Public as % total expenditure on health	:	:	:	:	:	:	68.4	66.7	67.4	67.1	69.5	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	11.6	12.1	13.7	13.4	13.1	12.6	12.2	13.0	11.9	10.8	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	100.0	100.0	100.0	100.0	100.0	100.0	:	:	:	:	79.0	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	34.3	35.2	34.8	32.9	34.6	37.9	28.4	29.4	28.8	28.8	26.4	14.1	14.4	14.1

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												**2009**	**2011**	**2013**
Population, current (millions)	10.9	10.9	11.0	11.0	11.0	11.1	11.1	11.1	11.1	11.1	11.0	502.1	504.5	506.6
Life expectancy at birth for females	81.8	82.0	82.3	82.6	82.5	83.0	83.3	83.3	83.6	83.4	84.0	82.6	83.1	83.3
Life expectancy at birth for males	76.5	76.6	76.7	77.1	76.9	77.5	77.5	78.0	78.0	78.0	78.7	76.6	77.3	77.8
Healthy life years at birth females	68.4	65.5	67.4	68.1	67.6	66.2	66.8	67.7	66.9	64.9	65.1	:	62.1	61.5
Healthy life years at birth males	66.7	63.9	65.9	66.5	66.0	65.6	66.1	66.1	66.2	64.8	64.7	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	123	117	110	104	97	92	86	79	163	166	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	4.0	4.1	3.8	3.7	3.5	2.7	3.1	3.8	3.4	2.9	3.7	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	:	:	:	:	:	:	3.66	3.43	3.84	4.25	3.81	3.13	2.99	3.01
Day cases curative and rehabilitative care	:	:	:	:	:	:	0.06	0.05	0.06	0.03	0.03	0.18	0.18	0.19
Out-patient curative and rehabilitative care	:	:	:	:	:	:	2.36	2.15	2.11	1.62	1.54	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.80	1.80	2.00	2.10	2.30	:	2.84	2.68	2.63	2.31	2.80	1.60	1.55	1.44
Therapeutic appliances and other medical durables	:	:	:	:	:	:	0.24	0.21	0.22	0.18	0.14	0.31	0.31	0.32
Prevention and public health services	:	:	:	:	:	:	0.13	0.13	0.13	0.11	0.10	0.25	0.25	0.24
Health administration and health insurance	:	:	:	:	:	:	0.19	0.17	0.20	0.18	0.22	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	:	:	:	:	:	:	3.02	2.71	3.02	3.33	2.83	2.73	2.61	2.62
Day cases curative and rehabilitative care	:	:	:	:	:	:	0.06	0.05	0.06	0.03	0.03	0.16	0.16	0.18
Out-patient curative and rehabilitative care	:	:	:	:	:	:	0.83	0.80	0.83	0.68	0.65	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	:	:	:	:	:	:	2.26	2.05	1.94	1.53	1.86	0.79	1.07	0.96
Therapeutic appliances and other medical durables	:	:	:	:	:	:	0.17	0.15	0.16	0.12	0.10	0.13	0.12	0.13
Prevention and public health services	:	:	:	:	:	:	:	:	0.13	0.10	0.10	0.25	0.20	0.19
Health administration and health insurance	:	:	:	:	:	:	0.15	0.12	0.15	0.14	0.18	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.12.2: **Statistical Annex - continued – Greece**

												EU- latest national data		
Composition of total as % of total current health expenditure	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	:	:	:	:	:	:	36.5%	36.7%	39.7%	46.4%	41.6%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	:	:	:	:	:	:	0.6%	0.6%	0.6%	0.3%	0.3%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	23.5%	23.0%	21.8%	17.7%	16.8%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	21.9%	22.6%	22.2%	23.4%	25.4%	:	28.3%	28.7%	27.2%	25.2%	30.6%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	2.4%	2.3%	2.2%	2.0%	1.6%	3.2%	3.3%	3.3%
Prevention and public health services	:	:	:	:	:	:	1.3%	1.4%	1.3%	1.2%	1.1%	2.6%	2.6%	2.5%
Health administration and health insurance	:	:	:	:	:	:	1.9%	1.8%	2.1%	2.0%	2.5%	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	:	:	:	:	:	:	43.3%	42.9%	45.8%	53.5%	47.1%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	:	:	:	:	:	:	0.8%	0.8%	0.9%	0.4%	0.5%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	11.9%	12.7%	12.6%	10.9%	10.8%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	:	:	:	:	:	:	32.4%	32.4%	29.4%	24.6%	30.9%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	2.4%	2.4%	2.4%	2.0%	1.6%	1.6%	1.6%	1.6%
Prevention and public health services	:	:	:	:	:	:	:	:	2.0%	1.6%	1.7%	3.2%	2.7%	2.5%
Health administration and health insurance	:	:	:	:	:	:	2.1%	2.0%	2.3%	2.2%	3.1%	1.4%	3.5%	3.5%

												EU- latest national data		
Expenditure drivers (technology, life style)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
MRI units per 100 000 inhabitants	:	:	1.32	1.63	1.79	1.96	2.17	2.26	:	:	2.42	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	:	:	0.9	0.9	0.9	0.9	1.0	1.0	:	:	1.1	0.9	0.9	0.8
CTS per 100 000 inhabitants	:	:	2.5	2.6	2.9	3.1	3.4	3.4	:	:	3.5	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	:	0.0	0.0	0.0	0.0	0.0	0.0	:	:	0.0	0.1	0.1	0.1
Proportion of the population that is obese	:	:	:	16.4	:	17.6	:	19.6	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	:	38.6	:	40.0	:	31.8	:	38.9	:	:	:	23.2	22.4	22.0
Alcohol consumption litres per capita	8.7	8.9	9.2	8.8	9.0	8.8	8.3	7.9	7.4	:	:	10.3	10.0	9.8

Providers	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Practising physicians per 100 000 inhabitants	474	488	501	536	557	606	617	621	625	627	629	329	335	344
Practising nurses per 100 000 inhabitants	429	428	423	429	429	432	438	:	330	360	390	840	812	837
General practitioners per 100 000 inhabitants	:	:	26	25	31	27	28	30	30	31	32	:	78	78.3
Acute hospital beds per 100 000 inhabitants	382	379	386	394	395	395	405	402	399	:	:	373	360	356

Outputs	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Doctors consultations per capita	4.2	4.2	3.9	4.0	4.0	:	:	:	:	:	:	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	:	:	:	:	:	:	:	:	:	:	19.9	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	6368	6530	7031
Acute care bed occupancy rates	74.0	75.0	73.0	75.0	73.0	73.4	72.5	70.6	:	:	:	72.0	73.1	70.2
Hospital curative average length of stay	6.0	5.7	5.6	5.8	5.4	5.4	5.3	5.3	:	:	:	6.5	6.3	6.3
Day cases as % of all hospital discharges	:	:	:	:	:	:	:	:	:	:	:	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060**	**EU Change 2013 - 2060**
AWG reference scenario	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	0.9
AWG risk scenario	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060, in %**	**EU - Change 2013 - 2060, in %**
Population projections until 2060 (millions)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	3.1

Sources: EUROSTAT, OECD and WHO

Greece

Long-term care systems

2.12. GREECE

General context: Expenditure, fiscal sustainability and demographic trends

Greece, member of the European Union since 1981, has a population of around 11 million. With a GDP of around EUR 180 bn or 20,173 PPS per capita, it is below the EU average GDP per capita of 27,881 PPS, and has contracted significantly in the post-crisis years. Public expenditure on long-term care is, with 0.04% of GDP ([386]), below the EU average of 1.0% in 2012.

Health Status

Life expectancy at birth for men and women was, in 2013, respectively 78.7 years and 84.0 years, close to the EU average (77.8 and 83.3 years respectively). In 2013, the healthy life years at birth were 65.1 years (women) and 64.7 years (men) well above the EU-average (61.5 and 61.4 respectively). The percentage of the Greek population having a long-standing illness or health problem was lower than in the Union as a whole (23.9% and 32.5% respectively in 2013). However, in the same year, the percentage of the population indicating a self-perceived severe limitation in its daily activities was 10.8%, above the EU-average (8.7%).

Dependency Trends

The number of people depending on others to carry out activities of daily living is projected to rise over the next 50 years. The number of people living with strong limitations due to health problems in 2013 were 0.87 million and an increase of 24% is expected until 2060, bringing this number to slightly more than 1.07 million. ([387]) The corresponding EU change for that period is 40%. Moreover, dependents are also projected to increase as a share of the population, from 7.8% to 12.5%, a rise of 60%, almost double the EU level over the same period (36%).

([386]) Estimated for 2013.

([387]) This figure is based on the Demographic Scenario, so the estimate is based on the effect of pure ageing.

Expenditure projections and fiscal sustainability ([388])

Based on the AWG reference scenario, the current value of public expenditure on LTC as a percentage of GDP is projected to grow from 0.5 in 2013 to 0.9 in 2060, a difference of 88% which is more than double that of the EU for that period (40%). According to the AWG risk scenario, which also captures non-demographic cost drivers in expenditure, is foreseen to increase from 0.5 in 2013 to 1.3 in 2016. This corresponds to a bigger projected change of 166%, higher than the EU average of 149% over the same period ([389]).

System Characteristics

In Greece, there is no universal statutory scheme for long-term care and there is a mixed landscape of services provided by public entities private entities and families.

Traditionally, long-term care was provided by the family, and only when the family was not able to care for the dependent or to afford alternatives, the solution would be institutionalisation. In the 1980s the state began the process of recognition of the specificities of long-term care as a separate item from primary care or secondary care, with the aim of allowing for the non –institutionalisation of the elderly who were in general good health but still required some sort of regular assistance or support. This was implemented through KAPIs ('Open Protection Centres for the Elderly'). During the decade, local authorities worked towards the expansion of this network relying on public funding, reaching the current number of 1000 centres over the territory. However, coverage was not even and there was a substantial degree of inequality in access to services over the territory and lack of quality assessment based on the intended goals. In the 1990s, a project to deliver community and home care through the network of KAPIs was initiated under the programme Help at

([388]) Greece is implementing the third adjustment programme monitored by the EU, the IMF and the ECB. The macroeconomic and budgetary prospects for Greece are assessed more frequently than for the other Member States. The time horizon covered by the forecasts for Greece is also different than for the other Member States and assume full implementation of the adjustment programme. Projections based on the fiscal sustainability indicators S1 and S2 are therefore not included here.

([389]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

Home and was run by the local authorities across Greece. This programme, though very popular, never managed to achieve the necessary coverage due to funding issues.

The result is that of a currently highly fragmented system with uneven coverage across users and low coverage overall. Due to the great fragmentation of the system and limited coverage, a large share of service provision is left to informal care.

Administrative organisation

The state provides both direct and indirect support, the former through social services, the latter through social security funds and allowances or tax reductions. The delivery of community and home care, in the form of help with activities of daily living, is left to local authorities and, informally, to the patient's network (mostly the family). Other (non-contributory) disability benefits (in cash and in kind) are provided by the social welfare system to persons who are in need of care because of a specific chronic illness or incapacity.

Available formal long-term care services (Help-at-Home, Day Care Centres, Care units for the chronic sick and limited public Residential Care Homes - MFI) are financed through the competent local authorities and are free to the user. Public nursing homes for the chronically ill are financed by the state budget and by per diem fees paid by social insurance organisations. There is also an individual contribution, ranging from 40% to 80% for pensioners in residential care.

Dependent on the level of invalidity, the state provides residential care to indigent, lonely aged people in need of care through Chronic Illness Nursing Homes. These, however, are not targeted at the elderly as only three centres have a proper geriatric section. On top of those within public nursing homes, there is an additional capacity of approximately 3000 long-term beds within other settings, namely acute and psychiatric hospitals (1000 and 2000 beds respectively). Additional beds are available within private structures.

Several private clinics operate under a contract with EOPYY to provide long-term care (mostly to terminally ill). In addition a total of approximately 15000 long-term care beds are available in residential care homes, both non-profit, partly subsidised by the state, and partly funded by donations (and per diem fees paid by social insurance organisation for those entitled to social insurance, both for-profit, financed by the beneficiaries. Semi-residential, day-care to the elderly is provided by the 68 Day Care Centres for the Elderly (KIFI).Since their establishment they have been funded mostly by EU resources.

As with the centres of day care, the Help at Home programme (introduced in 1998) has so far been operated by municipal enterprises and has been mostly funded by EU resources. However, the lack of criteria to contain expenditure undermines the viability of service provision, especially in the case of Help-at-Home. A fundamental weakness of this project was constituted by the poor stability of financing linked to the decentralisation to municipalities, and this resulted in very restrictive criteria to benefit from the programme (lack of both family support and financial means) and, ultimately, low coverage. ([390])

Lastly, some outpatient services are provided by rehabilitation centres.

Types of care

Public services include Help at Home, KAPIs (ΚΑΠΗ-Open Care Centres for Older People, i.e. local community day centres), public residential care homes for older people (residential care for the poor elderly is limited with waiting list up to 3 years in many cases), Day-Care Centres for Older People (ΚΗΦΗ, providing day care for dependent older people with no family or while their family carers are at work), Centres for chronic diseases and rehabilitation.

Private for-profit sector's services in the LTC system include: residential care homes (MFI), care workers at home (often migrants), medical care (private medical care).

Private non-profit include services and programmes run by NGO's, charity and philanthropic organisations, churches and their branches and privately funded foundations These

([390]) Mastroyiannakis, T., Kagialaris, G., Triantafillou, J.: "Governance and financing of long term care", Greek National Report (2010), http://interlinks.euro.centre.org/sites/default/files/WP6_EL_NRP_final.pdf.

include: NGO's for special groups, NGO's of older people, NGO's as service providers and NGO's combating social exclusion. ([391])

Eligibility criteria

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.

Dependent on invalidity levels as assessed by the Centres for Certifying Incapacity (KEPA), and based on the kind of chronic illness, recipients are entitled to different levels of care provision. The invalidity levels are set at 50%, 67% or 80%.

Co-payments, out of the pocket expenses and private insurance

There are no comprehensive formal long-term care services guaranteeing universal coverage nor any specific budget allocated to long-term care services. 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) is limited. This means that in many circumstances care must be financed privately.

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. In semi-private clinics, services of rehabilitation and nursing for older people may benefit from partial coverage by the social security funds, but this is a time limited (up to 6 months) and small share of the total expenditure which mainly burdens the beneficiary. Consequently, over the last few years occupancy of private for profit care homes has significantly fallen from 100% to about 80%.

In addition, 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.

Formal/informal caregiving

Although some formal care is provided, informal care giving is still an important part of the Greek LTC system. Due to the traditional central role of the family as a provider of elderly care, and to the financial hardship and lack of supporting private provision, families are increasingly resorting to the use of migrant carers. These are typically hired to look-after the elderly and often live with them, providing 24-hour care, and they are entirely financed by the patient or his network.

Prevention and rehabilitation policies/ measures

Three types of rehabilitation centres, recently transferred under the responsibility of the Ministry of Health and managed by ESY hospitals, provide outpatient long-term care 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). Prevention is a rather neglected policy area.

Recently legislated and/or planned policy reforms

In 2010, the Kallikratis plan transferred social care to local authorities, which have so far been unable to integrate services into a comprehensive package ensuring coverage to the citizens. In 2011, Law 4025 has redesigned the map of welfare organisations over the territory through a consolidation and stipulated the systematic registration of recipients of service benefits into a unified electronic database. The following year, Law 4052 has explicitly linked AKAGE's resources to the additional purpose to support the Help at Home programme, on top of its mandate to cover future pension deficit. AKAGE will transfer

([391]) Mastroyiannakis, T., Kagialaris, G., Triantafillou, J.: "The role of informal care in long-term care", Greek National Report (2010), http://interlinks.euro.centre.org/sites/default/files/WP6_EL_NRP_final.pdf.

those resources to IKA. An element of novelty within the new Help at Home is that the criteria of eligibility are clearly defined based mainly on means testing.

Another important feature was the introduction of competition among providers. Alongside municipal schemes, non-profit as well as for-profit Help at Home units would be able to submit bids for being included in the registry of certified providers in the schemes administered by IKA from which beneficiaries would be able to choose a provider. Those working in municipal schemes would be able to form "social cooperatives" and bid for becoming accredited providers under the new, competitive system. However, due to strong stakeholder opposition, the implementation of these changes is weak and progresses with slow pace.

Challenges

Greece has a highly fragmented and unstructured system of LTCs, with low coverage and high reliance on informal care. The main challenges of the system appear to be:

- **Improving the governance framework:** to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities wrt. the provision of long-term care services; to strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers; to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes; to deal with cost-shifting incentives across health and care.

- **Providing adequate levels of care to those in need of care:** to adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the depth of coverage, that is, setting the extent of user cost-sharing on LTC benefits and the scope of coverage, that is, setting the types of services included into the coverage; to reduce the risk of impoverishment of recipients and informal carers.

- **Improving financing arrangements:** To determine the extent of user cost-sharing on LTC benefits; to implement centralised means-testing to determine individual cost-sharing (or entitlement to public support) so that, while accounting for the economic context, it guarantees a uniform and equal treatment to all citizens, it captures different income components, including benefits, and it also captures wealth in the form of assets.

- **Encouraging independent living**: to provide effective home care, tele-care and information to recipients, as well as improving home and general living environment design.

- **Ensuring availability of formal carers:** to determine current and future needs for qualified human resources and facilities for long-term care.

- **Supporting family carers:** to establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **To facilitate appropriate utilisation across health and long-term care:** to arrange for adequate supply of services and support outside hospitals, while at the same time ensure that the payment systems and financial incentives discourage acute care use for LTC.

- **Improving value for money:** to encourage competition across LTC providers to stimulate productivity enhancements. To invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; to

invest in ICT as an important source of information, care management and coordination.

- **Prevention:** To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

- **Improving administrative efficiency.**

- **Ensuring good budgeting practices.**

Table 2.12.1: **Statistical Annex – Greece**

GENERAL CONTEXT

GDP and Population	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
GDP, in billion euro, current prices	179	194	199	218	233	242	238	226	207	191	180	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	24.4	25.2	24.5	25.6	25.6	25.1	23.2	22.1	19.9	19.6	20.2	26.8	27.6	28.0	28.1	27.9
Population, in millions	10.9	10.9	11.0	11.0	11.0	11.1	11.1	11.1	11.1	11.1	11.0	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	:	:	:	:	:	:	0.0	0.1	0.0	0.0	:	1.0	1.0	1.0	1.0	:
Per capita PPS	:	:	:	:	:	:	7.8	11.0	6.8	8.0	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	:	:	:	:	:	0.1	0.1	0.1	0.1	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	81.8	82.0	82.3	82.6	82.5	83.0	83.3	83.3	83.6	83.4	84.0	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	76.5	76.6	76.7	77.1	76.9	77.5	77.5	78.0	78.0	78.0	78.7	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	68.4	65.5	67.4	68.1	67.6	66.2	66.8	67.7	66.9	64.9	65.1	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	66.7	63.9	65.9	66.5	66.0	65.6	66.1	66.1	66.2	64.8	64.7	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	19.2	20.1	20.3	21.7	22.2	22.1	22.8	23.4	23.8	23.9	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	5.8	6.2	6.1	6.8	8.2	8.0	8.1	8.6	10.1	10.8	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
Number of people receiving care in an institution, in thousands	:	:	:	:	66	83	100	117	121	125	4	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	148	177	205	234	239	244	10	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	1.9	2.3	2.8	3.2	3.2	3.3	0.1	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	375	:	273	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.12.2: **Statistical Annex - continued – Greece**

PROJECTIONS

Population	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
Population projection in millions	11.0	10.7	10.1	9.6	9.1	8.6	-22%	3%
Dependency								
Number of dependents in millions	0.87	0.92	0.97	1.05	1.10	1.07	24%	40%
Share of dependents, in %	7.8	8.6	9.7	11.0	12.1	12.5	60%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	0.5	0.5	0.6	0.7	0.8	0.9	88%	40%
AWG risk scenario	0.5	0.6	0.7	0.8	1.0	1.3	166%	149%
Coverage								
Number of people receiving care in an institution	4,444	5,059	5,478	6,188	7,119	7,810	76%	79%
Number of people receiving care at home	10,456	11,452	12,067	13,173	14,516	15,207	45%	78%
Number of people receiving cash benefits	288,157	315,731	331,154	360,689	398,348	419,119	45%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	2.7	3.1	3.5	4.0	4.6	5.2	88%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	35.0	36.3	35.9	36.2	38.2	41.2	18%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	8.5	8.6	7.9	7.7	8.2	8.5	0%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	91.5	91.4	92.1	92.3	91.8	91.5	0%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	25.6	26.0	26.4	26.7	27.0	27.6	8%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	74.4	74.0	73.6	73.3	73.0	72.4	-3%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	26.0	25.9	23.1	22.0	23.0	23.2	-11%	-2%
Unit costs of home care per recipient, as % of GDP per capita	32.2	32.5	29.3	28.4	30.4	31.3	-3%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	16.9	17.0	17.0	16.9	16.9	17.0	0%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060).