GREECE: THE HEALTH CARE SYSTEM

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The history of the Greek and Lebanese health care systems .has a lot in common; both systems are becoming chaotic

INTRODUCTORY OVERVIEW

Greece, or the Hellenic Republic as it is officially called, lies at the southernmost end of the Balkan Peninsula. It covers an area of 131 957 km^2. Greece's topography is highly diverse.

The majority of Greeks (about 97%) belong to the Greek Orthodox Church, while there are small groups of Moslems, Jews, Roman Catholics and Protestants. In recent years there has been a large influx of illegal immigrants, mainly from Albania, and to a lesser extent from Poland, Romania, Russia and other eastern European countries.

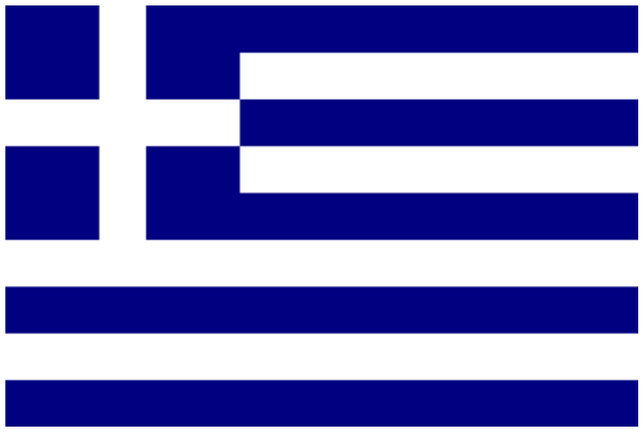
Greece is a parliamentary democracy with a 300-member unicameral Parliament whose majority party leader is the Prime Minister. The President, elected by Parliament, holds a largely ceremonial position. The largest political parties in the 1980s and 1990s are the Panhellenic Socialist Movement (PASOK) and New Democracy.

Education is free and compulsory for nine years (ages 6 through 15). The literacy rate is 94%. Life expectancy in Greece is among the highest in Europe and in the world.

HISTORICAL BACKGROUND

Following Greek independence in 1830 and until the end of the nineteenth century, no more than 10% of the active Greek population had coverage for health care by any type of statutory body. In 1922 The Ministry of Hygiene and Social Welfare was established. The level of care provided at that time was rudimentary compared to that in other European countries. Municipalities and communities controlled the few existing municipal and communal hospitals, while some large hospital institutions were controlled by the state at national level. Some private hospitals were also in existence.

The first serious governmental action intended to increase coverage of the population involved the establishment of the Social Security Organization (IKA) in 1934. This was to provide health and pension coverage to blue- and white-collar workers in urban areas and in industries employing more than seventy workers, and resulted in coverage of approximately one-third of the population.



In 1941 temporary public hospitals were established to serve the war needs, and remained thereafter. The next major step followed in 1953 with legislation intended to establish a National Health Service. The target was to decentralize health care competencies to the health regions and through them to the district health councils. Regional health councils would provide expert opinion on health care needs based on population, morbidity, etc. criteria, and would provide for the necessary equipment and building installations. Although the system foreseen by the legislation was hospital- and physician-based, it presented for the first time the perception of a needs-based approach to the health care system. However, the law was never implemented and in practice the opportunity was lost.

The 1960s saw a period of rapid economic growth during which a number of financial institutions, such as banks, established their own insurance funds financed mainly out of employer contributions. These funds provided full and high quality insurance coverage for their employees. During this period, social health insurance schemes were also established for public sector employees and self-employed professionals. Farmers and their families, who at that time comprised more than 50% of the Greek population, were for the first time provided with coverage in 1961 when legislation establishing the Agricultural Insurance Organization (OGA) was passed and subsequently implemented. This was the second major landmark after the earlier establishment of IKA covering blue- and white-collar workers. In addition, a network of rural medical stations was established, staffed mainly by a doctor (a graduate of a medical school doing one year of obligatory service), a nurse and a midwife.

Despite very high rates of economic growth during the 1960s and 1970s, public health care expenditure remained less than 2.5% of the GDP. With the exception of IKA, which developed its own health care infrastructure for its insured population, mainly in urban areas, all insurance funds contracted health care services from private specialist physicians in the case of primary health care services, and from public or private hospitals in the case of secondary care. Thus, the private sector expanded rapidly during that period due to the growth in numbers of physicians in solo private practice, as well as the erection of many small-scale private hospitals. The state, on the other hand, had only developed some public hospitals in large cities, while continuing to subsidize a number of charity hospitals.

The dictatorship of 1967–1974 tended to consolidate this pattern of health care services, although it was during this period that the first attempts to organize a comprehensive health care system emerged. In 1968, a plan for health care reform (L. Patras plan) was presented by the Ministry of Health with the following aims:

- Expansion of the public sector in the provision of services through the establishment of new public hospitals;
- Geographical redistribution of services in order to reduce regional inequalities;
- Improvement in health care services for the rural population;
- The introduction of a family doctor system;
- Efforts to cope with the great shortage in nursing personnel;
- Improvements in environmental programmes;
- Improvements in the levels and quality of psychiatric care.

In addition, the first proposals for a National Health Service were made by the Minister of Health, aiming at the harmonization of insurance fund regulations and the introduction of an agency that would be the sole source of funding. This agency would accumulate all insurance contributions and reimburse physicians and hospitals on a fee-for-service basis following negotiations with the medical associations. There were also provisions for the geographical redistribution of resources, and the introduction of a system of primary health care based on general practitioners who would gradually replace private specialists.

By the end of the planning period (1973), only a small

portion of the health care reform plan had been implemented, public expenditures on health care had actually dropped, while the proposals on the establishment of a National Health Service were abandoned.

Following the restoration of democracy in 1974, political and social pressures as well as the growing numbers of problems in the health care system intensified the need for health care reform, making this an issue of high priority for the new government. In 1976, a working party of the Centre of Planning and Economic Research (KEPE) prepared a study on the health care system, indicating the main problems and proposing measures for their solution similar to the ones noted above. According to this study the main problems included the following:

- lack of harmonization of finance and coverage;
- geographical inequalities in the provision of services, especially between rural and urban areas;
- large gaps in the provision of services in the rural areas;
- absence of capital development in public hospitals;
- lack of coordination between the Ministry of Health and other governmental bodies;
- methods of payment that encouraged inefficient and unethical practices, creating conditions for the development of an underground economy in the health sector.

The working party proposed the unification of the services of the three major insurance schemes (IKA, OGA, and TEVE) which covered about 85% of the population as well as any others who wanted to join, the creation of a unified fund, and the introduction of a family doctor system. However, due to political and medical opposition, the proposals were never passed into legislation.

Four years later (1980), a team of experts in the Ministry of Health worked out a plan for the reorganization of the system (Doxiades Plan). The plan anticipated the creation of a planning agency for the coordination of health care provision and the development of a network of rural health centers, staffed mainly by family doctors. When the plan came as a bill to Parliament, it faced strong opposition both by physicians and members of Parliament, and was rejected without any discussion.

In 1981 the Socialist Party (PASOK) came to power and the prevailing conditions were mature for a radical change of the Greek health care system. The main core of proposals remained almost unchanged and thus in 1983 the government passed legislation incorporating these and introducing a national health service (NHS). This law can be characterized as the major legislative reform ever attempted in the Greek health care system. The reform embodied the following principles:

- Equity in the delivery and financing of health care services: There was to be universal coverage and equal access to health services; the state was to be fully responsible for the provision of services to the population.
- Primary health care development: Special emphasis was to be placed on the development of primary health care; a system of referral was to be established.
- A new public-private mix in provision: Primary and secondary health care services were to be provided mainly by public health centers staffed by general practitioners, and by public hospitals; publicly provided health care services were to be expanded (health centers, new teaching hospitals, expansion of existing hospitals, new technology, increase in capital expenditures, etc.); establishment of new private hospitals was to be prohibited, while those already in existence were to either close or be sold to the public sector.
- Decentralization in the planning process, improvements in management, and community participation: A Central Health Council (KESY) was to be established, which would play an advisory role to the Ministry of Health on health policy and research issues. Health councils were to be established at regional level with planning and administrative responsibilities. The members of these bodies were to be representatives from the insurance funds, health care providers, trade unions, medical schools, the Ministry of Health, etc.
- Payment methods for health care providers: NHS doctors and other staff would be fully and exclusively employed by the NHS, and would be paid by salary.

Based on the above principles, the 1983 legislation provided for the establishment of health centers in rural as well as urban areas. These were to be staffed mainly by general practitioners and other health professionals, providing comprehensive primary health care services and implementing health promotion and disease prevention programmes within their respective communities. The health centers were to be attached to a local or regional hospital and patients referred to the hospital by the health centre's doctors.

In addition, the 1983 legislation anticipated the unification of the main insurance funds (though this was not made wholly explicit) with the infrastructure of IKA (the main insurance fund, covering 50% of the population) incorporated with that of the NHS. Moreover, no doctors working in the NHS were permitted to practice privately. Doctors, therefore, had to choose between exclusively salaried employment in the public sector or totally private employment. It was envisaged that this measure would reduce private health care expenditure and eliminate unethical practices by doctors.

Implementation of this legislation was to begin immediately and the following steps were to be taken in the period 1983–1988:

- substantial increase of public health expenditure: at least 4.5–5% of GDP was to be devoted to health;
- substantial increases in the salaries of doctors;
- substantial increase in public expenditure on capital outlays: 18 new hospitals were to be built, 3 of which were to be large regional university hospitals; 20 already existing hospitals were to be expanded; advanced technology was to be installed in provincial hospitals; 400 health centers were to be built, of which 180 were to be in rural and 220 in urban areas;
- Definition (in the near future) of the financial relationship between the NHS and the insurance funds.

The 1983 legislation and plans for its implementation were, however, only partially followed through:

- The rural health centers were established, equipped and staffed, and began operation as planned; in urban areas no health centers were established. Today 176 rural health centers and 19 small hospital-health centers operate, covering the primary health care needs of about 2.5 million persons. However, staffing of the rural centers is considered inadequate. In urban areas, primary health care services are provided mainly by IKA polyclinics for IKA members. There are also private providers who are contracted to the various insurance funds and hospitals (see the section on primary health care for more details). In 1987 there was a plan for IKA services to merge with the NHS, however, this plan was never implemented;
- Three large university hospitals were established (Ioannina, Patras and Crete), and certain improvements in hospitals and hospital departments were undertaken. In the private sector a large number of clinics were closed down or absorbed by the public sector and the establishment of new hospitals was prohibited. As a result, the number of hospitals actually declined and the ratio of private to public hospital beds shifted in favour of the latter. However, the establishment of private diagnostic centers was permitted and a large number opened during the 1980s and 1990s. As a result of the expansion in diagnostic centers, most of which have contracts with insurance funds, the insurance fund budgets have been heavily burdened through the provision of expensive and unnecessary diagnostic services induced mainly by doctors employed by the insurance funds;
- The employment of doctors exclusively by the NHS became a major issue. According to the law, doctors employed by the NHS were not allowed to exercise private practice. Their salaries were almost doubled but the restrictions on private practice were never strictly enforced with the result that the practice continued;

• The unification of the major funds and the establishment of a common fund never materialized. The mechanisms of financing and reimbursement remained unchanged. The Ministry of Health continued to determine premium levels and fees paid by the insurance funds to the health care providers. These fees were lower than the actual costs, especially in the case of hospital care, with the result that hospital budgets became increasingly dependent on government subsidies. The ratio of budget to insurance fund financing of hospitals changed from 40:60 in the 1970s and early 1980s, to 88:12 in the early 1990s. Whereas financing responsibility shifted substantially toward the state, in practice there was no change in the relationship between the NHS and the insurance funds and the funds continued to operate as before;
• The establishment of rural health centers represented the biggest project in the country to develop primary health care, but in fact this process stopped short with the failure to implement this portion of the 1983 legislation in urban areas, as well as with the failure to implement a referral system anywhere in the country;
• Decentralization in the planning process never materialized. A Central Health Council was established, but its role is minimal. The regional health councils were never established. The decade of the 1980s was devoted mainly to implementation of portions of the 1983 legislation, the establishment of the NHS and the expansion of public health services. In the early 1990s, the emphasis shifted in the direction of managerial and market changes due to macroeconomic constraints and ideological and political changes. In 1992, the conservative government introduced new reforms that altered some of the provisions of the 1983 legislation.

Specifically these were as follows:
• Primary health care centers previously financed through hospital budgets now became autonomous and financed through district health budgets;
• Doctors employed in public hospitals became free to choose full- or part-time employment within the NHS, allowing some private practice;
• The establishment of new private for-profit hospitals and clinics was once again permitted, with certain requirements concerning quality of services;
• Patients' freedom of choice and initiative were emphasized.

In addition to this legislation, other adjustments made in this period included the imposition of certain co-payments and fees in the case of drugs and visits to out-patient hospital departments and in-patient admissions. The most important measure in this period involved a huge increase in per diem hospital reimbursement rates (by 600%) which created deficits in the insurance funds for the first time.
The problems of the Greek health care system that have led to numerous efforts to initiate radical reforms persist to the present day, and are now held to be more pressing than ever. Another major reform proposal was put forward in 1995–1996, in an attempt to deal with all the major shortcomings of the system that the 1983 reform failed to resolve.

In conclusion, many aspects of the history of this system are very familiar to that of the Lebanese Health Care system. Is it due to Mediterranean water?

THE GREEK HEALTH CARE SYSTEM IN CRISIS: AN UPDATE

Dr. Abdo Jurjus

For 2 years the Greek financial crisis has captured global attention. In return for loans from the International Monetary Fund (IMF) and European institutions, Greece agreed on harsh across-the-board austerity measures, yet most commentators offer little hope for recovery, at least in the short run. The economy is expected to contract by a further 6.1% in 2011 and 3% in 2012, while unemployment is projected to reach 18.5% in 2012 up from 7.7% in 2008.

The Greek health-care system has been accumulating structural problems for a decade that have been exacerbated by the economic crisis. In terms of expenditure, a failure to contain costs, in part due to an absence of explicit funding criteria, created budget deficits for sickness funds. Although the system is highly centralized, resource allocation suffers from a lack of planning and coordination, weak managerial and administrative capacity, and underdeveloped mechanisms for assessing needs and setting priorities. In addition, an oversupply of specialist physicians coexists with an undersupply of general practitioners and nurses. The combination of an absence of a functioning referral system and irrational pricing and reimbursement mechanisms leads to poor coordination of care, large out-of-pocket payments and a sizable black economy, impeding the system's ability to deliver equitable financing and access to services.

Since the onset of the crisis, the Ministry of Health has considered a range of proposals for reform, all aiming to achieve greater efficiency and reduced expenditure, responding to one of the IMF's key loan conditions, that public health expenditures must not exceed 6% of GDP. The reforms include merging the four largest insurance schemes, collecting detailed monthly data on hospital activity and expenditures, reducing pharmaceutical expenses by means of policies including, but not limited to, adoption of e-prescribing, implementation of negative and positive lists of drugs and a reference price system, enhanced purchasing and procurement mechanisms, and centralized purchasing of medical supplies.

While many of the proposed reforms target known weaknesses in the system, implementation has been complicated by the economic climate.
The Greek public health system's post-crisis woes fall into three categories: fiscal, demand related and organizational.

First, fiscal austerity has taken its toll on public hospitals and other health services. The Minister of Health's directive for 2011 called for a 40% reduction in hospital budgets, but many hospitals failed to achieve this target. While there is scope for savings in the public health system and many measures go in the right direction, some necessary structural changes have been delayed while budgetary cuts place vulnerable groups at risk. Achievements so far include negotiating a price reduction of over 90% for certain generic drugs and reducing activity considered unnecessary with the assistance of hospital computerization. However, progress in adopting e-prescriptions has been slow, the publication of a recommended price list for medicines was postponed, pharmacy rebates are below target, prescribing guidelines are not yet adopted and generic prescribing is around 12.5%, well below the target of 50%. Reflecting the intense pressures to reduce expenditure, the Ministry of Finance imposed blanket cuts in budgets for public hospitals, agencies tackling illicit drug use and other public health organizations. Spending on mental health decreased by 45%, despite much greater need as a consequence of the crisis and, following a public outcry, the Ministry of Health announced that it would step in to cover the shortfall for these units.
Secondly, increased utilization of public health services has overstretched dwindling resources. Between 2009 and 2010 there was a 24% rise in hospital admissions and preliminary data for 2011 (covering January–October) indicate a continuation of these trends: an 8% rise in hospital admissions, 22% rise in patients visiting local health centers and 17% rise in laboratory tests. These increases reflect an inability to afford private health services, which previously played a large role in Greece, as well as a rise in self-reported ill health.

Thirdly, administrative weaknesses constrain the ability of the Greek National Health Service (Ethniko Systima Ygeias, ESY) to maintain services. Growing uncertainty, combined with current austerity measures, have led to waves of applications for early retirements by civil servants, including health workers, while the government has limited hiring of new personnel. The ESY is characterized by an abundance of specialist physicians, although concentrated in urban centers, while there are comparatively few nurses and general practioners, with numbers of the latter being the lowest in Europe per head of population, at only about 5% of all physicians. Since 2008, there has been a small decline in what has been a very high number of physicians (figure 1), most likely reflecting the public sector policy of recruiting only one individual for every five that leave. There is growing concern about long waiting times and more people are failing to seek treatment even though they feel they need to; out-of-pocket expenditures on primary care are high.

Although there is widespread recognition that the Greek health system requires wide-ranging changes, these will take time and some actions are needed now. Yet this is complicated by the imbalance between reduced resources and increased demand. A key priority is to curtail rising out-of-pocket expenditure but this will require action against tax evasion. In hospitals, a move to a DRG-type system will address value for money but more appropriate funding mechanisms are also needed in other areas. There is a need to safeguard programmes for vulnerable groups, such as those with mental illness and drug rehabilitation programmes. Action is also needed on the supply side; while the crisis has seen a substantial, and necessary, decline in the annual growth of physicians; more should be done to increase the number that are general practitioners and who work in rural areas. Measures are also needed to address the widespread out-of-pocket payments in primary care. More also needs to be done on pharmaceutical policy, such as measures to increase generic prescribing, to allow savings on drug expenditure to be reallocated to other important areas, such as recruitment of nursing staff. However, all these measures require political decisiveness and coordination across ministries, with a shared focus on equity and quality.

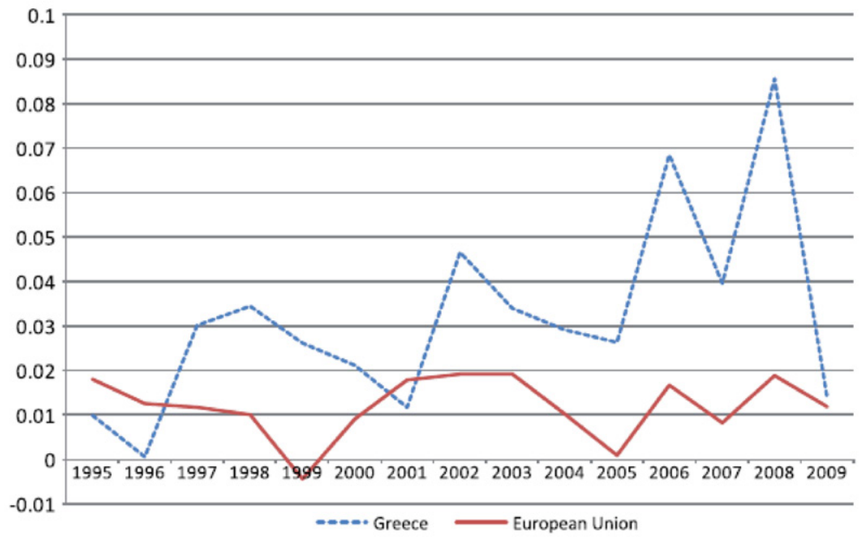


Figure 1 Growth of physicians per capita 1995–2009 compared to EU average. Data: WHO HFA

Welcome to Lebanon!!