

THE SOCIAL PROTECTION COMMITTEE

THE HELLENIC RESPONSE TO THE QUESTIONNAIRE ON HEALTH AND LONG-TERM CARE FOR THE ELDERLY [1]

1. ACCESS

1.1. HEALTH CARE

1.1.1. Mechanisms for guaranteeing access

Briefly outline the general structure and characteristics of the health care system (e.g. universal entitlement, or insurance based on compulsory affiliation). Describe the mechanisms for entitlement, or insurance based on compulsory affiliation). Describe the mechanisms for ensuring that it provides universal access? Describe the objectives of your system in terms of scope and coverage. Questions relating to scope could include:

- *Limitations in the type of healthcare which is covered e.g. on the basis of assessment of the most urgent medical needs;*
- *Does the system cover the entire cost of treatments or what contributions / co-financing are to be provided by the patient?*

Questions regarding coverage could include:

- *Does the system comprehensively cover the whole population?*
- *Which groups are not covered or only partially covered?*
- *Are there separate provisions on the basis of income or means/ability to pay?*

1. Response to the Questionnaire of the Social Protection Committee SPC/2002/APR/01En/rev 1. Original in Greek.

Describe any specific provisions relating either to the scope or coverage of the system aimed at facilitating access to healthcare for older people. Either in this section or under question 1.2.2, describe how policies for the provision of healthcare to the elderly and policies for long-term care are coordinated and integrated.

The Greek health system could be described as a **mixed system**, with elements and features characteristic of both the Bismarck model (active role and presence of social insurance) as well as the Beveridge model (with the state budget as the main source of financing). The main elements thereof are:

The **social insurance sector** (30 health insurance funds) through which health insurance is provided and free access and use of health services are ensured, and on the other hand **the sector of supply** (the health services) consisting of health services providers of **(a)** the National Health System – NHS (state hospitals and health centers), **(b)** insurance funds and in particular the Social Security Organization - IKA, (polyclinics and special centers) and **(c)** the private sector

(doctors, clinics, diagnostic centers and laboratories), which are contracted or not with the insurance funds.

All those who are employed within the Greek territory including foreigners (the salaried and freelance professionals as well as pensioners) are insured by the insurance funds. The family members of the aforementioned beneficiaries are covered as long as they themselves are not entitled to insurance, as well as the unemployed under certain circumstances. In addition, uninsured senior citizens over the age of 65 also entitled to free care on condition that the annual income thereof does not exceed the amount of 2,185.82 for the year 2002. For the few cases of those who are in financial need and the unemployed, a special health booklet is given and the cost of the health care thereof is directly assumed by the state budget. From the above, it appears that there is universal coverage for the entire population of the country. Furthermore, cases of emergency regarding the medical needs of tourists are also provided for, as well as those who stay illegally in the country without the economic contribution thereof.

Health care covered by insurance funds includes a complete package of health services. In particular the following are provided:

- Primary and dental care;
- Hospital care;
- Pharmaceutical care;
- Additional care (pace-makers, material for transplants, orthopedic items, appliances etc.)

In the **range of coverage** there are no significant variations from one fund to another besides minor exceptions. The most important variations are found in dental care where for example those insured with OGA (Organization for Agricultural Insurance) are not entitled to almost any dental care, those insured with IKA have a limited coverage and the beneficiaries of certain other funds have full coverage and the right to turn to private dentists who are either contracted or not.

The coverage of the health needs of all the beneficiaries **occurs without any economic charge thereof at the place and time of supply**. In certain cases and in some funds **a small contribution of the user – patient** is required. We mainly refer to the contribution of 25% in the cost of pharmaceutical care but also to the contribution of 25% of those insured by the Organization for the Insurance of Freelance Professionals (OAEE) for radio-diagnostic and microbiological tests, etc. In addition, and for certain items such as pacemakers, plastic artery transplants, respiratory appliances, means of therapeutic aid and orthopedic items etc, the contribution of the patient is provided for, the amount of which varies depending on the fund. However, it should be noted that in certain cases and especially in surgical cases, the phenomenon of ‘unofficial’ payments occurs, i.e. payments under the table made by the relatives of the patient to the doctor, either in order to accelerate the operation in cases where long waiting lists exist or to ‘thank’ the doctor. In any case, it is noted that the legislation provides strict penalties for such behavior.

For the elderly, and specifically pensioners that are entitled to the benefit of social solidarity (EKAS), a lower contribution (10%) is required for pharmaceutical care, and no contribution for certain chronic diseases and specific cases such as maternity and accidents at the workplace. Additionally, no contribution is required for those who are holders of penury health booklets provided that drugs are received from hospitals. At this point, it should be noted that measures, actions and interventions mainly monetary benefits that are aimed at special groups instead of specific age groups such as citizens above the age of 65. These special groups include pensioners, the poor, the unemployed, the uninsured, the handicapped etc. For the category of the elderly above the age of 65, although there exist demographic data available, there are not no specific actions and interventions aiming at better access for the required health services, quality etc.

The **financing** of the system comes mainly from the state budget (direct and indirect taxes) and the insurance funds (contributions of employees and employers). These two sources cover the operational cost of public hospitals and health centers, the health services of IKA and the private sector contracted with the insurance funds. Nevertheless, a significant amount of the total health expenditure, which is almost 40%, comes from out-of-pocket payments, with an increasing tendency during the last years.

The health infrastructure of the private sector, mainly doctor's offices, laboratories and diagnostic centers play a supplementary role in the infrastructure of the NHS and the insurance funds. The largest part thereof is contracted with the insurance funds, mainly covering the primary health needs of those insured, while simultaneously it offers services on a private basis to private patients and also to patients who have private health insurance. Private health insurance in our country has a supplementary role. The development thereof is determined by factors such as the disposable income of citizens, tax incentives given to those who are insured, the ease of access and the quality of the NHS services and of course the wish of the individual to have supplementary coverage and free access to private doctors, diagnostic centers and clinics. In spite the fact that the percentage of the population with private health insurance is relatively low compared with other E.U. countries, nevertheless, this market shows an increasing tendency.

1.1.2 Assessment

Are there indicators of performance regarding access to long-term care, e.g.

- *Waiting lists;*
- *Inequalities regarding access to certain 'advanced' innovative therapies;*
- *Regional or income related inequalities;*
- *Specific groups likely to be not fully covered.*

The completion of the Health Monitoring System, which is on-going, shall provide data and indicators, in order to evaluate factors which concern access to health care, as well as the efficiency of the system and the effectiveness of the resources available.

Although there is no discrimination or limitation to any person or population group to access health services, the system's responsiveness to meet citizens needs is not particularly high. From research carried out last years, a high percentage of dissatisfaction is steadily registered, which is one of the highest among the E.U. countries. This is due to the many insufficiencies of our health system, as well as the inability thereof to respond to the expectations of citizens, which show a steady increase in recent years.

Waiting lists are not long and do not create significant access problems as in other E.U. countries. A waiting lists study prepared by the Ministry of Health and Welfare, in the beginning of 2001, which was carried out in all public hospitals of Athens and Thessalonica, showed that waiting lists appear in a relatively small number of specialties at outpatient departments, at few specialized clinics and at small number of special laboratory tests. The said lists vary between 10 and 30 days and exceed the period of six months only in 3-4 cases. Without having new counts available, it is however certain that the waiting lists have become even smaller since 1/1/2002 due to the implementation of afternoon outpatient clinics in most hospitals of the NHS. Afternoon outpatient clinics is a new measure provided by the recent law of reform. The implementation thereof increases the patient's freedom of choice and enhances the access to hospital services.

At the **polyclinics** of IKA, waiting lists are restricted to very few specialties, while waiting time does not constitute a significant restricting factor for access. Indeed, the implementation of **phone appointment system** during the last two years in many polyclinics of IKA, with the aim of the expansion thereof within the next year to the health units of IKA all over the country, contributes in distributing the patients throughout the working hours, thus decreasing the waiting time in the morning rush hours. The first results have shown that the phone appointment system helps the insured and enhances access to health units and to doctors.

In recent years the health system is continuously being modernized and incorporates smoothly and quickly every **modern technology and innovative therapies**. Indeed, the incorporation speed of the said technology but also the uncontrolled diffusion thereof within the system, in particular of axial and magnetic tomography, creates conditions of induced demand and increased health expenditures. In any case, both modern technology as well as innovative therapies are accessible and are supplied without economic contribution and without exclusion to all who are in need. Concerning pharmaceutical care, no new drug has been excluded from the national list of drugs. In particular, the new HIV drugs are offered to all patients without the economic charge thereof.

Patients with health problems, which are difficult to diagnose or to cure in Greece, may turn to specialized centers abroad upon approval by their insurance fund. In such cases, the insurance fund covers all diagnostic and treatment costs, as well as the travel and accommodation costs of the patient and one accompanying person. Such cases have decreased dramatically in the last years.

In 1991, 2,738 patients insured by IKA (fund which covers 50% of the country's population) sought care abroad upon approval of their fund. The corresponding figure in 2000 was down to 900 people.

Due to the **geographical particularities** of the country, residents of small and remote islands face access difficulties, especially for specialized doctors, laboratories and of course, hospitals. Frequently, citizens with chronic health problems, residents of the said areas, are forced to either move permanently to urban centers or to bear each time the cost of their transport and temporary accommodation wherever there are appropriate health services for their cases. In some cases the transportation costs are partially covered by the insurance fund. In any case, the above difficulties in access constitute a significant health inequality. In recent years, health inequalities of this kind have been limited due to many factors, such as: the country's urbanization and the respective decrease of the agricultural population; the construction of modern road axes; the development and the spread of the means of transportation; the use of tele-medicine; the expansion and the modernization of the EKAB, (in particular with the recent acquisition of modern mobile units and five helicopters which are well equipped for the speedy transport of emergencies); the ability to staff health units in periods with increased needs from lists of specialty doctors who do not belong to the work-force of the NHS; and the total upgrading of the health units in such areas. We are well aware of the fact that in spite of the significant process to decrease inequalities, it is impossible to disappear completely.

Inequalities in access which are connected to the **income** and the **level of education**, although difficult to be observed and confirm, they are always ascertained by relevant scientific research. A recent survey carried out by the World Health Organization and the National School of Public Health found that individuals with low income and education assess the level of their health much lower compared to those of high income and education. This fact forms an indication that the lower income and education patients have increased health needs. Moreover, it appears that there exists a lack of appropriate and efficient prevention policies, as well as the need to adopt appropriate interventions in order to secure easy and unhindered access to health care services. Furthermore, from international research carried out in 14 OECD countries among which Greece was included, significant inequalities were found which are connected to income for consultations to specialized doctors.

Further to the above however, in our health care system, where a high percentage of private payments is noted (much of which is in the form of unofficial payments), it is obvious that inequalities in access for individuals with low income such as the elderly, the long-term unemployed, the chronic ill and the pensioners are created. The effort to combat this phenomenon requires a long – term effort and increased resources since it concerns behaviors and practices established for many years, which originate not only from the doctors but the patients as well.

Inequalities in access also exist, as it has already been mentioned, among the beneficiaries of different **insurance funds**. Different sickness regulations of the insurance funds allow for quantitative but also qualitative differentiations, in particular in services of primary medical and dental care. For example, resorting to the private sector is a right held only for those insured in some funds and this fact on its own constitutes an inequality, which is qualitative in nature.

There are no population groups among those living legally in our country who have no access to health services further to those mentioned already. There is even provision for illegal immigrants, in order to cover the emergency cases of their health needs. On the other hand, there is no separate health policy for the health needs of the elderly.

1.1.3. Challenges

What are the main challenges you face relating to the provision of access?

Easy and unhindered access to health services constitutes the dominant issue and main objective of every health policy in every country. In this broad sense, every health policy planned and every measure and intervention must contribute either directly or indirectly towards such an end. Therefore, all interventions which have occurred or are occurring in our country in recent years, such as the erection of new hospitals and health centers, the modernization and the completion of medical – technical equipment, the creation of new specialized departments (intensive care and step-down units, dialysis units) but also the enhanced staffing of the system have promoted the access to health services.

The coverage of significant shortages in infrastructure for long – term hospitalization, as well as infrastructure for physical and social rehabilitation of the elderly and individuals who are chronically ill constitutes a challenge for our health system. In addition, in order to face the major issues of public health, which concern the elderly in particular, such as cardiovascular diseases, cancer, diabetes, mental diseases and dementia, it is deemed necessary to **organize services for health prevention and health promotion**. The basic concern is to change the orientation of our health system **from therapy to prevention**.

1.1.4. Planned policy changes

Describe any planned changes to the system.

Securing a complete module of health services for the entire population is a major priority for the Hellenic government. This appears from the continuous increase in health expenditures during recent years but also from the major effort, which continues within the European Community Support Framework Programme for the completion and the modernization of infrastructures and medical – technical equipment of hospitals and other health units. In the context of such an effort, in the last ten years, many new hospitals have begun operation

adding to the NHS more than 5,000 modern beds. In addition, significant resources have been made available:

- For the expansion and the modernization of the National Service for Emergency Pre-hospital Care (EKAB) with the purchase of five helicopters for transportation by air, the renewal and replenishment of the fleet of ambulances and mobile units, the erection of modern building infrastructures in the regional areas (Larissa, Alexandroupolis, Ioannina, Tripoli, Thessalonica, Patras, Herakleio Crete) for the expansion of EKAB and the supply of digital phone centers;
- For the **Mental Health Care Reform**. After the successful results of the first phase (1984 – 1995), the program “PSYCHARGOS” is currently continuing with great success with the aim of de-institutionalizing as many psychiatric patients as possible. Up to date, 20 hostels and 15 protected apartments have operated with the aim of developing 30 more intermediate structures for the care of psychiatric cases by 2006. Upon completion of the second phase of the Mental Health Care Reform, we shall be in the position to offer better conditions of care to all patients. Our aim remains the de-institutionalization of as many psychiatric patients as possible and the gradual social rehabilitation of all those who are judged as able to return to society;
- For **Public Health** with the creation of a Central Public Health Lab and 5 Regional ones, as well as the National Center for Blood Donation;
- For **combating illicit Drugs** with the operation of new Units of Substitution with Methadone, a Help Center for users, Prevention Centers in all prefectures of the country, a Mobile Unit in Thessalonica and Youth Centers;
- For the **tele – medical link** up with remote health centers and regional surgeries with the major hospitals of the NHS.

With the absorption of budgets provided by the European Community Support Framework, but also the Programme State Investments by 2006 significant projects and major intervention for improvements in sectors such as **infrastructures, equipment, automation and the management of Hospitals, emergency pre-hospital care (EKAB), social protection services, the completion of the Mental Health Care Reform and the training of health and welfare professionals**. Such interventions comprise not only a simple quantitative enlargement of the system but also a qualitative upgrading of the services offered. This means that through the said projects the access of citizens to modern infrastructures and quantitatively upgraded services shall be facilitated. For example, the operation of the Attica hospital in Haidari, significantly improves the access of over 500,000 individuals of the Western suburbs of Athens to high-level hospital services. Furthermore, efforts are made to face the problems emanating from the geographical particularities of the Aegean islands. An example of such efforts is the erection of the hospital in Naxos, a project provides services to residents of this island who until recently were made to commute to the hospital of the island of Syros or the hospitals of Athens.

In addition, since 2001 a major effort to reform the health system is in progress with large-scale interventions in all sectors and levels of care. The said interventions include (a) the decentralization of the NHS through the creation of 17 Regional Health Systems (PeSY), (b) the organizational and administrative modernization of hospitals through the appointment of managers in all hospitals and the operation of special departments which create a favorable environment for efficient administration, (c) the ability to, provide more services to citizens, further to the economic participation thereof, outpatient's departments, the laboratories and surgeries during the afternoon hours (d) the periodic evaluation/revalidation of doctors with the aim of improving the quality of hospital care (e) better control of health services through the establishment and operation of a body of health and welfare auditors and the provision of the law for the Institute for Research and Quality Control of Health Services, and (f) the speed, the transparency and the efficiency in the procurement of hospital supplies.

In addition, the General Secretariat for Social Insurance is planning to regulate the extent and the manner of rendering uniformed dental supplies for all Insurance Organizations.

For the unification and effective financing of **Primary Health Care Services**, an action plan is being prepared, which includes the introduction of the family doctor and the creation of a Unified Fund, which will purchase services on behalf of insurance funds.

All these new interventions, which have occurred or are in progress, upgrade the system's administrative and operational potential (of hospitals in particular), thus resulting in better services and enhancement of patients' access to health care.

1.2 LONG TERM CARE

1.2.1 Access to long - term care.

Briefly outline the structures and the mechanisms in support of the provision of long – term care (e.g. direct provision via social services; coverage of the need for care via universal coverage, social insurance, social assistance and/or private insurance; supports for informal caring). Are such provisions comprehensive in scope (does it aim to cover all forms of care and their full cost or only some forms of care and part of the cost).

The Greek system of long – term care is of a mixed type, as it includes both direct care through social services as well as coverage of the need for care through the insurance funds, but also limited support for informal care mainly through tax reductions.

The formal services of long – term care for the elderly are supplied by the State, Non – Profit Private Organizations, and private Profit Making Organizations.

The State provides closed long – term care to the elderly through Chronic Diseases Clinics, Full Recovery Centers for Physical and Social Rehabilitation, Institutions and Psychiatric Hospitals. The total number thereof is in the amount of 30, 8 of which concern long – term psychiatric care. The majority of bodies are situated in major urban centers. The bodies are public law legal entities and are financed regularly by the state budget by a very high rate, from per diem reimbursements paid by the insurance funds, as well as from other resources (e.g. donations, estates etc.). In principle, public law entities receive no financial contribution from the elderly. According to data of the Ministry of Health & Welfare from July 2002, the total number of individual aged 65 plus, who are accommodated at state units for closed care is 2,660, 671 of which belong to the age group 60-65 years old, 483 to the age group 66-70 while 1,506 are above 70 years of age. It is noted that although individuals aged 60 plus are considered as elderly, the said bodies may also accommodate individuals who are younger.

Regarding the non-profit private sector, there are 57 care units for the elderly operating. These agencies are legal entities of private law and their revenue sources come from the insurance funds (per diem reimbursements) although most agencies are funded by a large proportion from the state budget. In addition they have other revenues (eg: donations, estates, etc.). As a general rule, the elderly do not contribute financially to these agencies. According to data of the Ministry of Health & Welfare from July 2002, the total number of individuals that receive care from the aforementioned units are 2805, 146 of which belong to the age group 60-65 years old, 247 to the age group 65-70 while 2,412 are above 70 years of age. It is noted that the said bodies may also accommodate individuals under 65 years of age.

There are no complete and exact data on the Private Profit Making Sector, however from rough estimations it is believed that the number of guests who are aged 65 plus is approximately 3,200 individuals. The fee for the services supplied by such Units is not covered by insurance and comes from private resources.

Further to closed hospitalization, long – term care in the type of open protection is offered, especially through the Project “Assistance at Home”. Up to the beginning of 2002, 284 Units were operating in 253 Municipalities, helping out almost 9,000 individuals aged 65 plus, in spite of the fact that not all cases were medical type long – term care. The total cost of the Project is covered by public funds. In addition, the new institution of Day Care Centers for the Elderly is expected to contribute to the coverage of the need for care to the elderly during work hours.

The proportion of elderly people who are accommodated at Institutions which offer long – term care (8,665 individuals) or to who care is offered at home (approximately 9,000 individuals) is extremely small comparing to the total number of elderly citizens. Characteristically, it is mentioned that the total number of individuals in Greece in 2002, who are above the age of 60, is 2,539,000 individuals (*source UN – World Population Prospects: The 2000 Revision, vol. 1*).

However, in Greece, the family continues to play a very important role in the care of the elderly in spite of the fact that the structure of the Greek family is changing

rapidly due to the prevailing socio – economic circumstances. Therefore, the informal care, which is offered in the context of the family institution, must be added to the formal care. In such a case tax reductions are mainly offered. In some cases benefits are offered by insurance funds for the coverage of expenses e.g. an exclusive nurse for dependent elderly people.

Further to the above mentioned, insurance organizations offer the following to those insured by them:

- A benefit for the assistance of another person, for individuals who need the assistance and care of a third person, which is in the amount equivalent to 50% of the amount of the basic pension thereof, provided the conditions required by law are met;
- Care at home (to a limited extent) for patients of chronic diseases and physiotherapy, injection – therapy etc. to the bedridden by IKA (insurance organization, which covers approximately 50% of the insured);
- A spa - therapy benefit, for the insured, who suffer of specific diseases and on condition the requirements are met. The benefit's amount varies per insurance organization and in any case it covers the costs of transportation, accommodation (stay/food) and the spa for a period of 15 – 20 days;
- Therapeutic social tourism for the pensioners of IKA with a low income, who are in need of a spa - therapy. Every beneficiary may be accompanied by one person and the stay thereof is subsidized and a daily benefit is also paid. In 2002, 21,000 pensioners participated in this project.

Furthermore, in the context of the effort to improve the income of pensioners substantially, the State provides the Social Solidarity Benefit for Pensioners (EKAS). Under certain conditions other benefits are also granted such as housing subsidy. In the case a disability is certified various kinds of disability pensions are given, the amount of which varies depending on the disability and the degree thereof, by the public as well as the insurance fund. The said benefits – subsidies may be used in order to cover the needs of long – term care despite the fact they have not been institutionalized for such an end.

Theoretically, the elderly have all access to long – term care regardless of whether they are insured or not. Structurally there is neither discrimination nor restrictions to access provided the individuals live in the country legally. In practice however, deviations from the general model are noted, as in general lines one can notice that the bodies of supply are concentrated in the urban areas and that there are shortages in quasi – urban and agricultural areas, as well as shortages of specialized bodies (e.g. bodies for the Completion of Therapy – Rehabilitation). In such areas, the family fabric contributes by large in the coverage of the needs of the elderly.

1.2.2. Assessment

Are there indicators of performance regarding access to long – term care, e.g.

- *Waiting lists for residential care places;*
- *Regional or income related inequalities;*

- *Specific groups likely to be not fully covered.*

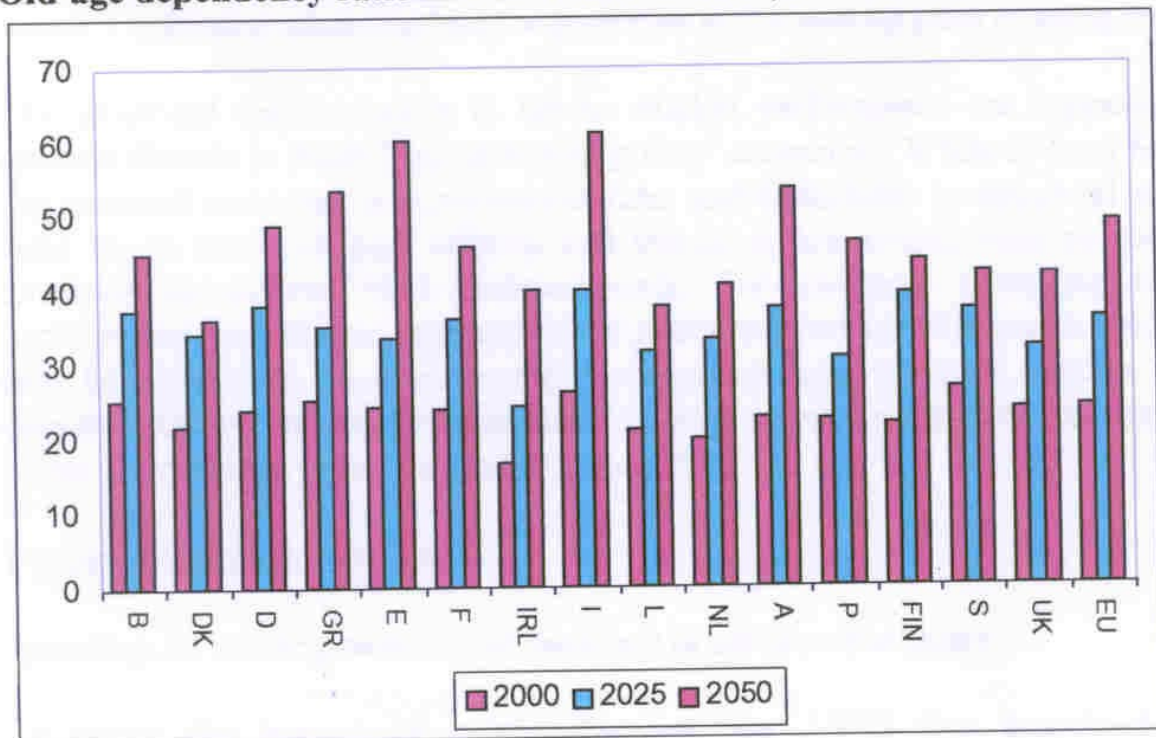
Further to the particulars mentioned above there are no specific indicators of performance for what concerns access to long – term care. However, the Welfare Charter which is under construction shall establish indicators in the short – term period and the first results shall appear in the middle – term period.

1.2.3 Challenges

What are the main challenges you face relating to the provision of access?

In Greece, much like in most European countries, the number of elderly people aged 65 plus is increasing. The demographic situation is characterized by a low birth rate and an increase in the expected life span and the tendencies show that the population shall continue to age. In 2002, the population which is over the age of 60 is in the amount of 2,539,000 while in 2050 it is estimated to reach 3,652,000. At a percentage on the entire population this corresponds to 21% and 36% respectively (*source: UN – World Population Prospects: The 2000 Revision, vol. I*). In particular, according to the projections of Eurostat for the year 2050 Greece together with Spain and Italy shall have very high percentages of dependent elderly citizens as shown by the histogram which follows.

Old-age dependency ratio in EU Member States, 2000-2050



Population aged 65+ as % of population aged 15 to 64

Source: Eurostat, central scenario

The ageing society is a result of the social and economic development in Greece, as well as the enhanced quality of life. Nowadays, people live more and better than in the past. However, the elderly do not form a coherent population. Variances in the

family status, the housing conditions, the educational level, the condition of health and the income determine the quality of life of the elderly. In addition, significant variations in ageing are to be noted, for example between men and women. Furthermore, despite the indisputable increase in life expectancy, significant variations are to be found in the death rate, morbidity rate, the disability rate and of course in well-being. A large number of the elderly expresses satisfaction by his/her life, on the other hand, a large number faces psychosomatic problems, such as the feeling of isolation, professional and social unworthiness, as well as pathological ageing phenomena. The households which are made up of lonely elderly individuals at risk of abandonment and social isolation are increasing, due to the general changes in the family composition, urbanism etc. This reality forms a challenge to adopt policies which shall reflect the differences in the social position of the elderly in a better way, i.e. policies which mobilize the available resources and combat the dangers of social isolation faced by the elderly in a more enhanced manner.

The increasing cost brought by the aging population is not an issue for easy conclusions to be made in view of the possible overburden of the social protection systems. Whereas by promoting healthy aging and the independence of the elderly, the potentials are created for further enhancement of the quality of life and simultaneously the cost for hospital and institutional care is reduced. Nevertheless, the continuous increase of the number of elderly citizens and the very elderly in particular, leads to the increase of the demand for nursing and care services, as well as prolongation of the period of care. In particular, the care system should develop in a rapid pace so as to meet the demand for services, and on the other hand it must be developed so as to limit the increase of dependence. This shall occur by promoting healthy aging, by preventing accidents and by offering rehabilitation therapy the soonest possible.

Within the context of responsibility for the maintenance, the qualitative upgrading and the modernization of the social state, the Hellenic Government is making an effort to reform / qualitatively and quantitatively enhance / coordinate the care services. The objective is to efficiently offer care to the elderly who are in need and who must enjoy equal but at the same time active protection and support in order to join the social and economic activities and to allow for the avoidance of phenomenon of social exclusion.

1.2.3. *Planned policy changes* *Describe any planned changes to the system.*

The structure of care services for the elderly has changed in recent years. The scope of services has broadened and completed by services of open care and care at home. There is continuous distance from hospital or institutionalized care without this meaning that such care is not offered when necessary. An effort is made to facilitate access to alternative services which take into consideration the wishes of individuals and maintain the independence of the elderly as the main idea.

The new model of confrontation sees the extension of therapy and the prevention of problems as priorities, which were absent from the programmes to date. The general objective is to move away from the 'clinical' model and to adopt the 'social' model, which is mainly developed at a local level. The success of the social and local orientation helps in restricting the option of institutional or hospital care to the least possible. Further to the anticipated saving of resources, there is one other significant reason for which the option of institutionalization must be avoided: the wish of the elderly to stay home, when various other external factors make there stay there problematic.

The first project which developed in the context of the new approaches was the Centers for the Open Protection of the Elderly (KAPI) in the decade of 1980. It has been proven that the long – term presence of the KAPI in Greece has influenced the daily life of the elderly in a positive way. In the decade of 1990 family policies began to be stressed, as phenomena of deconstruction of the family institution started to appear. Simultaneously, the Project 'Assistance at Home' was tried and implemented successfully, which aimed at the elderly who do not have a family or who live far away or are cut off from it, with the aim of offering care at the home of the elderly, the weak and lonely in particular, so that the quality of their life be enhanced and the their autonomy and independence be maintained.

The main principles in policy development for the elderly remain constant in recent years, and are the following:

- To guarantee a satisfactory living standard;
- To upgrade and enrich the care services supplied;
- To reinforce family oriented policies (to support the informal care networks);
- To promote the active participation of the elderly, as well as to provide opportunities for skills development;
- To interconnect the welfare policies and programmes;
- To encourage local, decentralized and small- scale structures.

Thus, the remarkable success of the Programme 'Assistance at Home' as ascertained by the assessment of the Programme, led the Government to resolve upon the expansion and the reinforcement of the structures thereof. In spring 2001, the Network for Social Solidarity was designed, which provides for the qualitative development, as well as for the quantitative – geographical expansion of the Programme 'Assistance at Home' aiming at the operation of 1,000 Units all over the country by 2002, which shall cover the needs to a satisfactory degree. To date, approximately 800 Units have been approved, while another 200 are scheduled to be approved by the end of the year.

Based on the above pillars, another new institution is being developed: The Daily Care Centers for the Elderly, which shall contribute in harmonizing family and working life, facilitating family members in this way, working women in particular, who have been assigned the burden of the aged member of the family, who is not in the position to care for self. The Centers are small

structures for day accommodation and operate in such a way as to sufficiently cover the working hours of the family members. The development of 80 Centers has been planned in all the Districts of the country in urban and quasi urban centers.

In addition, the development of the National Center for Urgent Social Assistance aims at supporting individuals who are confronted with a certain urgent kind of danger and who need support.

Securing the interconnection of health and social care services is fundamental. Among the priorities are also included, the development of more specialized Centers of Full Physical and Social Rehabilitation (KAFKA) which are subject to the regional health systems and the aim of which is post-hospital assistance, care, rehabilitation.

Furthermore, Social Supportive Services are being developed, which operate at a Municipal level. Social Supportive Services shall play a special role in the life of the elderly as well. Based on the plan, social scientists register the needs in the area of responsibility, diagnose and suggest the participation of individuals in special projects of social integration in cooperation with the citizen assisted. The aforementioned are associates and counselors to the local self-administration and simultaneously correspondents of the Central Administration.

2.QUALITY

2.1 HEALTH CARE

2.1.1 Standards

Are there national standards related to quality; targets in terms of access to medical professionals, hospital beds? Are patients' rights defined?

There are currently no institutionalized or complete mechanisms for guaranteeing quality, nor specific national standards and goals for what concerns access to services of primary and hospital care. To a large extent, this is also due to the absence of reliable information and data, on the basis of which we could set standards, targets, procedures and medical protocols. The completion of hospital automation, which is in progress, shall contribute significantly and create the conditions for the enhancement of the quality of services. Individual efforts are made to secure quality in a certain number of hospitals and clinics, but in no way do these form a complete policy at a national level. In the context of actions for the development of appropriate mechanisms of quality control, the establishment of the Institute of Research and Quality Control of Health Services is planned.

Concerning the **rights of patients** some progress has been made in our country. Since 1992, the rights of the hospitalized patient have been legislatively secured and in 1997 instruments for the protection of such rights have been enacted. In particular, the establishment and operation of the following have been provided for:

- (a) Independent service for the protection of patients' rights at the Ministry. The task of this service is to examine citizen's complaints and charges regarding the services supplied to patients.
- (b) Committee on the protection of patients' rights at the Ministry, the task of which is to examine charges submitted by patients and to present a relevant report to the Secretary General, who shall resolve on further action to be taken.
- (c) Communication Office with Citizen's and a Three Member Committee in every hospital for the information of patients and the protection of their rights.
- (d) National Committee on Bioethics.

Furthermore, in the context of modernizing services for mental health care, the establishment of an independent service for the protection of rights of individuals with mental disorders is planned for, as well as an office for the protection of the rights of such individuals and a special committee for the control of the protection of patients' rights.

Finally, the Greek Ombudsman operates in our country since 1998, where patients who consider that their basic rights to health have been violated can turn to. The Ombudsman 'looks into individual administrative actions or oversights or actions of public sector bodies, which violate rights or damage the legal interests of persons or legal entities'.

Despite the sufficient legislative and regulatory framework, more public dissemination of information to citizens and awareness of health professionals is needed in order to safeguard and respect the rights of patients.

2.1.2. Assessment

Describe mechanisms for assessing high levels of quality of treatment and for setting and monitoring high standards in healthcare and long – term care. What mechanisms are there to assess the quality of medical treatments? What criteria are used in making such assessment?

No mechanisms are in operation nor have clear criteria been formulated for quality assessment in the healthcare sector and of course for long-term care. The recent legislative regulation regarding the selection and evaluation-revalidation of NHS doctors may indirectly assist in upgrading the level of quality care offered. Until now, a list of national auditors has been completed, assessment standards and criteria have been set up, and shortly the revalidation of doctors shall begin. This process will happen for the first time for NHS doctors.

2.1.3. Promoting quality enhancements

What mechanisms exist for developing, promoting and ensuring accessibility to good quality practices? Is there a particular focus on developing, promoting and ensuring accessibility to such practices for healthcare for the elderly?

Here too, there are no mechanisms to ensure access to good quality practices, since, as we have already mentioned, no standards and criteria have been defined nor does sufficient and validated data exist, to allow us to pinpoint and certify such good quality practices. Patients usually choose their doctor, the hospital or the clinic based on information received from relatives, friends and in general through ‘the market’.

The provision of the last law (2889/01), for special centers or reference centers, which may upon assessment to become ‘Centers of Excellence’, could create within the NHS the first pockets of high quality services and good quality practices.

2.1.4. Challenges

What are the main challenges you face relating to the promotion of quality?

Ensuring quality in health care services is the greatest challenge for all countries, including the Greek healthcare system. This challenge becomes even more difficult, when taking into consideration the increased resource requirements, as a result of the ageing population. Clinical efficiency, therapeutic protocols and evidence based medicine are major challenges and fundamental factors of every healthcare system.

2.1.5. Planned policy changes

Describe any planned changes in this regard.

The gradual revalidation of NHS doctors and the services they offer, the initiation of a body of inspectors of health care and welfare services, and the completion of automation in the health units are measures, which shall offer a significant contribution to the enhancement of the quality services offered. In addition, the

operation of the Institute for Research and Quality Control of Health Services within the framework of the National Center for Research in Health Services forms a significant policy priority of the Ministry of Health & Welfare.

2.2. LONG TERM CARE

2.2.1. Standards

Are there national standards related to quality? Are care recipients' rights defined?

The conditions for the establishment and the operation of social welfare bodies per category of bodies and the content of services supplied to these, the premises, the equipment, the required number of persons as well as the appropriate qualifications are determined by the relevant Ministerial Decisions. Associations, organizations, private entities of private law, in general bodies which exercise social welfare as well as private individuals are not entitled to offer organized social services which deal with the protection of the elderly or the incurable or the chronically ill or to exercise similar activities prior to the issue of an appropriate operation license by the competent prefectural self-administration. Moreover, since 1995, old peoples' homes, the 'Homes for the Aged' and other businesses with similar names which offer closed care to the elderly change name and become 'Units for the Care of the Elderly' and licenses are issued only with the use of such title.

The conditions for the establishment and operation of Units for the Care of the Elderly by citizens (profit making character) and of non profit making character have already been determined. In addition, the definition and the objective of the Units for the Care of the Elderly have also been determined respectively, as well as the procedure (and the supporting documents) for the founding license, the building plan (few numerical particulars), the safety measures, the features of wards and common spaces, the few installations and the staff.

From the above, the rights of the elderly, the recipients of long – term care are defined either directly or indirectly. Additionally, an independent Service for the Protection of Patients' Rights has been established, which operates at the Ministry of Health & Welfare. This service also covers the rights of long – term care recipients.

For what concerns long – term care of the elderly psychiatricpatients, regulations have been enacted for:

- Determining the manner of organization and operation of the Units for Psycho – social Rehabilitation (boarding – houses, guest houses) and the Projects of Sheltered Apartments, the purpose of which is to place and to psychiatrically monitor at the place of living, therapy and assistance of individuals with mental health disorders when such have no home or an appropriate family environment. In the said Decision, among other things, the conditions of operation, the services offered, the premises, the staff are determined;
- Determining buildings, conditions, supporting documents, procedures and other details necessary for the approval of feasibility and the granting

of the operation license for Units of Mental Health in the Private Profit Making and Non – Profit Making Sector;

- Determining the conditions, the manner and the procedure for the supply of hospital care services and special services of mental health at home;
- Determining the manner of operation and staffing of the Mobile Units for Mental Health, by which among others, the conditions, the organization and the operation of Mobile Units are regulated but also the certification of the services supplied by these;
- Determination of the conditions, the organization, the operation, the principles as well as every detail of the programmes of Hosting Families, which regulates among other things the rights of patients, the training procedure for the hosting family, the duties and rights of the hosting family.

From the above, the rights of the elderly psychiatric patients who are recipients of long – term care are determined either directly or indirectly. Additionally, at the Ministry of Health & Welfare an independent service ‘Office for the Protection of Rights of Individuals with Psychiatric Disorders’ has been established.

Finally, the continuous training of personnel for the care of the elderly is offered only by accredited Centers of Vocational Training.

2.2.2. Monitoring and promotion of quality

Is there a system of assessment and recognition of carers and care institutions?

Where informal care is supported, are there policies in favor of quality (e.g. financial support for infrastructure/adaptation of homes; training of informal carers)?

The supervision and monitoring of services supplied by the Units for the Care of the Elderly of Profit Making and Non Profit Making Nature as to the quality and sufficiency thereof is exercised by the prefectural self-administrations through the ‘Social Consultant’. Social Consultants pay visits to bodies supervised by the competent prefectural self-administrations and draw up reports. The aforementioned should have experience in the organization and operation of welfare services and bodies, specialization in methods and techniques for the assessment of services and familiarization with the contemporary trends in the area of welfare and in particular in the care of the disabled and the elderly.

Since 2001, major changes in monitoring and promoting quality have been made through the establishment of the Body of Inspectors for Health and Welfare Services. This Body has a special section for auditing welfare services, in the competence of which the following are included among others:

- The inspection and the control for the ascertainment of quality and the sufficiency of facilities, equipment and the services offered by public services, by welfare services of Municipalities, Prefectures and Regions and by the services of supervising legal entities of the public and private sector which supply services to the sector of welfare such as Units for the Care of the Elderly, the Centers for Full Therapy and

Rehabilitation and the Institutions for the Chronically Ill;

- The inspection and control in order to ascertain that all services uphold healthcare provisions as well as the required safety measures or the healthy living circumstances of those cared for and the personnel.

An interesting element thereof is the fact that controls occur by virtue of one's office, either upon order of the competent organs of the Ministry of Health & Welfare, or upon request of the Ombudsman if it concerns an issue of more general interest. Another interesting element is the initial and continuous training of Inspectors at regular periods in addition to the increased qualifications these must hold.

The accredited higher education (Universities, Technical Colleges) of professionals occurs through the public educational system. Further to the aforementioned, professionals have other educational alternatives (e.g. public and private vocational institutions), however, accredited degrees are granted only upon state examinations. For many professions a license is required. The official initial or continuous training is provided only by Centers for Vocational Training, which are specially accredited.

For the non-governmental non-profit voluntary sector, an accreditation system was in 1998 for all services in the social care field. In the same year, a registry of accredited organizations was also established. The accreditation and registration for the aforementioned is a pre-requisite for state funding from any source.

2.2.3 Challenges

What are the main challenges you face relating to the provision of quality long – term care?

Many interventions have occurred in favor of quality and there is a satisfactory framework at least legislatively wise. However, the real materialization of the provisions is still pending, since many times a significantly large period intervenes between the adoption and the implementation thereof. Characteristically it is mentioned that although the institution of the Social Consultant has been initiated since 1995, there are still many Prefectures which have not proceeded to staffing or have insufficient staffing.

On the other hand, the monitoring and control of so many bodies which supply social care services is occasionally extremely difficult. In particular, for what concerns public bodies, the phenomenon of totally different quality situations appears. There are public bodies, which offer high level services, but at the same time there are many bodies with a very low level of services supplied. The challenge is to homogenize the supply of services, which must be above a minimum, accepted level in all the sectors of supply of each body. As a result, in recent years special emphasis is placed on the enhancement of the public sector with characteristic example the de-institutionalization of certain welfare Institutions. The objective is to ensure quality in care services while maintaining individuals close to the family and the social fabric.

2.2.4 Planned policy changes

Describe any planned changes in this regard.

The Body of Inspectors was institutionalized recently and must be tried in practice. Within the Body, the proposals for changes in quality policies shall surface. Thus, for the time being, no significant changes have taken place further to the regional re-organization of the National System for Social Care. Through the attempted legislative intervention, all legal entities of public law come to the competence of the appropriate Regional Health Systems as independent decentralized Units, in an effort to interconnect the health and welfare services, to enhance the monitoring of the sufficiency and quality of services supplied and to further enhance public bodies. Overall, the issue of quality is a subject of continuous consideration and study.

3. SUSTAINABILITY

3.1. HEALTH CARE

3.1.1. Expenditure and Financing

Describe current levels of expenditure on healthcare and recent and projected trends. If it is possible to present separate figures for healthcare for the elderly, please do so;

Describe financing mechanisms (social insurance contributions, general taxation, voluntary insurance including tax reliefs where relevant, patient charges). [Note: these may already have been described in the brief system description under section 1.1.1]

According to a recent study, the total health expenditure in our country for the year **2001 is 9.1% of the GDP**, which is higher than the average of the 15 E.U. countries. Approximately 60% of the said expenditure (5.5% on the GDP) is public and comes from the state budget and social insurance, and the remaining 40% (3.6% of the GDP) from private (out-of pocket) payments. The financial resources from the European Community Support Framework are not included in the above figures.

From the figures already mentioned, we can note that although the total expenditure is slightly higher than the E.U. average, there exists a problem of distribution between private and public ones, because the private expenditures are particularly high in Greece. Respectively, public expenditure is relatively low and the public system seems to be under-financed.

From the public expenditure, 54% comes from the state budget (direct and indirect taxes) and the remaining 46% from social insurance (contributions of employees, pensioners and employers). In hospital care, most expenditure comes from the public sector. On the other hand, the incomplete and fragmented primary care system and the abundance of doctors are the main reasons for high private expenditure in primary and dental care. The largest percentage of the private expenditure concerns dental care (34%), primary care (31%), pharmaceutical (15%) and hospital care (12%).

Trends during the last decade are increasing for both the total expenditure, as well as the public and private ones. However, the rate of increase of private expenditures is higher than that of the public ones. In particular, the total health expenditure in 1991 was 7.9% of the GDP and reached 9.1% in 2001. The respective rates for public expenditure (public budget and social insurance together) was 4.8% in 1991 and 5.5% in 2001 whereas private ones 3.1% and 3.6%.

Unfortunately, due to insufficient and unreliable data, it is not possible to estimate the rate in which such expenditures concern the healthcare of the elderly. However, based on facts such as (a) that the expected life span at birth is among the highest in Europe and the fertility indicator among the lowest, factors leading to the continuous increase in the rate of the elderly above the age of 65, (b) that the health needs and consequently the cost of care for the elderly, is multiple compared to the rest of the population, it is obvious that a large part of expenditures concerns the elderly.

The **financing modes and mechanisms** form a complex system of pricing, financial flows and payments, where the state budget is involved, insurance funds, public hospitals, polyclinics of insurance organizations as well as the private sector. In particular and very briefly we could mention the following:

1. **Health insurance** is made by the insurance funds, which collect the **contributions of the employees/pensioners and employers**. Then, insurance funds formally assume the obligation for the coverage of the health needs of the beneficiaries thereof. In practice however, they have a substantial role for only covering the needs of the primary care, where they either dispose of own units such as the IKA with its polyclinics or cooperate with the private sector, such as the OAEE, the OPAD, the Seaman's Fund etc. An exception to this rule is OGA, which covers its needs entirely by the infrastructures of the National Health System, i.e. the hospitals and the health centers.
2. The **financing of Primary Care** occurs in the case of IKA through its own resources and means with salaried doctors. Regarding the other insurance funds, there are different methods of remuneration for doctors. For example, in the case of OPAD (the Civil Servant's Fund) and the Mariner's Fund, doctors are contracted and paid on a per visit basis, and in the case of OAEE (free lance workers and merchants) doctors are paid on a per capita basis. In every case there are problems of inefficiency and waste due to induced demand. Finally, the OGA (agricultural workers) covers the health needs of its' beneficiaries totally free, and exclusively from NHS health centers and from the outpatients' departments of public hospitals.
3. For the needs of **hospital care** all beneficiaries turn mainly to the hospitals of the NHS with which all insurance funds are contracted. The method of remuneration based on a daily rate. The price thereof is determined by the State and is much lower than the real cost. The result of this method of remuneration was the creation of huge deficits in hospitals in recent years, which were covered by the state budget. Today, the salaries of the personnel come from the State budget, and the operational costs are financed from the payments coming from insurance funds.

4. Those among the insured who turn to a **private hospital or private clinic** undertake the responsibility to cover the costs on their own. However, in some cases, and according to the insurance funds illness regulations, some of the cost is covered by the fund.
5. The few in percentage citizens with **private / voluntary health insurance** usually turn to private doctors and hospitals connected to the insurance company. The method of doctor's remuneration is per visit and depending on the terms of the agreement the insured may have some contribution.
6. The large **private health sector** (surgeries, dentist's surgeries, laboratories, diagnostic centers etc.) which exists in the country mainly due to the abundance of doctors and dentists, draws revenue either through contracts with insurance funds with a set list of prices determined by the State, or directly from the ones privately insured. In the later case, fees are per visit and with prices set freely by the market. For patients with social health insurance, the greatest demand for services from the private sector is mainly for pediatricians, gynecologists and dentists, and the cost is faced entirely by the patient.

3.1.2 Expenditure trends

Give an assessment regarding trends in costs and in required funding. How can this be reconciled with other policy goals, e.g. sustainable public finance, in the light of the ageing of the population?

Health expenditures in the public sector (NHS and polyclinics of IKA) are mainly formed by the salaries of employees, doctors in particular. The government's tight salary policy, in recent years, has not allowed for significant increases. However, the continuous and pressing need to staff new hospitals and special units (Intensive Care Units, and Step-down Units, Dialysis Units, etc.) lead to a continuous increase in healthcare personnel. In addition, significant factors for increases in healthcare expenditures is due to over prescribing medications, in combination with the uncontrolled diffusion and use of high cost technology in the system.

From National Statistical Service data, we see that the progress of the **price indicator for health services** goes together with the progress of the **general price indicator for the consumer**. Starting with the year 1994 (1994=100) the price indicator for health services in 1999 was 134.2, whereas the general price indicator for the consumer at 133.7. With the exception of the price indicator for medicine and medical products, where in the period 1994-99 a drop is noted, in the remaining categories of medical services the relevant indicators show increase. For the estimation of the future course of expenses, it should be taken into consideration that the Greek health system is in a continuous process of quantitative enlargement but also technical and administrative reform, in the effort to cover the existing shortages. Furthermore, the ageing population as mentioned already, and in combination with the over prescribing of medication phenomenon, the exaggerated and quite often without a reason use of biomedical technology, the induced demand, the abundance of doctors, dentists and pharmacists, but also the increased expectations of citizens, lead to the conclusion that trends on the increase are to continue in the upcoming years.

In 2001, the Ministry of Financial Affairs and Economy submitted projected trends on public health expenditures to the Economic Policy Committee. According to this information, if one considers that: a) fertility rates remain below the ones required for the replenishment of the population or the stabilization of the age structure, (b) that the expected life span increases for both genders by approximately one year per decade and c) that the inflow of immigrants continues, then an increase in public expenditure for health is expected at a rate between 1.6% to 1.7% on the GDP between the years 2000 and 2050. In particular, an increase is expected by 1.1% both in the age groups 65-79 years old, as well as for the one 80 plus, while a decrease is expected in the group below 65 years of age by 0.5%. It is noted that the said projection covers hospital care only (It concerns a percentage of expenditure in the rate of 4.8% of the GDP). The expenditure projections on pensions, health and long – term care continues, in order to enhance the quality thereof and to allow for the total of parameters sought to be covered.

The margins for saving resources exist and these are big for our healthcare system. Savings can be achieved through rationalizing prescriptions and the consumption of medicine, control of the use of expensive biomedical technology, transparency in supplies and certainly the restriction of induced demand, phenomena which are found wherever the mode of remuneration of the doctor or the laboratory are per visit.

3.1.3 Cost control mechanisms

Describe the mechanisms to control spending:

- *The role of charges as a means of controlling demand;*
- *Financial incentives / market mechanisms to ensure cost control in provision;*
- *Mechanisms for raising the sensitivity of health institutions and professionals to cost considerations when deciding on treatments;*
- *Controlling the cost of materials and products such as pharmaceuticals;*
- *The role of health promotion, disease prevention and in particular the promotion of healthy lifestyles for the elderly.*

It is quite difficult to make reference to cost control measures and by extension spending on health, as it could be made for other healthcare systems in E.U. countries, which are developed and ‘mature’. The reason for this is that from the mid 70’s until the beginning of the 90’s emphasis was placed on the development and modernization of the public health sector.

The increase in spending which was caused by such an option was not combined with the implementation of cost control mechanisms. The strengthening of the public health sector through the establishment of the NHS in 1983 and the assumption of the major role by the State in health service provision formed the reasons for the increase instead of the restriction of health spending.

On the other hand, the continuous **overproduction of doctors, dentists and pharmacists** created explosive situations in recent years in the private sector, where

the potentials for controls are even less than those of the public sector. The great pressures put on insurance funds in order to have as many contracts as possible with doctors, dentists and pharmacies, larger than that dictated by healthcare needs and the patient's free will, significantly helped in the over-consumption of health services. For example, major insurance funds such as the OPAD and the Mariner's Fund are currently contracted to an inexcusably high number of private doctors for the coverage of primary care of their beneficiaries. It has been documented that the number of contracted doctors is connected positively with demand and consumption of health services. The administrative weaknesses of the insurance funds to control the contracted private doctors effectively, at least when it comes to the supply of health services to the ones insured by the said funds, have created favorable conditions for induced demand.

Under these conditions, the lack of measures and interventions for cost control on the **side of provision** could even be justified. Because when most countries were closing down hospitals, we had to build the health system's infrastructure, through the erection and operation of new hospitals and health centers, as well as specialized departments, units and laboratories equipped with modern and at the same time expensive technology. No measure was taken (numerus clauses) for what concerns the labor market in the health sector in order to restrict the number of doctors and dentists, the result of which is that currently the country has more than double the number of doctors and dentists needed. In addition, fragmentation of the system through the numerous insurance funds, the abundance of health care suppliers, as well as the different sources of financing without coordination and substantial control, create a situation of over – consumption, overlapping and waste, especially in the primary care.

Within such contexts we are unable to mention any coherent policy for controlling the cost of healthcare services. However, we are able to mention separate measures coming from either the Ministry of Labor and Social Insurance or the Ministry of Health & Welfare, or even the insurance funds, but also efforts which are in progress without having produced any results yet, or measures and interventions which are at the stage of development and planning in the framework of the effort to reform the NHS.

In particular:

From the General Secretariat for Social Insurance which is subject to the **Ministry of Labor and Social Insurance**, the **Service for the Control of Spending of Social Insurance funds** which was established and shall be staffed and set into operation in 2002, with main task:

- The supervision and the coordination of actions for the control of the healthcare system's spending in all insurance funds and health branches;
- The control of all health services towards beneficiaries;
- The coordination of controls for health provisions for which the approval of an inspector – doctor is required;
- The design and allocation of computerized applications at a central and regional level for monitoring the consumption of services and health provisions in general;

- The collection and statistical processing of data, which concerns health provisions.

In addition, computerized applications are expanding in all insurance funds for the monitoring and the control of healthcare spending. Furthermore, an effort is being made to change the manner in which contracts are made between the insurance funds and healthcare providers, through the establishment of a uniform type of contract with specific duties and responsibilities.

Other measures taken by the major insurance funds are:

- **A contribution of 25% by patients in the cost of radio-diagnostic and paraclinical examinations**, which exists in the Organization for the Insurance of Freelance Professionals (OAEF). In addition, the contracted doctors with OAEF are remunerated by a specific monthly amount, which is formed on the basis of the number of those registered in the list of beneficiaries. The combination of the two measures mentioned above seems to work efficiently, by discouraging doctors from phenomena of induced demand and the patients from behaviors of exaggerated demand and over-consumption (moral hazard). It is not by chance that the OAEF has one of the lowest annual spending per capita for primary care compared to other insurance funds. At this point however, we should note that while the patients contribution in the cost may be a relatively easy measure to implement, it nevertheless creates inequalities and mainly burdens individuals with a low income, especially pensioners and the elderly, who are usually with a low income and high consumption users.
- The **IKA** manages to keep primary health care spending at relatively low levels as well, because it has its own healthcare services. In order to control over-consumption or the induced demand of services offered by the contracted radio-diagnostic centers and clinics it has set a ceiling for each one of these, which cannot be exceeded. In addition through regular controls on the monthly medical profile of doctors, the IKA prevents phenomena of over-prescribing.
- Finally, for the control of **pharmaceutical spending** the contribution of the patient in the cost of medicine by 25% which we remind is lower (10%) for pensioners who are beneficiaries of EKAS and none for certain categories of those who are chronically ill. In addition, the follows have been implemented; a) the adoption of a positive list of drugs, which is common for all insurance funds; b) a ceiling on the number of drugs per prescription, as well as the adoption in certain hospitals of the individual per patient dose. Furthermore, within 2002, the computerization of all IKA prescriptions and the medical profiles of doctors will be created.

The measures taken to date by the **Ministry of Health & Welfare** mainly concern the improved organization and administration of hospitals through the **appointment of a Manager** in public hospitals for the first time. The choice of Managers is made by professional criteria and upon assumption of duties s/he signs an agreement of effectiveness with specific objectives among which is also the control of cost. In addition, the completion of **automation** in

hospitals and the introduction of a **double entry accounting system**, major interventions that are in the phase of materialization, are considered to allow for the improved management of financial resources and by extension the spending of hospitals.

For what concerns the method of pricing medical practices and hospitalization, the option is provided, further to the daily closed hospital cost, for remuneration on the basis of the total uniform hospital cost per diagnostic category and the hospital fee for a specific sum of examinations upon agreement between the Insurance Funds and the hospitals. The objective of such regulations is to create positive financial effects and the protection of users – consumers of healthcare services. Finally, the recent law on hospital procurement shall restrict phenomena such as over – pricing and lack of transparency, but also speed in supply and the payment of the supplier, factors which when restricted can decrease the total cost of supplies as well.

3.1.4 Challenges

Outline the main challenges regarding sustainability of healthcare.

It is apparent that the continuous and uncontrollable healthcare spending increase in recent years, especially with a pace that is faster than that of the GDP increase, endangers not only the sustainability of healthcare which forms the basic pillar of the welfare state itself but also the economic development of the country. For this reason, the measures to be taken should not only be restricted in the healthcare sector. On the contrary, interventions are also required in sectors such as the labor market and employment, social insurance, the economy and the tax system.

In the sectors of healthcare the measures to be planned and taken must in no case endanger the health of the population, and in particular of the elderly or restrict social solidarity. Maybe this is the most substantial challenge for all E.U. countries.

For Greece, the challenges that are connected to the financing but also and by extension to the sustainability of the system are:

- The taking of measures for the control of over production of doctors, a phenomenon which has assumed explosive proportions with negative consequences in healthcare spending;
- The assessment and control of the installation, the diffusion and the use of biomedical technology, which is to blame at a large extent for the continuing increase of healthcare spending;
- The taking of measures for combating over prescribing drugs;
- The search for alternative methods of financing the healthcare system in which incentives and measures for the control of demand shall be incorporated with the purpose of restricting costs;
- Better coordination of sources of financing and the stricter controls which shall limit phenomena such as over – consumption, waste, overlapping and induced demand;

- The full automation of health funds and hospitals and the keeping of information for every doctor and every clinic in relation to writing out prescriptions, consultations etc.;
- The development of an efficient primary health care system, with a family doctor;
- The search for solutions within the strengthening of the institution of the family and the encouragement of voluntarism. Measures towards these two directions significantly 'relieve' the public system of social protection thus releasing precious resources both human and economic;
- A bigger equality of the system, especially towards the poor and the elderly, who mostly suffer from measures of rationalizing healthcare spending.

3.1.5. Planned policy changes

Describe any planned changes in particular any initiatives focused on the provision of healthcare to the elderly.

It has already been mentioned that a separate healthcare policy referring to the elderly alone does not exist.

As already mentioned, there is no distinct health policy for the elderly. There are, however, partial actions and initiatives aimed at population groups with special health problems, for which specialized services are needed. We refer to individuals with special needs, individuals with chronic problems and are unable to care for themselves, individuals with incurable diseases who are in the last phase etc. For such individuals there either are already, or are in progress projects and initiatives for the creation of structures and infrastructures, for which relevant details are given in the questions on long – term care.

3.2 LONG – TERM CARE

3.2.1 Expenditure and financing

In relation to long – term care, give estimates of current cost taking into account as fully as possible the impact across different policy domains.

Describe, where these exist, specific funding mechanisms for long – term care (e.g. targeted social insurance contributions).

Due to the multifaceted nature of long – term care, the various and different bodies and kinds of offer thereof, but also the shortage of a satisfactory definition, one which is common and accepted at a national and a European level, it is not possible to give an estimate on the total amount of the relevant spending.

In any case, it is repeated that a significant part of long – term care is informal and offered by the family, and any effort to estimate the cost thereof shall not correspond to reality if the cost of informal care is not too included therein, considering that the proportion of the elderly who are accommodated by bodies which offer long – term care or official care is offered to these at home is very small.

As mentioned in a previous unit, the financing system for formal care is of a mixed type (state budget – public resources, social insurance but also private resources). The percentage of financial coverage from the various sources differs depending on whether it concerns open or closed care and depending on the legal status of the body providing (public law, private law non profit, private law profit making).

In summary:

- Public bodies of closed care are financed on a regular basis primarily from the state budget, and secondly by per diem reimbursements paid by the insurance funds, as well as other resources (e.g. donations, estates etc.). There is by rule no contribution of the elderly in bodies of private law;
- For the Non Profit Private Sector, the cost is covered by insurance funds (per diem reimbursements), although most bodies are financed significantly by the state budget;
- For the Private Profit Making Sector, the cost is covered in the majority of bodies from private resources;
- For the project ‘Assistance at Home’ which is implemented by the State, the cost is covered by public resources, whereas for the assistance at home implemented by the insurance organizations the cost is covered by social insurance;
- State benefits are covered by the state budget whereas the benefits of insurance organizations by social insurance.

It should be noted that there is no uniformed nominal per diem reimbursement or cost of **medical interventions** for the insurance fund of the Public Sector or for all insurance funds.

Efforts are being made to reach a consensus on a common amount for the per diem reimbursement, with characteristic example that of the Centers for Full Therapy – Rehabilitation where a uniform per diem reimbursement will be established.

3.2.2 Cost control mechanisms

The role of charges in controlling demand for formal care.

How to ensure cost consideration in the planning and provision of long – term care: are there comparative assessments of different approach (institutional/home-based); formal/informal)? Are there mechanisms for raising the sensitivity of care professionals and decision makers (e.g. social workers) to cost consideration?

Are there mechanisms for assessing long – term care and healthcare costs in an integrated way?

The field of cost control is not developed and there are no mechanisms for assessing long – term care and healthcare in an integrated way.

Nevertheless, concerning the determination of tariffs for controlling demand of formal care, the per diem reimbursement is nominal, differs, between the insurance fund of the public sector and other insurance funds, or among insurance funds

themselves, and does not correspond to the final cost of care as an effort to control the cost and limit expenses.

In addition, in the context of continuous training of personnel multidisciplinary training programs are materialized in recent years on cost issues, for the improved preparation of the planning and control of spending.

3.2.3 Challenges

Outline the main challenges regarding sustainability of provisions for long – term care.

The aging population has a positive as well as a negative impact on public spending. The increase in the number of elderly individuals who live independently without problems drops care expenditures.

However, the more general increase of life expectancy and the total number of elderly individuals brings an increase in care expenses.

Since expenses concentrate in the later years of life, assessing the situation of the elderly, of the morbidity, but also assessing the life expectancy in good health and without need for care, are all crucial factors, which determine the cost of long term care.

The higher standard of quality of life and the higher educational level contribute to the improvement of health status of the general population. As a consequence, the age that people need care and medical support has shifted upwards, the dependency risk has decreased, leading to decrease in total expenditures in care. However, the said decrease must be compared to the increase in the demand for services and in the cost, due to the expansion of the aging population.

The increasingly higher percentage of elderly people creates new demand for the supply of long – term care. Illnesses related to age and dependence (pathological aging) do require less healthcare in a purely medical terms, but more healthcare in socio – medical terms. This means relatively less cost but for a much longer period of time. On the other hand, informal care (which is offered in the context of the family and the community and is based on solidarity), due to the increased instability of family structures and the smaller size of families becomes weaker thus making it more difficult for the elderly to stay the family environment. Therefore, the demand for formal long – term care increases, as well as the period for which it is provided.

The new conditions of demand in combination with scientific and technological progress but also the parameter of universal access to those in need, require an increasing level of financing in order for efficient and good quality services to be supplied. The increase in demand and cost brings multiplying effect in expenses for which the financial systems can not correspond unless revenue is increased or measures are taken to restrict spending.

Demand could be limited by focusing in the improvement in the health status and the independency of the elderly that should start at a younger age. But mainly demand could be limited either by increasing social or tax contributions, or by increasing direct contributions from the recipients of care. In case it should be ensured that the pace of spending progress is within accepted limits, without putting at risk the quality or the performance of the social care system.

Indeed, certain types of care must be provided regardless the cost in the framework of the welfare state and in the framework of effective provision of care to the elderly in need. Furthermore, for ethical or bioethical issues, decision making with single criteria the cost or the public interest becomes even more difficult.

Finally, financing of long – term care must also be seen as a parameter of the sustainability of the insurance and tax systems, since a large part of expenses is covered through these.

3.2.4 Planned policy changes

Describe any planned changes.

The sustainability of long – term care is a new subject and one which is under continuous examination because it is connected to increasing and changing needs. By forming the Welfare Charter and the continuous update thereof we shall have the indicators needed for correct social planning and policy changes. Our main objective is to develop a modern, efficient and accessible network of social care services.

The changes planned for the efficiency of the network presuppose the following:

- Ability to recognize needs and to assess the programmes implemented;
- Participation of the local communities and administration;
- Cooperation of all responsible bodies involved;
- Prevention of problems.

True translation of the attached herewith Greek document.
Athens 23 October 2002. Translator: D.Karatza