ESPN Thematic Report on Inequalities in access to healthcare

Greece

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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

For more information on the ESPN, see:
http:ec.europa.eusocialmain.jsp?catId=1135&langId=en

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Summary / Highlights

The Greek healthcare system is characterised by the coexistence of a national health system (which is rather hospital oriented), compulsory work-related social insurance and a fairly strong private for-profit healthcare sector. Since 2011, a number of reforms have sought to rationalise the system and curb public expenditure on health. In this context, a new organisation was established, namely the National Organisation for the Provision of Health Services (EOPYY), to act as a single purchaser of healthcare services for the vast majority of the insured; since 2016 it has also covered the uninsured. This is considered an important step towards universal healthcare coverage. Insured people are entitled to access (free of charge) to all public primary (medical care, dental care and diagnostic examinations) and secondary (hospital treatment) healthcare services, while they also have access, though on a cost-sharing basis, to healthcare services delivered by certain private providers contracted with EOPYY. This also applies to uninsured citizens (including migrants) who are legally residents in Greece and to certain migrant vulnerable social groups (irrespective of legal status) – except that, unlike the insured, they are not entitled to access on a cost-sharing basis to private providers contracted with EOPYY. As to pharmaceutical care, the same co-payment rules apply to both insured and uninsured persons, though certain categories of persons are exempt from any co-payments – e.g. people on a very low income, refugees, prisoners, etc.

The recent reforms in the Greek healthcare sector include the creation of an e-prescription system, the application of new pricing rules for pharmaceuticals and, most importantly, the establishment – as part of the National Health System (ESY) – of the National Network of Primary Healthcare (PEDY). This was created in 2014 to strengthen access to primary healthcare and thus to reduce overcrowding in hospital emergency departments and unnecessary hospital admissions. However, full functioning of this primary healthcare network was never achieved, mainly on account of financial limitations and administrative obstacles. Very recently (August 2017) new legislation was adopted with the aim of reforming and reorganising the primary healthcare system. Although the recent reform of the primary healthcare system is considered a long-overdue and positive development, it would appear that implementation is proceeding rather slowly.

Although healthcare reforms are developing in the right direction, some of them have focused on drastic cuts both in spending and in the scope of publicly provided services; also they have hardly touched on problems relating to access, equity and quality. Major problems remain with regard to accessibility to healthcare, creating inequalities in access, especially among certain groups of the population. Public underfunding of health, the increased burden of out-of-pocket payments (due to a decrease in household income), staff shortages and poor-quality provision in the public healthcare sector, and the uneven geographical distribution of doctors and healthcare facilities are among the main challenges that need to be addressed. For unless concerted action is taken to tackle these challenges, inequalities in access to healthcare will persist and will even widen further. Besides, these challenges should be seen in the context of the pressure imposed by population ageing, which is expected to increase significantly the demand for healthcare services. This in turn brings to the fore the need to ensure sufficient quality of service provision. A common denominator in addressing all these challenges effectively is securing sufficient financial resources; this is a challenge in itself, given the current fiscal constraints.

Overall, although efforts have been made by the government to improve universal access to healthcare services, this has yet to be fully accomplished; meanwhile improving equity and service quality remain challenges that have not been met. There is a particular lack of mental health services for children and the elderly (to say nothing of refugees and migrants), and many geographical areas are lacking mental health services. Public healthcare infrastructure is missing and services for children are still not widely available, especially for children with disabilities. Particular reference should also be made to specific vulnerable population groups, such as Roma people, patients with chronic illnesses, refugees and migrants; they face notable inequalities in accessing healthcare services in Greece.

When examining available indicators from different sources with regard to the various dimensions of access to healthcare, one observes that in Greece certain indicators reflect the actual situation, while others have limitations and thus fall short of depicting a clear picture of some aspects of the healthcare sector. Moreover, there are areas of concern, including those dimensions of access to healthcare for which data or relevant indicators are missing. The development of new indicators (such as the range of services covered, the variation in coverage and the utilisation of services by different groups, etc.) and the regular updating of all relevant indicators would definitely allow a much more comprehensive picture to be painted of the situation with regard to inequalities in access to healthcare in Greece. That could be used, in turn, for policy-design purposes, in order to address effectively the inequalities identified.

1 Description of the functioning of the country's healthcare system for access

The Greek healthcare system has a mix of public and private funding and service delivery (Mossialos et al., 2005). It is characterised by the coexistence of a national health system (which is rather hospital oriented), compulsory work-related social insurance and a fairly strong private for-profit healthcare sector. In Greece, the turning point for healthcare came in 1983, when the Greek parliament adopted Law 1397/1983, which laid the foundations for the development of a universal public healthcare system. This law concerned the establishment for the first time in Greece of a National Health System (ESY), which comprises both primary and secondary healthcare, and which is financed by the General Government Budget and the Social Insurance Funds.

However, although in its initial conception the ESY clearly focused on universality, it finally came to be an expensive, fragmented and over-regulated system that mainly worked for the insured. All insured citizens, along with their dependants, were covered by various work-related social and health insurance schemes, which gave them access to healthcare services. Yet, the range of services offered to them varied, depending on the specific benefit schemes and the regulations of the various social insurance funds.[1] This diversity of coverage persistently contributed to significant inequalities in healthcare provision among insured citizens (Petmezidou et al., 2015). As for the uninsured, access to the public healthcare services was granted exclusively to those living in extreme poverty, who received a 'Welfare/Uninsured Booklet'. This allowed them to be treated in public hospitals and to visit doctors in the public outpatient clinics of hospitals and public health centres, as well as to get medicines from the public pharmacies of hospitals.

Overall, it may be argued that, up to 2011, the public healthcare system in Greece was characterised by over-regulation, poor administration, low cost-effectiveness and failure to ensure universal access. Nevertheless, with the outbreak of the fiscal and economic crisis and the urgent need to curb public expenditure, the rationalisation of the healthcare system came to the forefront of the political agenda. This led to a number of reforms, which were agreed in the framework of the three consecutive "Memoranda of Understanding" signed between Greece and the European Commission, European Central Bank and the International Monetary Fund. The main reforms undertaken since 2011 and which have shaped the current healthcare system are outlined below.

In 2011, a new organisation was established: the National Organisation for the Provision of Health Services (EOPYY) (Law 3918/2011, modified by Law 4238/2014), which is regarded as the most significant healthcare policy development since 1983. With the establishment of EOPYY, which unified all the health branches in the majority of social insurance funds, the whole (extremely fragmented) system for the provision of healthcare services was simplified and is now underpinned by a unified regulation (Unified Healthcare Regulation – EKPY). EOPYY is a public corporate body acting as a single purchaser of healthcare services for the vast majority of the insured;[2] since 2016, it has also covered the uninsured segment of the population. This is considered an important step towards universal health coverage.

Healthcare coverage by EOPYY for the insured is financed by contributions paid by employees, the self-employed and retired persons through the Unified Agency for Social Insurance (EFKA).[3] Insured people pay a fixed premium, which is collected by EFKA and then transferred to EOPYY.[4] They are entitled to access (free of charge) to all public primary

[1] Until 2011, some of the social insurance funds, apart from providing access (free of charge) to public primary and secondary healthcare services, also provided access (on a cost-sharing basis) to private healthcare providers.
[2] EOPYY covers over 98% of the insured population, while the remaining 2% are covered by their own social insurance funds (e.g. employees of the National Bank of Greece and the Central Bank of Greece) and continue to enjoy service provision through their own funds.
[3] In January 2017, the vast majority of the social insurance funds were integrated into EFKA.
[4] This premium concerns the contribution rate for healthcare coverage, which is set at 6.95% of the insured's monthly income for self-employed people, while the rate for employees is set at 7.1% in total (one third paid by

(medical care, dental care and diagnostic examinations) and secondary (hospital treatment) healthcare services; they also have access, though on a cost-sharing basis, to healthcare services delivered by certain private providers contracted with EOPYY.[5] In the latter case, for diagnostic examinations EOPYY pays 85% and the insured person pays 15%; for medical examinations by doctors contracted with EOPYY (but not dentists), EOPYY pays 100% of the doctor's fee.[6] With regard to hospital treatment in private clinics contracted with EOPYY, 70% of the total cost is paid by EOPYY and 30% by the insured. It is worth noting that the total cost of hospital treatment is calculated in accordance with the Closed Unified Hospital Expenditures/Diagnosis-Related Groups classification system (KEN-DRGs).[7] In the case of healthcare services delivered by private providers not contracted with EOPYY (i.e. visits to doctors and diagnostic examinations/hospital treatment in diagnostic centres or private clinics), insured persons have to pay the whole cost by themselves (out-of-pocket payments) or through private insurance.

For the uninsured citizens (including migrants) who are legally residents in Greece and for certain migrant vulnerable social groups (irrespective of legal status), public healthcare coverage by EOPYY has been ensured since February 2016 (Law 4368/2016) and is mainly financed by the General Government Budget. This was the response of the Greek government to the dramatic increase in the number of uninsured citizens following the outbreak of the economic crisis in Greece and the subsequent inability of a very large number of citizens to cover their health needs.[8] The relevant legal framework provides them with the right to access (free of charge) all public healthcare services, both primary and secondary. The only condition for free access to the public healthcare services is that individuals must possess (or acquire, if they do not already have one) a Social Security Number (AMKA). Those who are unable to produce the documents necessary to receive an AMKA are required to show a Foreigner Healthcare Card (KYPA).[9] It should be pointed out, however, that (unlike the insured) uninsured persons (AMKA and KYPA holders) are not entitled to access private providers contracted with EOPYY on a cost-sharing basis. In all cases, all persons irrespective of legal status are entitled to access health emergency departments for the management of life-threating conditions.

As for pharmaceutical care, it should be stated at the outset that since 2009 public pharmaceutical expenditure per capita has been declining (from EUR 430 per capita in 2009 to EUR 181 per capita in 2015) (IOBE, 2018), mainly because of the reform measures taken to control prices and restrict waste in pharmaceutical expenditure. The creation of

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the employee and two thirds by the employer). As for retired persons, their contribution for healthcare coverage is set at 6% of their main monthly pension benefit; an additional 6% of auxiliary pension benefit is paid by those who are entitled to it.

[5] EOPYY has contracted with 5,471 doctors/physicians of various specialisations, as well as with 144 private clinics and 2,778 diagnostic centres. Yet there are no official up-to-date reliable data on the total number of private providers who are not contracted with EOPYY, and thus it is not possible to provide the actual proportions of public providers, private providers contracted with EOPYY and private providers not contracted with EOPYY. Nevertheless, according to our estimates, based on relevant data from various sources, it appears that of the total number of doctors/physicians, the share of doctors/physicians working in the public sector is approximately 37%, while the share of doctors/physicians contracted with EOPYY is nearly 8%.

[6] For each doctor contracted with EOPYY, there is a limit of 200 appointments per month (not more than 20 appointments per day) for which the doctor can be reimbursed by EOPYY. If this limit is exceeded, the insured person has to pay a EUR 10 fee per appointment. It should be noted that doctors/physicians contracted with EOPYY are also allowed to work as non-contracted providers, while those working as public employees are not allowed to work in the private sector. An exception to this is doctors/physicians working in public university hospitals or in university clinics of public hospitals and military/army doctors, who are public employees but are allowed also to have a private practice.

[7] Closed Unified Hospital Expenditures/Diagnosis-Related Groups (KEN-DRGs) were introduced in 2011 to control public expenditure on secondary healthcare services. The KEN-DRGs are encoded by disease category, which, in turn, determines the average length of hospital treatment and the total cost.

[8] In 2015, the estimated number of uninsured persons in Greece who did not have access to healthcare services was approximately 2.5 million. But this is only an estimate, since there are no reliable official data on the actual number of uninsured people in Greece, either for 2015 or for subsequent years.

[9] KYPA is granted by the Offices of Rights Protection of Health Services Recipients or Social Services of the Public Health System. KYPA is issued for 6 months and can be renewed; KYPA for women beneficiaries who are pregnant is valid for 1 year.

an electronic prescription system, the imposition of ceilings on the monthly prescription budget for each doctor, the application of new pricing rules for pharmaceuticals and the promotion of generic medicines are considered the most important actions taken in this respect. These constitute the main features of the functioning of the pharmaceutical care system in Greece.

Moreover, following a review of the pharmaceutical co-payment rules in 2011, a 25% participation fee has been set, as a general rule, to be paid by the insured for medicines prescribed by a doctor.[10] However, for medicines for certain illnesses, the participation fee is set at 10% or 0%, depending on the kind of illness. It should also be noted that no participation fee is paid by insured persons for high-cost medicines, which are only supplied by the pharmacies of public hospitals and EOPYY. The same rules apply to uninsured persons (AMKA and KYPA holders),[11] though certain categories of persons are exempt from any co-payment: (a) those who fulfil specific income and property criteria and (b) those belonging to vulnerable social groups, such as asylum seekers, refugees, prisoners, disabled persons with more than 67% level of disability, etc.

Reforms have also been undertaken in recent years to strengthen access to primary healthcare and thus to reduce overcrowding in hospital emergency departments and unnecessary hospital admissions. In 2014, Law 4238/2014 introduced the National Network of Primary Healthcare (PEDY) as part of ESY. This was designed to act as a public health provider of primary health and diagnostic services to all citizens and to operate under the administrative responsibility of the regional health authorities. This Network, which functioned until August 2017 when new legislation was introduced, consisted of all the urban and rural health centres (previously operating under the administrative authority and medical responsibility of public hospitals) and all the decentralised primary health medical units (previously operating under the administrative authority of EOPYY).

The establishment of PEDY was undoubtedly a step forward in improving system integration, since it aimed at creating a universal primary healthcare network, organised and administered regionally. Yet full functioning of this primary healthcare network has never been achieved, mainly because of financial limitations (i.e. budgetary constraints leading, among other things, to staff shortages and thus to limited provision of services) and administrative obstacles. As a result, the extent of coverage, the qualitative aspects and the prospects for the services provided have fallen short of PEDY's original objectives.

To address this situation, new legislation was adopted in August 2017, with the aim of reforming and reorganising the primary healthcare system[12]. Among the basic components of this reform are the following. First, the law provides for the establishment of local health units (ToMYs), which operate within a defined catchment area and constitute part of a unified and decentralised system managed by the regional health authorities. These units, which will also act as 'family doctors', consist of a 'healthcare team' comprising general practitioners, health visitors, nurses, social workers and administrative personnel. Secondly, it includes a number of arrangements for the upgrading of urban-type health centres, which are decentralised units of the regional health authorities; this includes linking them to the new ToMYs.[13] Thirdly, for the first time in Greece, it introduces the concept of the 'family doctor'. And fourthly, it envisages the establishment of the 'individual electronic health record'.

Although this recent reform of the primary healthcare system is considered a positive and long-overdue development, it appears that implementation is proceeding rather slowly,[14]

[10] An additional surcharge of EUR 1 is paid only by the insured persons per prescription.
[11] These persons do not pay the additional surcharge of EUR 1 per prescription.
[12] The name 'PEDY' was abolished, while the urban health centres and the decentralised primary health medical units were all renamed to 'health centres' and continue to be part of the primary healthcare system.
[13] The initial plan foresees the creation of 239 local health units across the country.
[14] An indication of this is that, of the 239 ToMYs initially planned, only 30 have so far (May 2018) been set up. This is partly due to the fact that, although a number of calls for tender for the recruitment of doctors, nursing

while understaffing continues to be a serious obstacle to the proper functioning of the whole primary healthcare system in Greece. Besides, there is a need to improve coordination of the various primary healthcare units at the regional level, the responsibility for which lies with the regional health authorities. Questions are raised, however, about the ability of the latter to perform effectively the role of service coordinators (OECD/European Observatory on Health Systems and Policies, 2017), while it is also questionable whether the new institution of 'family doctor' will succeed in acting as a gatekeeper for the primary healthcare system.

In general, the problems remaining in the public health sector that impede effective access to care and erode the universality concept are mainly related to understaffing[15] –in both primary healthcare centres/units and public hospitals – and the lack of basic equipment. These are largely a result of the public underfunding of the healthcare system in Greece. Although some of the reforms of recent years have been fairly effective in terms of their economic goals, the serious cutbacks in health spending have negatively affected the capacity and efficiency of the healthcare system. Although no official data are available on the efficiency of the system (other than the increase in the share of people who report unmet medical need and the worsening of the health expectancy indicator – see Section 2), the deterioration in the system's capacity is reflected, among other things, in the downward trend observed over 2012-2015 in both the number of available inpatient hospital beds and the number of medical and nursing personnel employed in the country's hospitals (EL.STAT., 2017c).

Total healthcare spending was severely affected by the economic crisis, leading to a decrease of 36.6% during the period 2009-2016. In particular, after the outbreak of the crisis in 2009, total spending on health declined from EUR 23.2 billion to EUR 14.2 billion in 2014; there was then a slight recovery in 2015 and 2016 (when the figure reached EUR 14.7 billion) (EL.STAT., 2015; 2018). This decrease was largely due to the significant decline (approximately 44%) in total public expenditure on health (both government schemes and compulsory contributory healthcare financing schemes)[16] over the period 2009-2016 – from EUR 16.1 billion in 2009 to EUR 9 billion in 2016; meanwhile out-of-pocket payments[17] on health declined at a slower pace (a decrease of approximately 23%) – from EUR 6.6 billion in 2009 to EUR 5.1 billion in 2016 (EL.STAT., 2015; 2018). In contrast, private health insurance[18] spending increased by 30.8% over the same period – from EUR 433.8 million in 2009 to EUR 567.5 million in 2016 (EL.STAT., 2015; 2018).[19] It is worth noting that public expenditure cuts in healthcare have concentrated more on reducing inpatient care and pharmaceutical (medical goods) costs. Nevertheless, these two items continue to have large shares of the total health spending in Greece (40% and 28%, respectively, in 2015) – far higher than the OECD-31 average of 28% and 19%, respectively (OECD, 2017).

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staff, social workers and administrative personnel have been announced over the period August 2017-May 2018, recruitment of the necessary personnel for the operation of these units is still pending.

[15] Understaffing is mainly due to the hiring freeze imposed in 2010 on public sector employees, including doctors and nursing personnel, to curb public expenditure. OECD data reveal that this led to a 15% decrease in staff employed in public hospitals during the period 2010-2015, while according to EL.STAT. (2017a), there was a decrease of 33% in doctors, 7% in nursing personnel and 36% in the non-medical personnel of health centres (urban and rural) of the primary healthcare system.

[16] The decrease observed in public expenditure on health is mainly due to significant cuts in public resources caused by the need to rein in public expenditure, along with a decrease in social insurance contributions for health (due to the dramatic increase in unemployment and a series of cuts in salaries).

[17] Out-of-pocket payments concern, in particular, co-payments (i.e. direct payments without any reimbursements) and informal payments.

[18] Voluntary (private) health insurance in Greece, which also includes a small part of occupational health insurance, can be categorised as 'duplicate', playing an additional role to the compulsory work-related social insurance by providing faster access, better quality and larger choice of healthcare providers. There is no state support for voluntary health insurance. According to OECD (2017), in 2015 some 12% of the total population of Greece was covered by voluntary health insurance.

[19] Total private funding (out-of-pocket payments and private health insurance expenditure) decreased by 20% over the period 2009-2016, i.e. from EUR 7 billion in 2009 to EUR 5.6 billion in 2016, though it remained almost unchanged from 2012 to 2016.

As regards the share of public expenditure in total expenditure on health, this has also shown a decrease (from 69.5% in 2009 to 61.3% in 2016), and is among the lowest figures for EU Member States (OECD, 2017). By contrast, the share of private expenditure has increased over the same period (from 30.3% in 2009 to 38.2% in 2016), which is mainly due to a significant increase in the share of out-of-pocket payments (from 28.4% in 2009 to 34.3% in 2016) – mainly co-payments for pharmaceuticals and for medical care from private providers contracted with EOPYY. This can be explained by the fact that the cost-containment measures for healthcare expenditure taken in recent years to rein in public spending have rather shifted the financial burden onto patients. Needless to say, the share of private insurance expenditure in total expenditure on health remains very low,[20] though it did increase over the period 2009-2016 (from 1.9% in 2009 to 3.9% in 2016) (OECD, 2017).

Turning to the geographical distribution of healthcare services (including facilities and human resources) across the country, one can observe that healthcare services are unevenly distributed, and in some geographical areas are even non-existent. As regards the distribution of hospitals in the 13 regions of Greece, EL.STAT. (2017c) data reveal that in 2015, of the 283 hospitals (both private and public), a relatively high percentage (34.3%) were located in the region of Attica (mainly in Athens), followed by 15.9% in Central Macedonia (mainly in Thessaloniki) and 12% in Thessaly. The rest of the hospitals (37.8%) were spread across the remaining 10 regions of the country. Although the distribution of hospitals appears to be more or less proportional to the population of each region (with only a few exceptions), the capacity of the public hospitals in the smaller regions of the country,[21] in terms of both the range of services provided and the range of medical specialties offered, is by and large considered rather limited, mainly because they are often understaffed.[22]

Indeed, medical and nursing staff are particularly unevenly distributed across the country, being highly concentrated in the main urban areas. Evidence suggests that Greece faces large geographical inequality in the distribution of physicians/doctors. In particular, Eurostat data reveal that the number of physicians per 1,000 population in 2015 ranged from 3.4 in the South Aegean region and 3.7 in the North Aegean region to 8.6 in Attica region (wider Athens area), as compared to the 6.3 national average.[23] Moreover, it should be pointed out that the public health centres, which are mainly located in rural areas, also face staff shortages. In the period 2010-2015, a 33.3% decrease was observed in the number of medical personnel employed in the public health centres of the country, i.e. from 2,438 persons in 2010 to 1,624 persons in 2015 (EL.STAT., 2017a). It should be noted that, among the various specialties of the medical personnel, there is a serious lack of general practitioners across the country:[24] in 2016 there were only 3.6 per 10,000 inhabitants, compared to a figure for surgeons of 11.8 per 10,000 (EL.STAT., 2017d).

[20] As Economou (2016) argues, 'VHI [voluntary health insurance] coverage remains relatively low in Greece due to economic, social and cultural factors – downward pressure on household incomes, high unemployment, full coverage provided by the social insurance system, people's preference to pay a doctor or hospital directly when the need arises – and factors concerning the VHI market itself, such as low organizational capacity, cream-skimming and the absence of insurance products meeting consumer requirements …'.

[21] It should be noted that in certain regions of the country, especially on the islands, there are no private hospitals at all.

[22] It should be noted that for certain isolated or remote areas (and especially small islands), doctors have been offered specific financial incentives by successive governments to take up positions in public hospitals or health centres in these areas. Yet, to a large extent, these have fallen short of achieving the ultimate goal of attracting (and retaining) doctors to these underserved areas.

[23] According to the OECD, this number is overestimated, as it includes all doctors who are licensed to practise but may no longer be practising for various reasons (OECD/European Observatory on Health Systems and Policies, 2017).

[24] Among the main reasons for this lack is the fact that the Greek healthcare system is hospital oriented and that general practitioners in Greece are perceived as having lower social status than specialists, while the prospect of earning higher incomes has influenced graduate doctors to choose other specialties over general practice (Economou, 2015).

As for nursing personnel, the issue at stake is not so much their unequal distribution across the country, as the longstanding deficit in the number of nursing personnel in public healthcare facilities overall. The ratio of nurses to population is far lower than the EU average (i.e. 3.2 per 1,000 population in Greece in 2015 against the EU average of 8.4 per 1,000) (OECD/European Observatory on Health Systems and Policies, 2017). Undoubtedly, the hiring freeze on all public personnel has a bearing on this situation.

All these inadequacies – especially inadequate public funding – result in long waiting times or waiting lists[25] in public hospitals and create inequalities in access to healthcare services. More often than not, informal payments (under-the-table payments) are made by the patient or the family to physicians, surgeons, etc. in order to bypass waiting times or waiting lists and ensure better quality of service provision (European Commission, 2017a). This is a rather widespread phenomenon characterising the public healthcare sector in Greece, and no concerted action has thus far been taken to address it effectively.

Overall, and although efforts have been made by successive governments in recent years to rationalise the healthcare system and to improve universal access to healthcare services, these have yet to be fully accomplished; meanwhile improvements in equity and service quality remain challenges that have not yet been addressed.

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

As the preceding section shows, the public healthcare system in Greece appears to be moving towards strengthening access to healthcare services, along with achieving universal coverage. Undoubtedly, a number of reforms that have taken place in the healthcare sector over recent years have contributed to this. Among them, Law 4368/2016 which extends healthcare coverage to all the population of Greece.[26] From 2016, it provides for the uninsured and those belonging to vulnerable social groups to have the right to free access to public healthcare facilities and an entitlement to nursing and medical care.

On the other hand, however, some of the reforms have focused on drastic cuts both in spending and in the scope of publicly provided services, and have hardly addressed problems relating to access, equity and quality. What is more, fiscal constraints continue to be imposed on the operation of the healthcare system. Major problems with regard to accessibility to healthcare remain, creating inequalities in access, especially for certain groups of the population. Public underfunding of healthcare, the increased burden of out-of-pocket payments (due to decreases in household income), staff shortages and poor-quality provision in the public healthcare sector, and the uneven geographical distribution of doctors and healthcare facilities are among the main challenges that need to be addressed. For unless concerted action is taken to tackle these challenges, inequalities in access to healthcare will persist and even widen further. Besides, these challenges should be seen in the context of the pressure imposed by population ageing, which is expected to increase significantly the demand for healthcare services. That, in turn, brings to the fore the need to ensure sufficient quality of services provision.

Adequate public funding for healthcare constitutes a prerequisite for addressing effectively many of the challenges identified above; moreover, inadequate public funding may exacerbate existing inequalities in access to healthcare services in Greece. Tackling public underfunding of healthcare in Greece is considered to be of utmost importance, given that healthcare spending has been severely affected by the economic crisis, while the cost-

[25] It should be pointed out that until recently, waiting lists for surgery in Greece lacked any priority criteria and, as such, they lacked any transparency. However, following the adoption of a relevant ministerial decision in December 2016, which set specific priority criteria for waiting lists for surgical operations, public hospitals have gradually begun to create and publish waiting lists based on specific priority medical criteria. This appears to be a rather transparent process, though it is too early to assess its impact and effectiveness.

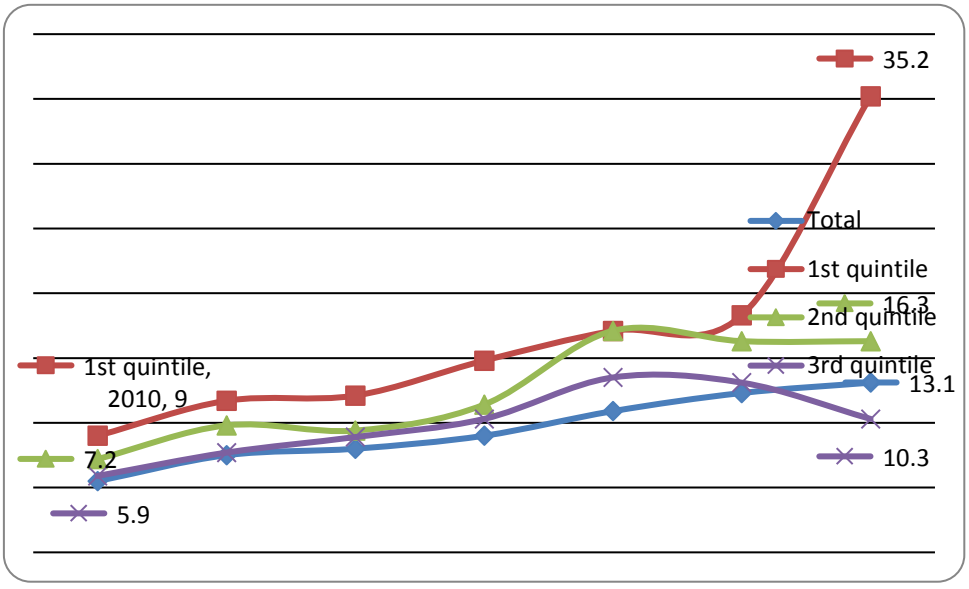
[26] According to OECD (2017), prior to 2016 Greece had the lowest healthcare insurance coverage rate (86% in 2015) of all EU Member States.

containment measures taken to curb public healthcare expenditure have shifted the financial burden onto patients, thus increasing household out-of-pocket payments.

As for out-of-pocket payments, it is commonly acknowledged that these may create barriers to healthcare access, especially for low-income population groups. And this is the case in Greece, where out-of-pocket payments constitute one third of all health spending – far higher than the EU average. At the same time, the highest shares of those who report unmet medical need due to cost in Greece are found to be among the households with the lowest income (first and second quintiles). The relevant data reveal that 'As a share of final household consumption in 2015, out-of-pocket medical spending in Greece reached 4.4%, the third highest among Member States, after Bulgaria and Malta, and almost double the EU average (2.3%)' (OECD/European Observatory on Health Systems and Policies, 2017). Moreover, available relevant data reveal that most out-of-pocket medical payments go on pharmaceuticals (35%) and inpatient care (32%), followed by outpatient care (18%) and dental care (13%) (OECD, 2017). Nevertheless, it may be argued that all these data are rather underestimated, given that it is hardly possible to put a figure on actual expenditure relating to informal payments (under-the-table payments) for healthcare. As stated in OECD (2009) 'the practice of unofficial supplementary payments means that the level of out-of-pocket spending may be underestimated'. Moreover, according to the Updated Study on Corruption in the Healthcare Sector (European Commission, 2017a) 'although informal payments have increased [in Greece], they also have become less visible', which, in turn, implies that it is hardly possible to have a reliable estimation of their extent.

When it comes to examining self-reported unmet need for medical examination or treatment, EU-SILC data reveal that the share of people who report unmet medical need (main reasons) increased sharply from 2010 to 2016 – by 7.6 percentage points, i.e. from 5.5% in 2010 to 13.1% in 2016[27] (Figure 1), far worse than the EU-28 average of 2.5%. In 2016, 12% stated that they had unmet need due to cost (too expensive), 0.9% due to waiting lists and 0.2% due to distance (too far to travel). Unmet need is reported far more frequently by people in the first income quintile than by people in the second and third income quintiles (which are also well above the respective EU-28 averages).

Figure 1: Self-reported unmet medical need (main reasons) (%)

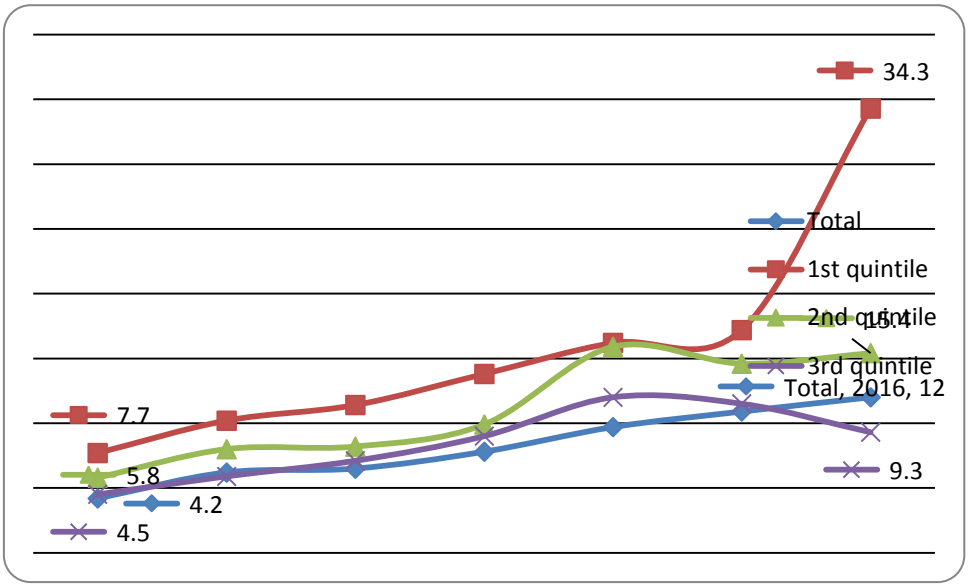


Source: Eurostat, Data extracted: 10 May 2018.

[27] A high percentage of those who declare unmet need (main reasons) were unemployed (21.5% in 2016). It should be pointed out, however, that EU-SILC 2016 data for labour status use 2015 as the reference income period, and therefore do not take into account the impact of Law 4368/2016, which provides healthcare coverage to the unemployed.

Moreover, the data reveal that a significant increase (of 7.8 percentage points) is to be observed between 2010 and 2016 in the percentage of those who had unmet need due to cost (Figure 2): that is from 4.2% in 2010 it climbed to 12% in 2016. What is of rising concern, however, is that the percentage of people on low income (first quintile) who report unmet medical need increased from 2010 to 2016 by 26.2 percentage points, i.e. from 9% in 2010 to 35.2% in 2016 (against 5% for the EU-28). This dramatic increase in the first quintile is mainly related to the increase of 26.6 percentage points in the number of people who reported unmet medical need due to cost (i.e. from 7.7% in 2010 to 34.3% in 2016). As for the second and third income quintiles, the share of people declaring self-reported unmet need due to cost is also particularly high, though the increases observed over the period 2010-2016 are much slower than in the first income quintile.

Figure 2: Self-reported unmet medical need (too expensive) (%)



Source: Eurostat, Data extracted: 10 May 2018.

The data presented above confirm that ever more people from lower- and middle-income groups in Greece face difficulty in meeting their medical needs, mainly due to cost. This situation is even worse for those aged 65+ in the first income quintile: the data reveal that there has been a dramatic increase in the share of people aged 65+ who report unmet need for medical care due to cost over the period 2010-2016, i.e. from 11.4% in 2010 to 48.5% in 2016 (against 31.9% for people aged 16-64 in 2016).

Self-reported unmet need for dental examination has also been on the increase over the period 2010-2016 and remains at a very high level. As EU-SILC data reveal, the share of those reporting unmet need for dental examination increased by 7.8 percentage points, from 6% in 2010 to 13.8% in 2016. This increase is particularly high among those in the first and second income quintiles (from 10.8% in 2010 to 26.5% in 2016 and from 8.8% in 2010 to 24.1% in 2016, respectively); equally significant is the increase observed in the share of people declaring unmet need for dental examination due to cost in the first and second income quintiles (from 10.3% in 2010 to 26% in 2016 and from 8.4% in 2010 to 23.5% in 2016, respectively). The high percentages observed can be partly explained by the fact that there is limited public healthcare coverage for dental treatment in Greece. This is in keeping with the high share of out-of-pocket medical payments allocated to dental care.

As regards the demand for healthcare needs in Greece, what is also of rising concern is the fact that the healthy life expectancy indicator (Eurostat), which measures the number of healthy years that a person is expected to live, declined for both men and women over the period 2010-2016. In particular, in 2016 men were expected to live for 63.8 years in good health, against 66.1 in 2010; meanwhile in 2016 women were expected to live for 64.7

years in good health, against 67.7 in 2010. This is likely to increase demand for healthcare, given that the percentage of people who perceived their health as 'good or very good' decreased over the period 2010-2016 (from 75.5% in 2010 to 73.9% in 2016), while those who perceived their health as 'bad or very bad' increased over the same period (from 9.7% in 2010 to 10.4% in 2016). The challenge that all these indicators pose for the healthcare sector (including long-term care) becomes even more pressing, given that the country exhibits one of the highest rates of population ageing[28] among the EU-28. This is also reflected in Eurostat data, which reveal that the share of people aged 65+ in Greece continues to increase, i.e. from 19% in 2010 to 20.9% in 2015 and 21.3% in 2016; the case for people aged 80+ is similar (i.e. a rise from 4.9% in 2010 to 6.3% in 2015 and 6.5% in 2016).

Moreover, there is an imbalance in healthcare service provision due to the geographically uneven development of healthcare infrastructure and services, with the majority of healthcare providers (both public and private, including doctors) located in the urban areas of the country (mainly Athens and Thessaloniki). This is particularly the case with regard to children, for whom public healthcare infrastructure and services are still not widely available across the country, while healthcare services for certain illnesses/diseases (e.g. cancer) are missing altogether in rural areas. This implies that access to healthcare is heavily dependent on the location of residence of the person in need. This constitutes one of the main barriers in access to healthcare, especially for those living on the islands and in isolated rural areas of the country.

Following from the above, it may be argued that two of the main barriers to access to healthcare services in Greece are this uneven geographical distribution of services and staff shortages, especially in public health centres in rural areas. These factors tend to increase both the cost and the travel times for those who live in rural/remote areas, creating (or widening) inequalities in access to healthcare among the population.

Nevertheless, the low quality of healthcare services constitutes another important barrier to access to healthcare, which leads to inequalities in access. As Economou (2015) argues 'the Greek population has a negative attitude towards the ESY, challenging the quality of services provided. In all Eurobarometer surveys, Greece is among the countries in which the highest proportions of people consider it likely that they will be harmed by a medical error and that it has become more difficult to afford health care … Dissatisfaction is related not to the core therapeutic services provided but rather to other structural, organizational and administrative problems of the health system, [including] the absence of a referral system; long waiting lists and delays in scheduling appointments with contracted physicians.'

This situation is reflected in the findings of the 2016 European Quality of Life Survey (Eurofound, 2017) with respect to the perceived quality of public health services. In particular, in spite of the fact that perceived quality for the EU-28 showed an increase between 2011 and 2016 (i.e. from an average rating of 6.3 to 6.5), the rating of health services in Greece showed a slight decrease, being the lowest among EU Member States in 2016 (i.e. from 4.8 in 2011 to 4.6 in 2016). Similarly, Greece presents the lowest ratings for perceived quality of public health services among the EU-28 with regard to both hospitals and general practitioners/health centres (i.e. 5.1 against the EU-28's 6.9 for hospitals, and 6 against the EU-28's 7.4 for general practitioners/health centres). It may be argued that the current fiscal and economic crisis and the remedies taken to address it, including the cost-containment measures for healthcare, have exacerbated the quality problems of the healthcare sector in Greece. Besides, concern for improving the quality of

[28] The Ageing Ratio is already at a record level, as 100 children corresponded to 148.3 people aged 65+ in 2016 (compared to 145.5 in 2015, 141.8 in 2014 and 138.3 in 2013), while the figure is expected to surpass 230 by 2030. Worse still, the old-age dependency ratio for Greece is expected to double by 2056 (i.e. from 35.8% in 2016 to 76.3% in 2056) (EL.STAT., 2017b; European Commission, 2017b).

healthcare provision appears to be absent from most of the health reform actions taken in recent years.

In addition, particular attention needs to be paid to improving availability, access and quality of mental health services provision. In spite of the efforts taken, there are significant gaps between the services provided and the non-covered needs of the population. These gaps have widened in the last few years, mainly as a result of the cuts in public spending and the effects of the economic crisis on the mental health of people. There is a particular lack of mental health services for children and the elderly (to say nothing of refugees and migrants), while many geographical areas are lacking mental health services.

Moreover, public healthcare infrastructure is lacking and services for children are still not widely available across the country, especially for children with disabilities (including those with mental health problems). Particular reference should also be made to specific socially vulnerable population groups, such as Roma people, refugees and migrants. Among the additional barriers they face (on top of the barriers identified for the general population) are: economic hardship, inadequate information on access to services and on functioning of the system, language and communication difficulties, geographical remoteness and negative stereotypes. In addition, patients with chronic illnesses also face limitations in access to healthcare services in Greece. As an example, no oncology services (either public or private) are provided in rural areas, and consequently those with cancer face severe waiting times in the metropolitan/urban areas, where such services are concentrated.

Overall, it is evident that upgrading the public primary and hospital health services should be prioritised by the government, while the crucial issue for the public healthcare system remains the funding of the whole system, which continues to be of rising concern. To this end, efforts should be concentrated on promoting restructuring and on the effective implementation of the reforms in the healthcare area. This implies, among other things, placing greater emphasis – along with increasing expenditure – on health prevention, while strengthening the integration and continuity of care, especially by establishing a well-functioning referral system and appropriate coordination mechanisms to ensure effective linkage between various healthcare services and providers (primary and secondary). The rationalisation of the use of resources (financial, human, physical) should also be given high priority, to ensure that all capacity within public healthcare facilities is utilised effectively.

However, although healthcare reforms are developing in the right direction, understaffing – particularly in regional hospitals and health centres – remains an important factor impeding the effective implementation of the reforms. Specific measures should be taken to address effectively those challenges identified. Such measures would entail, among other things, strengthening the incentives for the recruitment of doctors to public facilities located in rural areas; introducing specific tools and mechanisms to measure the quality and effectiveness of the services provided; actively involving the regional and local authorities in healthcare planning, organisation and provision; and making specific arrangements to improve hospital management and operational capacity. The overriding objective of such measures should be to ensure universal access, underpinned by equity and quality of healthcare services provision.

3 Discussion of the measurement of inequalities in access to healthcare in the country

When examining available indicators from different sources on the various dimensions of access to healthcare, it becomes clear that, as far as Greece is concerned, certain indicators reflect the actual situation, while others have limitations and fall short of painting a clear picture of some aspects of the healthcare sector. Moreover, there are certain areas of concern: namely those dimensions of access to healthcare for which the data and the relevant indicators are missing.

As regards indicators measuring coverage of the healthcare system in Greece, only the overall indicator is available; nevertheless, this is considered useful, especially for comparative purposes among Member States. Yet there are no sub-indicators available to measure the range of services covered or the variation in coverage between different population/occupational groups. Availability of the latter type of sub-indicators would allow us to estimate equity of coverage with respect to the services offered by the compulsory healthcare insurance system.

As for 'availability of care', Greece lacks administrative data on items such as waiting times, waiting lists, delays in getting appointments with doctors or for diagnostic examination or for surgical procedures; as a result, indicators for this aspect are not really available. The only relevant indicators available in this respect are those based on data from various surveys, such as the European Quality of Life Survey, EU-SILC, etc. But as well as being to some extent subjective, these indicators have certain limitations. In particular, the most commonly used indicator – namely the 'unmet need for medical/dental care' – is based on a very general and limited question. Furthermore, the response to the question is limited to 'yes' or 'no'; if the participant reports unmet need, he/she is then asked to choose the main reason from among certain pre-defined reasons. In the case of Greece, however, given the economic crisis, the answer is likely to be 'too expensive'; thus, the other possible reasons – 'too far to travel' or 'waiting list' – are under-reported.

Affordability of care is also an issue that the available indicators are unable to measure. For, in the case of Greece, although out-of-pocket payments represent a large share of total health spending, the data on such payments are underestimated, since they do not take account of the extensive use of informal payments for healthcare (including long-term care). This is especially the case with under-the-table payments, which is the most prevalent form of corruption in Greece. Besides, it is debatable whether the costs of transportation for healthcare (which are quite high in Greece, given the country's geographical peculiarities) are considered to be out-of-pocket payments for healthcare.

Finally, it may be argued that there is a need for data collection with regard to the use of healthcare services and the socio-economic characteristics of the users. Such data, which are not really available in Greece, would provide the basis for identifying access by utilisation of services in relation to different socio-economic groups. These data, in turn, would lead to specific indicators, which nevertheless need to be complemented by the development of other relevant indicators, such as patient satisfaction, quality of care, ability to pay, geographical location, etc. in relation to the utilisation of the services.

Overall, it may be said that availability and regular updating of all these indicators would definitely enable a much more comprehensive picture to be painted of inequalities in access to healthcare in Greece. This, in turn, could be used for policy-design purposes, in order to address effectively those inequalities identified.

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