The health sector in Greece has been severely affected by the economic crisis, raising concerns for the future of the Greek health system.

The financial crisis has had a tremendous impact on Greece's economy, exacerbating existing problems. The health sector has been seriously affected by the economic situation, and the two Memorandums of Understanding (MOU) that Greece has signed since 2010 dictate a series of measures that focus on the reduction of public expenditure. **Daphne Kaitelidou** *and* **Eugenia Kouli** *outline some of the main effects the crisis has had on the Greek health system.*

In Greece, the negative repercussions of the economic crisis have already led to increased demand for services. Rising unemployment has led to falls in household income, resulting in patients seeking services covered by statutory health insurance funds, rather than paying privately, meaning there are additional pressures on the public health system. Since the beginning of the crisis, the Greek government has had to act to increase contributions to the health system, reduce the coverage of the National Health Services Organisation (EOPYY), and reduce the costs of healthcare, raising concerns for the future of the Greek health system.

Policies targeting financial contributions to the health system

In the context of the two Memorandums of Understanding (which outline how Greece will reform its economy in exchange for the IMF's bailout) , public health expenditure must be reduced by 0.5 per cent of Gross Domestic Product (GDP). The health budget for 2011 decreased by €1.4 billion, with €568 million saved through salary and benefit-related cuts and €840 million saved through cuts in hospital operating costs.

From 2011, the government's (employer) contribution rate to civil servants' social insurance fund (OPAD), was set at 5.1 per cent of civil servants' salaries, while the contribution rate of the fund's retired employees will be gradually increased from 2.55 per cent to 4 per cent in 2013. Moreover, for the insured people covered by the EOPYY, which was established in 2011 with the merging of the four largest statutory health insurance (SHI) funds (IKA, OGA, OAEE and OPAD, covering salaried employees, agricultural workers, the self-employed and civil servants, respectively) the contribution for examinations in contracted private diagnostic centres has been set at 15 per cent. Prior to the merger the contribution rate fluctuated between 0 per cent and 25 per cent, with almost 60 per cent of the population paying no contribution for such examinations.

User charges have increased in an attempt to bolster the revenues of public facilities. From 2011, the examination fee in out-patient departments of public hospitals and primary care health centres increased from €3 to €5, with exemptions for certain vulnerable groups.

Policies targeting volume and quality of care

Since June 2011, the benefit packages of SHI funds have been rationalised and unified to provide the same reimbursable services across all health insurance funds. This process coincides with the effective merger of SHI funds under EOPYY. Some expensive examinations (for example, polymerase chain reaction (PCR) tests and thrombophilia screening), that used to be covered, even partially, on an out-patient basis, were removed from the EOPYY benefit package.

Significant increases in the number of admissions to public hospitals have also been reported: at least 24 per cent in 2010 compared with 2009; and 8 per cent in the first half of 2011 compared with the same period in 2010. As a consequence, it is estimated that waiting times have also increased. According to the General Secretariat of the Ministry of Health (MoH), out-patient visits to public health centres also increased by 22 per cent in 2011 compared to the previous year. These increases in the volume of patients in public facilities may have an adverse effect on the health system's capacity to maintain standards of care.

Policies affecting the costs of publicly financed health care

From 2011, cuts in the salaries of health care personnel have been implemented. For example, the salaries of nurses have been reduced by 14 per cent compared with 2009. Additionally, temporary staff employed under fixed-term contracts have not had their contracts renewed and there has been a significant reduction in the replacement levels of retiring staff (for every five people retiring only one will be appointed).

The MOU aims to save €2 billion from pharmaceutical products (with a target of €1 billion in 2011), thus reducing pharmaceutical expenditure by 1 per cent of GDP. According to estimates, pharmaceutical expenditure fell from €5.4 billion in 2010 to €4.4 billion in 2011 and, it is expected to fall even further in 2012, with a savings target of close to €1 billion in 2012 compared to 2011.

From2011, a positive list for reimbursable medicines was reintroduced with a focus on cheaper generic medicines, along with a policy that at least 40 per cent of medicines used in public hospitals should be generics. From July 2012 the maximum price of generic medicines cannot exceed 40 per cent of their equivalent branded drugs, and there has been a reduction in value-added tax for medicines (from 11 per cent to 6.5 per cent) Finally, e-prescribing has been made compulsory, including at least 90 per cent of all medical activities covered by the health insurance funds.

Additionally, a cap on the profits of pharmacists was set at 20 per cent and a rebate system for sales over a predetermined threshold was established, from 2011. This has been accompanied by measures to liberalise the pharmacies market to introduce greater competition.

From 2011, hospital mergers and closures have been planned. Efforts so far have focused mainly on administrative mergers of adjacent hospitals and merging similar departments within the same hospital. In addition, new measures allow the expansion of private clinics to build infrastructure, develop new departments, units and laboratories, and expand the stock of hospital beds, within certain defined limits.

The situation raises a number of concerns, namely that public access to the health system could worsen; the burden on family budgets could increase; the provision of health services could deteriorate; and private capital in the health sector could expand without adequate monitoring. The current high levels of unemployment also negatively affects the revenues of SHI, reducing the contributions of both employers and employees dramatically, and leading to larger deficits. Thus, the deficits of public hospitals and SHI funds are expected to increase, affecting the quality of health services and patient satisfaction with these services.

A longer version of this article appeared in the latest edition of Eurohealth.

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About the Authors

Daphne Kaitelidou- *University of Athens*
Daphne Kaitelidou is Assistant Professor at the Department of Nursing, at the University of Athens, Greece.

Eugenia Kouli - *University of Athens*
Eugenia Kouli is a Research Associate at the University of Athens, Greece.

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