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Impacts of the economic crisis on access to healthcare services in Greece with a focus on the vulnerable groups of the population¹

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Οι επιπτώσεις της οικονομικής κρίσης στην πρόσβαση στις υπηρεσίες υγείας στην Ελλάδα με επίκεντρο τις ευάλωτες ομάδες του πληθυσμού

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ABSTRACT

In 2010, the Greek economy entered a deep, structural and multi-faceted crisis, the main futures of which are a large fiscal deficit and huge public debt. The negative effects can also be observed at the societal level, as all social indicators have deteriorated. The present paper discusses the impact of economic crisis on access to healthcare services especially for the vulnerable groups. Uninsured, unemployed, older people, migrants, children and those suffering from chronic disease and mental disorders are among the groups most affected by the crisis in Greece. High costs, low proximity and long waiting lists are among the main barriers in accessing health care services.

KEY WORDS: Economic crisis, vulnerable groups, access to healthcare services.

ΠΕΡΙΛΗΨΗ

Το 2010, η ελληνική οικονομία εισήλθε σε μια βαθιά, δομική και πολύπλευρη κρίση, τα κύρια χαρακτηριστικά της οποίας είναι το μεγάλο δημοσιονομικό έλλειμμα και το πολύ υψηλό δημόσιο χρέος. Αρνητικές επιπτώσεις παρατηρούνται και σε κοινωνικό επίπεδο, καθώς όλοι οι κοινωνικοί δείκτες έχουν επιδεινωθεί. Το άρθρο αυτό εξετάζει την επίπτωση της οικονομικής κρίσης στην πρόσβαση των υπηρεσιών φροντίδας υγείας ιδιαίτερα των ευάλωτων ομάδων του πληθυσμού. Οι ανασφάλιστοι, οι άνεργοι, οι ηλικιωμένοι, οι μετανάστες, τα παιδιά και οι πάσχοντες από μακροχρόνιες ασθένειες και ψυχικές διαταραχές είναι οι ομάδες που επλήγησαν περισσότερο από την οικονομική κρίση στην Ελλάδα. Το υψηλό κόστος, η χαμηλή εγγύτητα και οι μεγάλες λίστες αναμονής είναι μερικά από τα εμπόδια στην πρόσβαση των υπηρεσιών υγείας που αντιμετωπίζουν οι παραπάνω ομάδες.

ΛΕΞΕΙΣ-ΚΛΕΙΔΙΑ: Οικονομική κρίση, ευάλωτες ομάδες, πρόσβαση στις υπηρεσίες φροντίδας υγείας.

1. Financial crisis and adjustment program in Greece: Economic, social and health effects

In 2010, the Greek economy entered a deep, structural and multi-faceted crisis, the main features of which are a large fiscal deficit, huge public debt and the continuous erosion of the country's competitive position. In order to address the problem, the Greek government requested from the EU and the IMF the activation of a support mechanism, adopted a strict income policy, increased direct and indirect taxes, enhanced flexibility in the labour market and cut public expenses.

Indicative of the situation are the figures of Table 1, which present data published by the Hellenic Statistical Service (ELSTAT, 2014a). GDP declined at current prices from €242.1 bln in 2008 to €182.4 bln in 2013. The real economy has been in recession since 2009 and GDP contracted by 6.1 in 2013, mainly on account of a sharp drop in investment, but also because of falls in private consumption. The debt-to-GDP ratio continued to rise and the deficit remains high. In addition, compensation per employee has been declining at an increasing rate since 2010.

The negative effects can also be observed at the societal level, as all social indicators have deteriorated (ELSTAT, 2014b). The recession spread across all sectors of activity negatively impacted on employment and caused an increase in the rate of unemployment which climbed to 27.5% in 2013. The same year, 28% of the Greek population was at risk of poverty, 35.7% was at risk of poverty or social exclusion and 37.3% faced financial burden with an enforced lack of at least 3 out of 9 categories of basic goods and services. Inequality of income distribution also increased as the income quintile share ratio (S80/S20) reached 6.6 in 2013 from 5.9 in 2008. The population that can afford the adequate heating of the dwelling decreased from 76% in 2008 to 38.1% in 2013 (ELSTAT 2014b).

Table 1. Economic and social indicators, Greece, 2008-2013 (ESA 2010)

	2008	2009	2010	2011	2012	2013
GDP at current prices (bln Euros)	242.1	237.4	226.2	207.8	194.2	182.4
GDP growth % (at current prices)	4.0	-1.9	-4.7	-8.2	-6.5	-6.1
Public consumption (% change)	-2.1	1.6	-4.3	-6.6	-5.0	-6.5
Private consumption (% change)	3.0	-1.0	-7.1	-10.6	-7.8	-2.0
Gross fixed capital formation (% change)	-6.6	-13.2	-20.9	-16.8	-28.7	-9.5
Government gross debt (% of GDP)	109.3	126.8	146.0	171.3	156.9*	174.9
Government deficit (% of GDP)	-9.9	-15.2	-11.1	-10.1	-8.6	-12.2
Compensation per employee (% change)	3.3	3.2	-2.6	-2.3	-2.0	-7.1
Employment rate	48.9	48.3	46.7	43.3	39.5	37.7
Total unemployment rate (%)	7.8	9.6	12.7	17.9	24.4	27.5
Long-term unemployed % of unemployed	47.1	40.4	44.6	49.3	59.1	67.1
Population at-risk-of-poverty rate (%) before social transfers	23.3	22.7	23.8	24.8	26.8	28.0

Population at-risk-of-poverty rate (%) after social transfers	20.1	19.7	20.1	21.4	23.1	23.1
Population at-risk-of-poverty or social exclusion rate (%)	28.1	27.6	27.7	31.0	34.6	35.7
Income quintile share ratio (S80/S20)	5.9	5.8	5.6	6.0	6.6	6.6
Material deprivation (% of the population) **	21.8	23.0	24.1	28.4	33.7	37.3
Households (%) with central heating	76.0	73.5	73.1	72.1	55.7	38.1

Sources: ELSTAT, 2014a and 2014b.

*Includes debt reduction under the private sector involvement (PSI) initiative.

**Enforced incapacity to face unexpected financial expenses, to afford one week's annual holiday away from home, to have a meal with meat, chicken, fish -or vegetarian equivalent- every second day, to afford the adequate heating of the dwelling, to purchase durable goods like a washing machine, colour TV, telephone, mobile telephone or car, or being confronted with payment arrears, such as for mortgage or rent, utility bills, hire purchase installments or other loan payment.

Although quantifying the health effects of the economic crisis and of the government policies introduced in response to it in Greece is difficult due to lack of timely and relevant data, some preliminary evidence of targeted studies concerning self-reported health, mental health and infectious diseases indicate negative trends. In relation to self-reported health in Greece, studies conclude that the probability of reporting poor self-rated health is higher at times of economic crisis, especially for the vulnerable groups including older people, unemployed, pensioners, housewives and those suffering from chronic disease (Zavras et al., 2013, Vadoros et al., 2013). Mental health has also been deteriorated due to the economic crisis. Between 2008 and 2011 one-month prevalence rate of major depression increased from 3.3% to 8.2% (Economou et al., 2012). Besides depression, between 2009 and 2011 there was also a substantial increase in the prevalence of suicidal ideation and reported suicide attempts in Greece (Economou et al., 2013).

The economic crisis in Greece seems to impact the infectious disease dynamics too. Since 2010, Greece has been suffering a high burden of different large-scale epidemics including the increased mortality of influenza during the pandemic and the first post-pandemic seasons, the emergence and spread of West Nile virus, the appearance of clusters of non-imported malaria and the outbreak of Human Immunodeficiency Virus infection among people who inject drugs (Bonovas and Nikolopoulos, 2012). The increase of the reported number of HIV infections among injected drug users from 15 in 2010 to 522 in 2012 (Hellenic Center for Disease Control and Prevention, 2012) suggests that the recent economic crisis through the increasing socioeconomic disparities and difficulties such as unemployment, extreme poverty, homelessness, stigma, discrimination and social isolation and through the budgetary constraints and poor policies for financing prevention and treatment have been translated to heightened risk behaviors on the individual level and impaired public health response on the population level (Paraskevis et al., 2013).

Children are one of the population groups that have been affected by the crisis. The stillbirth rate from 3.31/1000 live births in 2008 increased to 4.28 in 2009 and 4.36 in 2010, that is an increase of 32% between 2008 and 2010 (Vlachadis and Kornarou, 2013). Similarly, after a continuously decreasing from 40.1 deaths per 1,000 live births in 1960 to a low of 2.7 deaths per 1,000 live births in 2008, infant mortality rate increased to 3.1 in 2009 and 3.8 in 2010 (Eurostat, <http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do>, accessed 20/1/2014).

At the time, although the available morbidity and mortality data are few, given that the effects of economic recessions on the population health are visible in the long run, we have to be aware of even more negative trends in the Greek population health that we will have to confront with in the future. This is suggested by the results of a small Greek study conducted in 2013 which found a significant increase in all-cause mortality and death from ischemic heart disease in workers of a Greek bus company which closed in 1992 (Drivas et al., 2013).

2. Trends in the coverage, use and financing of health care services

2.1 Increasing self-reported unmet needs for examinations

One way to measure problems of access to health care is by reported unmet health care needs. Inequalities in unmet care needs may result in poorer health status and increase health inequalities. The SILC conducted on an annual basis, provides information on the proportion of people reporting having some unmet needs for medical examination for different reasons. Table 2 summarizes the situation in Greece.

Table 2. Self-reported unmet needs for medical examination (too expensive or too far or extended waiting lists (2008-2012))

	2008	2009	2010	2011	2012
Total population	5.4	5.5	5.5	7.5	8.0
By income quintile					
1st quintile	8.7	11.2	9.2	11.6	11.6
2nd quintile	7.1	7.4	6.7	9.8	9.6
3rd quintile	6.1	4.6	5.9	7.6	9.2
4th quintile	3.4	2.7	3.2	4.8	4.7
5th quintile	1.8	1.7	2.2	3.6	4.8
By labour status					
Employed	3.3	2.8	3.1	4.7	5.6
Unemployed	8.6	7.5	9.4	11.3	10.8
Retired	7.6	7.8	7.3	10.2	9.4
Other inactive	5.9	7.3	6.3	6.9	8.1

Source: EUROSTAT, http://epp.eurostat.ec.europa.eu/portal/page/portal/health/health_care/data/database, (accessed 20/1/2014)

From the data presented three conclusions can be drawn for the Greek population. First, during the period 2008-2012, the percentage of the population reporting unmet needs for medical examination due to high costs, low proximity or long waiting lists increased from 5.4% to 8%. Second, people with low incomes are more likely to report unmet care needs than

people with high incomes. Although deterioration has been observed in the period 2008-2012 in relation to the situation of all income quintiles, the gap between the first and the fifth quintile remains large. Third, labour status seems to be a significant determinant of access to health care in Greece. The percentage of the unemployed who report problems with access is almost twice the percentage corresponding to the employed. This raises serious questions for health care coverage given the very high unemployment rate in the country.

2.2 Reductions in public health spending

Started in 2010, the Greek Government continues to implement a reform program with the objective of keeping public health expenditure at or below 6% of GDP for 2012. In practice, this health policy has led to the deepest depression of the health economy. While nominal gross domestic product declined by 6.5% in 2012 (see Table 1), health expenditure dropped down by 12.1%. These cuts were driven by a reduction in public spending and especially social security funds spending on health (Table 3).

Table 3. Total current health expenditures (in million euro)

	2009	10/09 %	2010	11/10 %	2011	12/11 %	2012
General Government	6,271	-11.5	5,548	2.2	5,673	-10.5	5,077
Social Security Funds	9,836	-13.6	8,499	-4.8	8,089	-14.0	6,957
Total Public Current Expenditures	16,107	-12.8	14,047	-2.0	13,762	-12.6	12,034
Private Insurance	434	23.7	537	-0.4	534	-1.6	526
Private Payments	6,593	-7.5	6,096	-4.7	5,809	-12.3	5,096
Total Private Current Expenditures	7,027	-5.6	6,633	-4.4	6,343	-11.4	5,622
Other Expenditures (Church, NGOs etc)	53	39.2	73	-28.4	52	2.1	54
Total Current Health Expenditures	23,187	-10.5	20,753	-2.9	20,157	-12.1	17,710

Source: ELSTAT, 2013.

*Preliminary data

Private expenditures increased as a percentage of total health expenditure during the crisis mainly due to an increase in private insurance. However, out of pocket payments remain the major segment of private health expenditures (Table 4). Since informal payments, represent a significant part of out-of-pocket payments (approximately 30%) there are serious concerns about the barriers imposed to access to health care services. In a previous study it was shown that more than 36% of people who were treated in a public hospital reported at least one informal payment to a doctor mostly in order to have access or faster access to public inpatient health care services (the probability of extra payments were 72% higher for patients aiming to jump

the queue compared to those admitted through normal procedures) (Liaropoulos et al., 2008). Although these payments are very common in order to support insufficient health care budgets, they represent a bad option for financing the health sector, as they cause several inequalities affecting mostly the poor and vulnerable groups (Kaitelidou et al., 2013). It is very likely that health sector staff salary cuts implemented after 2010 in Greece, in relation to increases in waiting times analyzed in the next section, will result in increased informal payments.

Table 4. Current health expenditures (percentage contribution by sector)

	2009	2010	2011	2012
General Government	27.0	26.7	28.1	28.7
Social Security Funds	42.4	41.0	40,1	39.3
Total Public Current Expenditures	69.5	67.7	68.3	68.0
Private Insurance	1.9	2.6	2.7	3.0
Private Payments	28.4	29.4	28.8	28.8
Total Private Current Expenditures	30.3	32.0	31.5	31.7
Other Expenditures (Church, NGOs etc)	0.2	0.4	0.3	0.3

Source: ELSTAT, 2013.

*Preliminary data

2.3 Increases in the use of publicly funded health care services and NGOs facilities

A 35.6% increase in patient admission was recorded between 2009 and 2012 along with a 11% increase in the hospital bed occupancy rate (from 64% in 2009 to 71% in 2012). There were also 6% and 18% increases in surgical interventions and laboratory examinations, respectively, from 2010 to 2011. Visits to public hospital dental services and obstetricians also increased as well as emergency visits increased by 1.8% (from 2011 to 2012) (Ministry of Health and Social Solidarity, 2012a and 2012b).

Visits to afternoon surgeries of public hospitals (compulsory afternoon shifts) decreased by 6% in 2010 compared to 2009, by 19% in 2011 compared to 2010 and by a further 7% in 2012 (from 559,358 in 2009 to 527,602 in 2010, 429,903 in 2011 and 398,731 in 2012) (Ministry of Health and Social Solidarity, 2012a and 2012b). In afternoon surgeries of public hospitals patients are obliged to pay a predefined fee (from €45 to €90 until August 2013 and from €24 to €72 since September 2013) and this maybe explain the decline of visits during the crisis.

However, increased utilization in a time at which funding of publicly funded services was decreased may raise concerns. In particular, the Memoranda of Understandings (MoUs) between the Greek Government and the Troika (IMF, European Central Bank and European Union) required major cuts to hospital and pharmaceutical expenditure. Total public hospital sector expenditure decreased by 26.4%, from €7 billion in 2009 to €5.15 billion in 2011 (OECD, 2013), with major savings in hospitals supplies (medical supplies, orthopedics, pharmaceuticals etc.) and through MoUs conditions stipulating cuts to health personnel salaries and benefits.

A consequence of the above situation is that according to limited evidence but also from unofficial sources from public health services, waiting times to receive public health services have increased. For example according to the only available official data from the Greek Health Map (National School of Public Health and KEELPNO, 2013) waiting times for the use of outpatient services have been increased by more than 200%.

In a survey concerning chronically ill patients, it was found that 64% of respondents (N=1,496) reported problems in accessing a physician or a primary care unit due to economic restrictions and 60% of them due to long waiting lists. Access to health care services was associated with the socioeconomic status. Chronically ill patients with higher income and educational level were less likely to face accessibility problems due to economic constraints or waiting lists (National School of Public Health, Department of Health Economics, 2013).

Increased demand by the Greek population has led some NGOs to develop a number of activities and programs, intended to provide the local population not only with health services, but also with a wider range of social care services (dormitory for homeless people, food distribution, elderly care programme, etc.) which until recently were not typically part of their activities. For example Medicines du Monde established two new polyclinics, one in Perama, a low-income district in the area of Athens in 2009 and one in the city of Patras in 2012 as a response to crisis. Additionally, a vaccination programme was introduced for children of Greek uninsured citizens. In 2012, only in the area of Perama 880 children were vaccinated.

According to a survey conducted by Medicines du Monde in seven European countries, it was reported that approximately half (49.3%) of the patients seen in the four Greek clinics in 2012 were Greek nationals. In Perama (wider Athens area) this figure reaches 88%, in Thessaloniki 52.1% and in Athens 11.8%. In the other countries, this proportion was less than 5% (except in Munich where 12% of patients were nationals) and was almost zero in Amsterdam, Antwerp, Brussels and London (Chauvin and Simonnot 2013). The respective percentage of Greek nationals visiting NGOs polyclinics before the economic turmoil (2007 data) did not exceed 3-4% (Karatziou, 2011) while the Greek citizens visiting the MdM polyclinics in the area of Athens did not exceed 1%.

2.4 Increased demand of emergency services

For the needs of the study, 19 emergency units of rural (9) and urban (10) Greek hospitals have provided data in order to better understand the impact of crisis on access to healthcare services.

During the crisis, the number and the status of patients visiting emergency units has considerably grown. In fact, 95% of the urban hospitals, participating in this survey face an increase of the number of patients ranging from 10 to 35% when only 30% of rural hospitals face an increase of 5 to 15% of the number of patients. One of the reasons for this situation may be the deterioration of the affordability of patients to use private services.

It's important to note that the majority of interviewed urban hospitals (90%) and of rural hospitals (75%) reported greater use of ER services mostly during the afternoon and night shifts. This may partly be explained by the absence of any co-payments at the use of ER, while for the use of outpatient clinics the patient is charged by a €5 co-payment. It may also be linked with barriers in accessing hospitals, associated with long waiting lists.

Regarding the use of ER, some of the emerging groups or the groups of patients which increased the visits included: (a) persons with anxiety problems (depression and stressful

situations), (b) young people uninsured and (c) retired persons with small pensions. More than 68% of the respondents confirmed the finding.

In order to face this large demand of emergency services, the hospitals participating to this survey stated the implementation of various mitigating measures, including triage system, intensive education and professionalization of staff, use of volunteers and restricted use of health materials.

2.5 Reductions in coverage

In 2011, the healthcare sector of all major social insurance funds covering salaried employees, agricultural workers, the self-employed, civil servants, sailors and merchant seamen, and banking and utilities employees formed a single healthcare insurance fund (EOPYY) which act as a unique buyer of medicines and health care services for all those insured, thus acquiring higher bargaining power against suppliers. The benefit packages of the various social health insurance funds merged in EOPYY, were standardized and unified to provide the same reimbursable services.

A basic characteristic of the unified package is the reduction in benefits to which the insured are entitled. For example, some expensive examinations including polymerase chain reaction (PCR) tests and thrombophilia that used to be covered, even partially, were removed from the EOPYY benefit package and have to be compensated on an out-of-pocket basis. In addition, restrictions in entitlement were introduced in relation to childbirth, air therapy, balneotherapy, thalassemia, logotherapy and nephropathy.

Moreover, the introduction of a negative list for medicines in 2012 resulted in the withdrawal of reimbursement status of various drugs that were previously reimbursed. Under the terms of the MOU, this negative list should be updated twice a year. In parallel, an over-the-counter drug list has been in place since 2012, comprising many medicines that until then had been reimbursed (eg. some pain relief medicines) but which now must be paid for out-of-pocket.

In 2011 an increase in user charges from €3 to €5 was imposed in outpatient departments of public hospitals and health centres. From 2014 onward an extra €1 for each prescription issued by ESY has been introduced. A €25 patient fee for admission to a state hospital from 1st January 2014 was applied however the measure was soon revoked due to strong reaction by the health care professionals and the opposition party and it is planned to be replaced by an extra tax of 10 cents on cigarettes.

An increase in co-payments for pharmaceuticals for specific diseases also took place in 2013, including Alzheimer, Dementia, Epilepsy, Diabetes II (from 0 to 10%), Coronary Heart Disease, Hyperlipidemia, Rheumatoid Arthritis and Psoriatic Arthritis, Chronic Obstructive Pulmonary Disease (COPD), Osteoporosis and Paget, Crohn Disease and Liver Cirrhosis (from 10 to 25%). Furthermore, in 2013 the total number of medicines for which a 25% cost-sharing arrangement was imposed has been increased. As a result of these increases, the average co-payment rate for medicines increased from 13.3% in the first and second month of 2012 to 18% in the corresponding period of 2013 while monthly expenditure for households was increased on average from €36.3 mil. in 2012 to €38.2 mil in 2013 (for the same periods over the two years), despite the price reductions (Siskou et al., 2014)

In an effort to further cut costs and combat excessive prescription among doctors, a ceiling to the monthly amount prescribed by a doctor was set in January 2014 (at 80% of the last years' prescription budget). The measure caused a number of reactions as the measure exacerbated the

patients' discomfort, having to refer to a number of doctors in order to get the prescription from a doctor who didn't reach the prescription limit. As a result some exceptions were introduced and doctors who work at public hospitals, as well as those who work for retirement homes and nongovernmental organizations, are among those who are excluded from the measure.

Since the Greek health care system was characterized as inequitable in access even before crisis (Economou and Giorno, 2009, Economou, 2010, Liaropoulos et al., 2008, Siskou et al., 2008), it seems that the crisis has exacerbated existing problems, and many of the policy measures introduced under pressure from bailout conditions have made the financing of the health sector more inequitable. Most of the above mentioned measures are horizontal, not means-tested and as a consequence they impose higher burden to the least well off. The imposition of public health spending restrictions (to no more than 6% of GDP in 2012) and the simultaneous decline in GDP (since 2009, with further decreases forecast in the next few years) means that the public health sector is called upon to meet the increasing needs of the population with decreasing financial resources. This has negative effects, especially for the middle and the low-income households that do not have the disposable income to buy private health services (Economou et al., 2014).

3. The access of vulnerable groups to health care services

3.1 The unemployed and the uninsured

In 2013 the number of employed amounted to 3.5 million persons while the number of unemployed amounted to 1.3 million. The unemployment rate was 27.5% and long-term unemployment raised to 67.1% of all unemployed (ELSTAT, 2014b). Those who are unemployed for less than 12 months, they continue to have access to sickness benefits in kind for 1 year after the commencement of unemployment with the prerequisite proof to be given of at least 50 working days in the year prior to the commencement of unemployment.

After the expiry of the one year, OAED provides for health coverage in the following three cases: (a) Long-term unemployed aged over 55 years with the prerequisite to have completed at least 3000 daily wages (Article 10, Law No. 2434/1996). (b) Long-term unemployed aged 29 to 55 years old are covered for a period of up to two years with the prerequisite to have completed 600 working days, to be increased by 100 days per year on completion of 30 to 54 years of age (§4, Article 5, Law No. 2768/1999). (c) Unemployed aged up to 29 years are covered for 6 months with the prerequisite to have been registered in OAED as unemployed for a period of at least 2 months (Article 18, Law No. 2639/1998).

After a person has exhausted its insurance right for sickness benefits, and its eligibility for OAED programmes and health voucher, an option is to request for a poverty booklet. Since 2006 (ministerial decision 139491/2006) a special mechanism has been developed in the framework of protecting the vulnerable population with the provision of the "poverty booklet". It addresses poor and uninsured population that have exhausted their social insurance right and it provides them with free access to public hospital, medical services and pharmaceuticals. The basic eligibility criteria are the lack of insurance, low income (the annual family income not to exceed 6,000 euros, increased by 20% for the spouse and every under age or dependent child, provided that this income does not come from employment giving access to insurance) and permanent and legal residency in Greece. Beneficiaries who are eligible for the uninsured booklet are registered in the Registry for the Uninsured and Financially Weak kept by the Health or Welfare Directorate

of each municipality. The duration of the poverty booklet is 1 year with the possibility of annual renewal for as long as the eligible remains under the status of being poor.

A certificate of social protection is issued for foreign nationals with residence permit for health reasons, nationals of member-states of the European Social Charter, expatriates applying for the expatriate identification card or for Greek nationality. For recognized refugees or immigrants that their application for refugee status is being processed and, beneficiaries of subsidiary protection, immigrants with residence permit for health reasons, free access to healthcare services, identical to the ones available for Greek citizens, is provided on condition that they are uninsured and poor.

Since June 2014, according to new law amendments (Government Gazettes 1465 05/06/2014 and 1753 of 28/06/2014) the uninsured and their families are entitled to primary and in-hospital health services as well as pharmaceutical care. The ATLAS plan was completed in June and therefore the provision of insurance to those recorded with no coverage (which currently exceed 2.5 million) started officially in June. Eligible to participate to this program are the uninsured Greek citizens, the legally residing Greek expatriates, the nationals of EU member states and national of third countries who legally and permanently reside in Greece. In order to receive free access, they should not fulfill conditions to issue a "booklet for uninsured" and they shouldn't be insured in any public or private fund. However, the fact that the beneficiaries have access to pharmaceutical care for acute and chronic disease, with the same terms, conditions, and charges for prescribed medicine as for insured patients may impose obstacles in accessing care (as mentioned earlier co-payments vary from 0% to 25% with the mean co-payment rate increased to 18% for 2013).

3.2 Health vouchers

The "Health Voucher" programme launched in September 2013 mainly funded by the National Strategic Reference Framework. It targeted people who had lost their insurance coverage (and were either directly or indirectly insured) and their dependent family members and allowed them access only to primary healthcare services (visits to contracted physicians, NHS facilities and services provided by contracted diagnostic centres).

The health vouchers were divided in two categories: a) General Voucher for people of all ages. It provided only for up to 3 visits to a doctor or a diagnostic center contracted with EOPYY. The program did not cover pharmaceutical treatment or inpatient care. b) Health Voucher for pregnant which provided up to 7 visits (with the prerequisite that the voucher was issued in the first three months) to a doctor or a diagnostic center contracted with EOPYY. Again, the voucher did not cover the cost for hospital care.

Health vouchers had duration for 4 months without a potential to be renewed. They intended to cover unemployed and uninsured that were actually more than two years uninsured, since OAED provided the right for the unemployed to extend their insurance status up to two years after they lost their jobs (see section 3.1). The specific criteria set made it available to people who were former insured in Social Security Funds which joined the EOPYY, with an individual income up to 12,000 euros (for singles) or family income up to 25,000 euros (for married) (<http://www.healthvoucher.gr>). The program was estimated to cover approximately 230.000 uninsured citizens for 2013-2014. However, no more than 23,000 health vouchers had been issued until

March 2014 and applications didn't exceed 85.000 (data provided by EOPYY). The small number of vouchers issued and the very limited scope raised serious doubts about its effectiveness.

3.3 The migrants

Migrants legally residing in the Greece enjoy the same rights as citizens in terms of access to the healthcare system (Cuadra, 2010). The requirement is however to have insurance, as they cannot claim the welfare benefit, nor the card which allows persons with low income free access to healthcare. Free (or subsidized) healthcare is strictly connected to affiliation to a social insurance. Only legal aliens, namely those holding a residence and employment permit, have a right to social insurance.

Until today, there hasn't been a formed policy in Greece regarding the access and use of health care services mainly due to a lack of sound data for the epidemiological profile of immigrants and the use of health services by them. According to a recent study regarding the access of migrants in health care services conducted in 2012 in Greece (Galanis et al., 2013), only 56.5% of participants had health insurance coverage, a proportion relatively small compared to the natives. Interestingly, over half of the participants in the study (62.3%) expressed unmet needs regarding health care services. The most important reasons according to the respondents were long waiting times in hospitals, difficulties in communication with health professionals, high cost of health care and system's complexity, findings also confirmed by other studies. In a more recent study contacted by the same authors in 2013, with a similar questionnaire and methodology, both the respective percentages have been increased since 67,4% of the participants reported no health insurance coverage (Kaitelidou et al., 2014).

The problem is even bigger for undocumented migrants who can only access public healthcare services in cases of emergency or if there is a risk to the patient's life. The most significant change during the crisis, which is also true for all other categories of uninsured patients, is that hospitals and other healthcare providers do not any more turn a blind eye, as they used to do often in the past, since they are obliged to follow strictly the rules for uninsured people, who are only eligible for treatment in cases of emergency. According to a new directive of 2014 from the ministry, asylum seekers, who otherwise have the same rights as Greek citizens, can receive treatment in hospital for free, provided that they can demonstrate to the management of the hospital that they are in a poor economic position.

The Directive of 2 May 2012 issued by the Minister of Health provides that treatment for undocumented migrants is provided by public services, public corporate bodies, local authorities and social security institutions only until the patient's health has been "stabilised". This provision poses a real problem because nothing in the law or other regulations defines clearly the concept of "stabilisation". Once again, the decision is left to the discretion of the medical professionals who in most of the cases do not stop treatment. Moreover, an effort that started in 2009-10 to introduce cultural intermediaries in hospitals has frozen, which makes the issues of language and culture an additional obstacle to access.

3.5 The Roma

According to a study of the National School of Public Health (2013) 77% of Roma people are completely uninsured. Also, 13% of their children don't have vaccination card, and 78% of them reported that they have not made any vaccines. It is noteworthy that an inadequate coverage with two doses of vaccine MMR was reported among Roma children (8.7%) since the respective percentages were 83% of the total population, 86% of children who do not belong to a specific group and 75% of children of immigrants.

Also, findings from a small scale survey conducted in 2011 assessing the use of health services by Roma people in rural districts in Greece (n=103), reported that the most frequent barriers, according to the respondents, concerning access to health services were high waiting time in hospitals, the attitude of health professionals and high cost of health care. The majority of the participants (61.1%) reported that they don't have the ability to cover the financial costs of health services. A significant proportion of the participants (45%) reported that during the last 12 months, needed at least one time to use health services but they cannot afford it. Also, 38.8% reported that during the last year they were in need for medication, but didn't receive any because of the high cost (70.8%) (Galanis et al., 2012).

The above mentioned studies indicate that Roma lack access to or do not use preventative healthcare and they face inequalities in accessing health services in Greece. This is linked to a lack of targeted information campaigns, limited access to quality healthcare and exposure to higher health risks. Roma experience ill health in part because they are much more likely to be poor. Data show that Roma have lower socio-economic status, and diseases such as TB, measles, and hepatitis disproportionately affect the lowest socioeconomic strata. Roma are also likely to be sicker than other poor people with the same income level. The few studies that have been conducted in EU countries assessing both health and poverty among the Roma confirm this assertion (European Centre for Disease Prevention and Control, 2013). Therefore, although there are no sufficient data and research documentation, it could be argued that economic crisis has negative effects on Roma health status not only due to restrictions in coverage and access to health services posed on the population of Greece as a whole but mainly due to deterioration of their living conditions.

3.6 The chronically ill patients

According to some preliminary results of a study conducted by the National School of Public Health (2014), regarding chronically ill patients approximately 60% reported facing significant economic limitations or extended waiting lists to their access to health services. According to the respondents, they have reduced by 30% the number of visits to primary care services during the period 2011 – 2013 and 20% have decreased the out of pocket health expenditures. Out of pocket expenditures for primary health services has been reduced by more than 50% during 2011 – 2013. As a result, visits of people with chronic diseases (especially diabetes) have increased to NGOs and other social clinics. According to Doctors of the World, visits by chronically ill patients to their polyclinics have increased by 23%, mainly in order to receive their medication, since with the increase in co-financing for medicines they are unable to afford them.

Cancer patients represent one of the most vulnerable groups as all changes described above are particularly striking in cancer care, with its lengthy and expensive treatments. Cancer patients are one of the most hit patient groups by the health care budget cuts and are facing serious problems during the economic crisis regarding waiting times and access to appropriate medicines (Apostolidis, 2013). During the last two years delays and discomfort have been reported by patient organizations in receiving their drugs. Until recently, uninsured cancer patients didn't have access to health care coverage (including pharmaceuticals) having thus significant problem in accessing their therapy. Extended waiting times in order to access the appropriate therapies were also reported by patient associations. According to unofficial sources, the waiting times for a cancer operation might be 6-8 months, and the waiting times for radiation therapy exceed two to three months. Data derived from the Greek Health Map showed that waiting times for a visit to outpatient oncological clinic have been increased from 2010 to 2012, however the data are limited and only for a sample of hospitals.

4. Efforts to increase the accessibility of health care services

Recently, (6/2/2014) the Greek Parliament passed a new legislation for primary health care. A National Primary Health Care Network (PEDY) is going to be established, coordinated by the Regional Health Authorities (DYPE). All primary health care facilities of EOPYY, rural health centers and their surgeries as well as the few urban health centers are going to be under the jurisdiction of DYPEs. The aim is these structures to function for 24 hours a day, seven days a week. In addition, the law provides for the establishment of a referral system based on family general practitioners. In the first article of the law it is stated that "primary health care services are provided to all citizens equally, independently of their economic, social and labor status, via a universal, integrated and decentralized network".

Furthermore, in June 2014 two joint ministerial decisions signed by the Ministers of Finance, Health, and Labor, Social Insurance and Welfare were issued, according to which all uninsured Greek citizens and legal residents of the country without social or private health insurance, not eligible for poverty booklets, or having lost their insurance right due to inability to pay their social insurance contributions, as well as their dependants, are covered for:

(a) Inpatient care, free of charge, at the expense of public hospital budgets, provided that they have received a referral from a doctor of the National Primary Healthcare Network or an outpatient department of a public hospital and the special three-member medical committee which will be set up in each hospital, certifying the patient's need for hospitalization.

(b) Pharmaceuticals, at the expense of the state budget, provided that they are prescribed by a doctor of the National Primary Healthcare Network or a doctor of a public hospital. However, beneficiaries are required to pay the same copayments that apply for the insured.

Although the above mentioned legislation is expected to have positive effects, four issues have to be considered. The first is that the establishment of a referral system based on family general practitioners has not yet been implemented. The second is the stigmatizing procedure of getting access to hospital services for the uninsured, given that a specific committee is in charge of certifying the patient's need for hospitalization, a procedure that is not applied to the insured population. Thirdly, the provision of the legislation for the uninsured to pay copayments may have negative effects to the needy of pharmaceuticals, given their difficult economic situation.

A last but not least issue is the fact that until now the Ministry of Health has not clarified to the public hospitals how to implement the ministerial decision about the hospitalization of the uninsured. As a consequence, the uninsured seeking for hospital services face serious unjustified administrative barriers to access of health care due to their differentiated treatment by different public hospitals.²

The role of NGOs and other health and social networks should also be mentioned. In Greece there are few NGOs (up to seven), active in providing health services to migrants, uninsured and other vulnerable groups, which have developed more than twelve clinics and diagnostic centers, in Athens and other cities of the country. In these clinics and centers, patients mainly receive primary healthcare, provided by all the basic medical specialties (GPs, pediatricians, gynecologists), prevention medicine (diagnostic tests) and mental health services.

With the demand increasing and the public health system deteriorating, NGOs (through their community clinics and pharmacies) and other unofficial networks of health professionals and volunteers which were set up to help poor and uninsured patients, contribute significantly to retain access of poor and unemployed to a basic set of medical services. A network of around 40 community clinics operates across Greece providing mostly primary health services and medications free of charge to people not able or not eligible to use the public services. The Metropolitan Community Clinic at Helliniko is an illustrative example, having offered services to more than 20.000 people since December 2011 when it was established in a volunteer basis as a response to a society operating in austerity and difficulty.

According to the report of the Social Mission Infirmary (2014), which operates since February 2012, a major problem was that 10% of the patients needed to receive systematic continuous care or at least be hospitalized, but this was not possible unless their situation could be classified as an emergency. Thus, 86% of people visiting the Social Mission Infirmary lost their social insurance during the years 2010, 2011 and 2012. The organization has created a network of support with a number of hospitals, which could provide care to 2-3 cases each month.

However, since the number of uninsured and unemployed is constantly increasing such initiatives should be under the umbrella of National Health System and Ministry of Health should implement a coordinated policy. The establishment of mechanisms to ease the access of vulnerable groups to the Public Health System is an imperative need and the last law amendments are definitely towards the right direction. Yet, it is important that equal access should be re-established along with the provision of integrated, qualitative and undifferentiated care.

Notes

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2. According to a newspaper article, a journalist contacted 7 public hospitals, pretending the uninsured and asking information about the necessary supporting documents and the procedure in order to be hospitalized free of charge. The answers he received were far from identical (Ta Nea, Friday 10/10/2014).

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