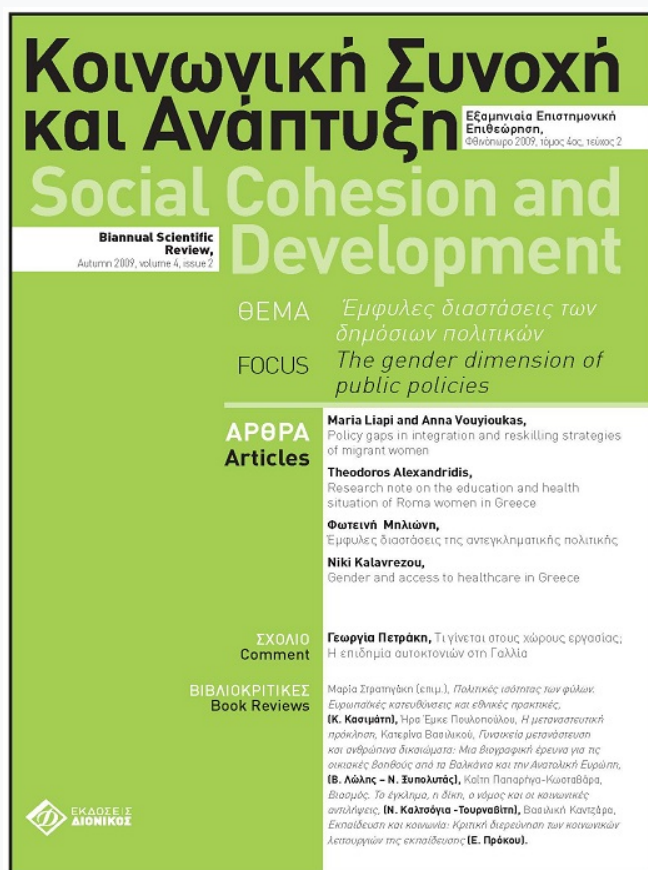


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Gender and access to healthcare in Greece

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Gender and access to healthcare in Greece

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Φύλο και πρόσβαση στις υπηρεσίες υγείας στην Ελλάδα

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ABSTRACT

Access to the healthcare sector can be mediated by a significant number of socioeconomic factors, giving rise to inequalities among different social groups. Gender consists one of the above-mentioned socioeconomic factors, with women generally considered to be in less advantaged position than men regarding this particular issue. In this article we examine the financial, cultural and geographical inequalities in access to healthcare between men and women in Greece. We argue that the significant problems faced by the National Health System in Greece are reflected, among other things, in the intense presence of gender-related inequalities in access to healthcare. The problem is further intensified by the absence of administrative provisions and of a comprehensive policy of dealing with this particular issue.

KEYWORDS: Access to healthcare, gender, socioeconomic inequalities, health policy, Greece

ΠΕΡΙΛΗΨΗ

Η πρόσβαση στις υπηρεσίες υγείας είναι δυνατόν να διαμεσολαβηθεί από έναν σημαντικό αριθμό από κοινωνικοοικονομικούς παράγοντες, δημιουργώντας ανισότητες ανάμεσα σε διαφορετικές κοινωνικές ομάδες. Το φύλο αποτελεί έναν από τους προαναφερθέντες παράγοντες, με τις γυναίκες να θεωρείται γενικά πως βρίσκονται σε δυσμενέστερη θέση από τους άνδρες αναφορικά με το ζήτημα αυτό. Στο εν λόγω άρθρο εξετάζονται οι οικονομικές, πολιτισμικές και γεωγραφικές ανισότητες στην πρόσβαση στις υπηρεσίες υγείας ανάμεσα σε άνδρες και γυναίκες στην Ελλάδα. Διαπιστώνεται πως τα σημαντικότερα προβλήματα που αντιμετωπίζει το Εθνικό Σύστημα Υγείας στην Ελλάδα, δεν θα μπορούσαν παρά να αντικατοπτρίζονται, ανάμεσα στα υπόλοιπα, και στην έντονη παρουσία ανισοτήτων πρόσβασης στις υπηρεσίες υγείας με βάση το φύλο. Το πρόβλημα επιτείνεται με την απουσία συνεκτικής πολιτικής αντιμετώπισης και διοικητικών προβλέψεων για το ζήτημα αυτό.

ΛΕΞΕΙΣ-ΚΛΕΙΔΙΑ: Πρόσβαση σε υπηρεσίες υγείας, φύλο, κοινωνικοοικονομικές ανισότητες, πολιτική υγείας, Ελλάδα

1. Introduction

The National Healthcare System of Greece (ESY), which was founded in 1983, is set up to provide healthcare services to the entire Greek population, irrespective of socioeconomic characteristics.

The aim of this paper is to explore the presence of inequalities in access to healthcare (and long-term care) in Greece between women and men. The paper begins with a brief presentation of the main mechanism which produces inequalities in health according to socioeconomic status, with gender being a part of the latter. It proceeds with the presentation of epidemiological data

(which provide a concrete picture of the health status of the Greek population and reveal the different health needs according to gender), as well as of existing service provisions in order to address this particular issue. The last part of the paper is focused on the impact of financial, cultural and geographical inequalities according to gender.

2. The causes of socioeconomic inequalities in health and the role of gender

Exploring the causes of socioeconomic inequalities in health is a matter of great importance. This holds in the theoretical but also in the practical level, as only by understanding the underlying mechanism that produces these inequalities, is it possible to tackle them.

In a purely methodological language, if inequalities in health are the dependent variable, the independent one is an ensemble of factors known by the term “socioeconomic status” (“SES”), which includes income, level of education, profession, nationality, gender, etc. The “rule” is that when a person’s socioeconomic status is reduced, so is this person’s performance in health (“social gradient” = socioeconomic position ↓ → morbidity, mortality ↑) (Braveman, 2004).

Therefore, the factors connected to socioeconomic status are considered to be the “root causes” of inequalities in health and have a direct impact on health (for example being employed in a dangerous profession causing stress and providing a small income is enough to put a person in a disadvantaged position concerning his or her health status *and* his or her possibilities to access health services¹). Nevertheless, low socioeconomic status can have an indirect impact on health through the adoption of harmful habits or of a certain unhealthy lifestyle (low SES → behaviour/ way of life/ environment → health problems) (Whitehead & Dahlgren, 2007).

Even though income and educational level are most commonly identified in the literature as the more important factors leading to diverging outcomes in health, gender is also believed to account for such outcomes. The WHO has acknowledged this very fact, stating that “*The distinct roles and behaviors of men and women in a given culture, dictated by that culture’s gender norms and values, give rise to gender differences.... Gender norms and values, however, also give rise to gender inequalities... Both gender differences and gender inequalities can give rise to inequities between men and women in health status and access to health care*”². The way that gender may have an impact on access to healthcare will be elaborated throughout the paper, while trying to illuminate the relationship of the two in the case of Greece.

3. Epidemiology and existing provisions

The health status of men and women in Greece: some epidemiological data

According to data provided by Eurostat, the total population of Greece amounted to 11,192,763 people in 2007³. Among them, 5,542,971 people were male and 5,649,792 female. The reduction of infant mortality, as well as the reduction of mortality at all age groups, have contributed to a rise of life expectancy in Greece in the past decades (Tountas et al, 2007). According to Eurostat, life expectancy at birth was at 81.8 years for Greek women and at 77.2 years for men. A closer look at these statistics shows that life expectancy for Greek men is significantly above EU-15 average (75.4), but the same cannot be stated for the life expectancy of Greek women, which rank just below EU-15 average (82.3). Equally important is the fact that, life expectancy in Greece seems to rise with a quicker pace for men than for women. It is quite

probable that this trend can explain the “life expectancy gap” between Greek men and women when compared to the EU average, but the deeper reasons for this trend are unclear.

As regards healthy life expectancy, both men and women in Greece enjoy relatively high rates compared to the EU-15 average. Greek men are expected to live 66.7 years of their life in health (EU-15 average for men is at 64.5 years), while Greek women are expected to be in good health for 68.4 years (EU-15 average for women is at 66 years). The data is less optimistic concerning mortality. Even though mortality rates are constantly falling in Greece, this is happening with a slower rate than in most other European countries. According to WHO data for the year 2004, Greece had the higher general mortality rate among EU-15 countries. In addition to the above, there seems to be a gender-related difference in Greek mortality rates, when compared to the average European ones. Just as in health life expectancy, men are above EU-15's average (784.05 deaths per 100.000 inhabitants for Greek men, while the EU average is at 890.22 deaths per 100.000 inhabitants), but the same does not apply for women (with 552.94 deaths per 100.000 inhabitants, while the EU-15 average is at 536.51 deaths per 100.000 inhabitants in the population). It is also significant to look at the main causes of mortality for both men and women in Greece. According to Eurostat, as concerns mortality rates due to ischaemic heart disease, Greek women fair much better (48.4 deaths per 100.000 inhabitants) in comparison to Greek men (207.3 deaths per 100.000 inhabitants). This is not solely a Greek characteristic, as the same trends are observed throughout Europe, with men being more vulnerable to this specific cause of mortality. Nevertheless, Greek men and women alike, find themselves in a fairly good rank when compared to their co-Europeans. The same applies to death due to cancer, with Greek men and women being considerably below EU-15 average mortality rates. The gender differences in mortality due to cancer, follow the same patterns in Greece as in other European countries, with women dying less often (110.9 deaths per 100.000) than men (207.3 deaths per 100.000). Nevertheless, in the age group between 30-44 years, an inversed image can be observed, with Greek women dying more frequently than men because of cancer. This occurs because breast cancer has a higher impact in this specific age group. In general, in all age groups, Greek men's mortality due to cancer is linked to neoplasms of the organs of the respiratory system (prostate cancer follows but with a rather big difference), while Greek women's mortality due to cancer is linked mainly to breast neoplasms (neoplasms of the organs of the respiratory system are the second cause) (according to OECD data). Suicide rates are rather low in Greece according to Eurostat: 5.1 per 100.000 inhabitants for men (while EU-15 average is at 14.5 suicides per 100.000 inhabitants) and 1.1 incidents for women (EU-15 average: 4.6 per 100.000 inhabitants). In spite of the low rates, Greek men are more likely to commit suicide than Greek women. Homicide rates for men are just above EU-15 average (1.3 per 100.000 inhabitants as opposed to 1.1 for EU-15), while for women they are just below EU-15 average (0.3 per 100.000 inhabitants as opposed to 0.5 for EU-15). Death due to all types of accidents is significantly above EU-15 average for men (43.2 per 100.000 inhabitants); women on the other hand, are below EU-15 average, with only 10.1 incidents per 100.000 inhabitants. This large difference in mortality rates between Greek men and women, regarding mortality rates due to accidents is believed to be associated with high mortality rates in Greece due to transport accidents. Even though both Greek men and women fair much worse than other Europeans in this domain, Greek men seem to be in a significantly disadvantaged position with 24.4 deaths per 100.000 persons. On the other hand, mortality rates due to chronic liver disease, alcohol abuse and drugs dependence in Greece are relatively low for both men and women according to the available Eurostat data.

Morbidity in Greece is linked to healthy life expectancy data as presented above, but there is also the matter of self perceived health, for which not much data is available. The data from a relevant research ("Hellas Health I") conducted on behalf of the Medical School of the University of Athens in 2006⁴, shows that 35% of the Greek population state they suffer from chronic diseases. These include: high blood pressure (16% of the population), high cholesterol levels (9,1%), osteoarthritis (6,1%), diabetes type II (6%), anxiety-related diseases (4%) and heart failure (3,1%). An important finding of this study is that Greek women state they suffer from a chronic disease more frequently (39,6%) than Greek men (30,7%). With the exception of heart disease, in all other cases women in Greece seem to be (or believe they are) in a worse health condition than men, with the percentages being remarkably high in relation to osteoarthritis and health problems linked to anxiety. As far as behavioural factors leading to mortality and morbidity are concerned, the above-mentioned study is quite revealing. Greek men surpass Greek women relatively to smoking habits (49.9% of adult men in Greece are smokers, as opposed to 30.8% of adult women), but women are more likely to be obese (18,3% with BMI>30) and less likely to follow the so-called "Mediterranean diet" and exercise. As for socioeconomic conditions (such as housing and environmental conditions) and their direct or indirect impact in the prevalence of certain gender-related differences in mortality and morbidity in Greece, there is a serious lack of relevant data.

Disability rates in Greece don't seem to be extremely divergent for men and women. According to Eurostat, in 2006, 90.1% of Greek males and 89.4% of Greek females lived without any form of physical or mental disability. The higher general percentage of Greek women with a disability, is mainly because of their higher rates in less severe forms of disability, while men are slightly more likely than women to suffer from severe disabilities. This could be attributed to the higher physical risks men face at work (which are also reflected at the higher prevalence of serious accidents at work for men in Greece) or at their generally riskier behaviour (which is also reflected at higher mortality rates for men in all types of accidents).

Last but not least, according to a recent study, domestic violence issues are not predominant in Greece, as there are few women reporting such incidents. Nevertheless, there is evidence that Greek women do face some forms of violence, that they do not however recognize as violent behavior. More specifically, 56% of the sample are subjected to abusive behavior that is linked to verbal and/or psychological violence, whereas, 3.6% of the sample state they face violence in its severe, physical form and 3.5% have to deal with sexual violence (Zoulinaki et al, 2005).

Service provisions in health promotion, prevention and treatment.

General health promotion strategies in Greece, as presented by the Ministry of Health and Social Solidarity, do not seem to have a gender-oriented character. There are numerous campaigns, advertisements and TV spots, as well as information provided through the Ministry's website, but none of them seem to be targeted specifically at women or men.

This gap is somewhat filled by NGOs, associations and various initiatives, even from the private sector, focusing on health promotion for women, but these interventions are fragmented or focused on specific health problems of women. Therefore, they do not correspond to the health promotion definition given by WHO (that applies to a variety of risk factors, diseases and in various settings). Given the serious problems that characterize the health sector in Greece, health promotion does not differ, and further action should be taken from the Greek state in order to address this matter more decisively.

The situation is very similar concerning health prevention strategies targeted specifically at women. Even though screening programmes are considered to play a major role in prevention and early detection of health problems, there doesn't seem to be a concrete national screening strategy in Greece dealing with women's (or men's) specific health issues.

It would be inaccurate to state that health prevention is not one of the general goals of the national health strategy from time to time. There are a number of campaigns trying to raise awareness concerning specific health issues. Nevertheless, this does not apply to every case of disease that may arise in the course of one's lifetime, nor is a gender perspective easily detected. Moreover, besides public awareness, screening strategies play a decisive role in health prevention and, consequently, a lack of such a strategy, could seriously compromise the efficiency of the whole system.

As far as women's health problems are concerned, the example of breast cancer is the most characteristic. It cannot be easily understood why a national screening strategy does not exist, especially since the statistics show that there is no reduction in the number of breast cancer incidents in Greece over time. This important gap is filled by associations, such as the "Greek Association of Women with Breast Cancer", or the Municipality of Athens (that offers free mammographies to women residing in Athens) but such actions have only a limited impact, as they are localised and do not apply to the whole of the country's territory. Furthermore, since timely diagnosis is so important to the treatment of the disease, the role of the doctors in preventing it, through the recommendation of tests, is crucial. Nevertheless, studies have shown that doctors do not always recommend the relevant screening tests, even if patients fall in the age group which deems them necessary (Trigoni et al, 2008).

Another example in the field of prevention and its role for women is the recent campaign of the Ministry of Health against depression. Even though this campaign is, beyond doubt, an important step towards the prevention of this disease (which mainly affects women in Greece), nevertheless there is no specific targeting at women (in fact the campaign's "motto" is "depression concerns everyone"), although there are specific forms of depression which affect women, like post-natal (or post-partum) depression. As far as this particular type of depression is concerned, we can once more put forward the example of an association (funded by the Ministry of Health) which offers significant help in the field of its prevention.

The question of general treatment provisions for women's health issues in Greece is very difficult to address due to a very specific reason: because the organisation of the "ESY" on the basis of a vast number of health funds (the extreme "Bismarckian" side of the mixed model existing in Greece) would need in-depth research in every single fund, in order to realise which provisions have been made in each case. Given the fact that such a study has not yet been made and that the relevant information is not easily accessible, it would probably be enough to stress that the problem of the multitude of "rights" and provisions that exists in the greater sector of health services in Greece, is also evident in the provisions for general treatment for women's health problems. This of course raises the degree of inequality between groups of women insured in different funds in Greece. Therefore, to the extent that there are no identical provisions for general treatment for the entire female population in Greece, the task of identifying the various coverage patterns existing in each fund is a very arduous one. But even when some provisions are identical for every single (insured) woman in Greece (such as the coverage for reproductive care) it is not at all certain that Greek women are bound to use them, and will instead turn to the private sector with the case of childbirth being a very characteristic one). Another very important

factor concerning childbirth is that, in Greece caesarean sections (cs) are much more frequent (52%) than in other European countries (due to motives such as convenience and financial gains of Greek doctors) (Mossialos et al, 2005). Furthermore, in cases such as this one (in which the private sector becomes dominant), considerations of financial equity come forward. These matters are addressed in the next section.

4. Gender and various forms of inequalities of access to healthcare

Gender and financial inequalities in health

The Greek National Health System (ESY), was created almost three decades ago, with the aim of insuring the entire Greek population thus contributing, to the achievement of the goal of equity in health and health care. Even though the expectations from the ESY were very high at the time of its creation it gradually became clear that it could not respond adequately to these expectations, neither in terms of efficiency, nor in terms of equity.

One of the basic characteristics of the Greek national health system is the co-existence of numerous health funds (reflecting its “Bismarckian” side) alongside the coverage of the entire population by a public health system (its “Beveridgean” side), which is often referred to as the “Greek Paradox”. The significant fragmentation of the system (due to this pluralism of health funds in Greece) is believed to negatively affect the performance of the NHS in terms of equity. But it is not the sole factor. Greece is considered to have the most “privatised” health sector in Europe, with private expenditure for health being at remarkably high levels. Furthermore, the majority of the private spending for health is consisted of “out-of-pocket payments” (direct payments, as well as “unofficial” or “under the table” payments), whereas private health insurance is not at significant levels in Greece (Liaropoulos & Tragakis, 1998). High private health expenditure is believed to be directly linked to increased levels of dissatisfaction from the NHS (Venieris & Papatheodorou, 2003). The above mentioned facts show that access to health care is achieved irrespective of need but mainly on the basis of income. It has also been observed that there are very significant differences in the occurrence of preventive tests between members of different health funds (Tountas et al, 2007). Nevertheless, other studies have showed that it is “need” that plays an important role in health services’ utilisation in Greece, with people reporting bad health being the ones using health services more often (Pappa & Niakas, 2006).

Generally speaking, there have not been many studies addressing the income-related health inequalities in Greece and the same applies to gender-related health inequalities. Surely, the fact that the whole of the Greek population is eligible to health insurance coverage is an important factor. On the other hand, the problems described above demonstrate that it is not sufficient to look at the eligibility criteria. The fact that private spending for health is “thriving” in Greece, combined with the high levels of dissatisfaction from the ESY, leads to the conclusion that disposable income (lack thereof) can indeed play an important role to good quality health services utilisation in Greece. This conclusion is in line with a study conducted recently, showing that there are income-related inequalities in the utilisation of 16 basic health services and preventive tests in Greece (Mergoupis, 2003). With the exception of hearing and osteoporosis tests, the utilisation of the rest of the services has been found to be income-dependent, with people with lower income being the ones using these services more rarely. What is quite alarming

is the fact that this study concerns very basic services and tests like cholesterol or diabetes tests. It also includes basic tests affecting the health of women such as breast examination, breast screening (mammography) and Pap test. The study shows that these tests also have a high income elasticity. One of the more concerning findings of the study is that the income elasticity of all 16 services is by 50% higher for women compared to the rest of the population. This demonstrates that gender-related income inequalities in health are more severe than the rest of the income inequalities in health.

Even though the above mentioned facts demonstrate the need to tackle these inequalities, we could not find any good practices in provisions to overcome financial barriers for women (or men). The fact that these inequalities in utilisation of health services result in inequalities in the health status later on in life makes the adoption of relevant measures an urgent matter.

Gender and cultural inequalities in health

Differences in cultural characteristics, such as religion or language, are believed to affect the actual possibilities of access to health services (Whitehead & Dahlgren, 2007). Not many studies can be found in Greece to address such matters and that could be contributed to the fact that the Greek population is considered to be more or less homogenous (there are for example no dialects nor many different religions in Greece). Nevertheless, there are some groups of Greek citizens (such as the Roma) which face general problems of exclusion in the Greek society, which could also easily translate into inequalities in the access of health services. Furthermore, the fact that Greece has become, in recent years, a country of reception of a large number of immigrants (both legal and illegal), raises significantly the heterogeneity of the population residing in Greece, as well as the overall needs of the population for health care services.

Generally speaking, no evidence exists as far as the existence of cultural differences between men and women in Greece and their impact on health-care utilisation are concerned. In addition to this, there is evidence that women in Athens tend to use primary health services more often than men and relatively to their self-perceived needs (Pappa & Niakas, 2006). However, the same may not apply to other regions in Greece where cultural differences may be more apparent. Further research is required in this field.

As far as the use of health services by immigrants is concerned, relative research is also underdeveloped. According to a study effected among the personnel of Greek hospitals, there seems to be the feeling that the existing institutional set-up does not correspond to the special needs of immigrants⁵. What is more, most members of the personnel seem to believe that minorities are ill-informed as far as their rights are concerned. On the other hand, according to another study, the personnel in Greek hospitals state that many problems arise due to the fact that cultural differences often lead to different demands and because language differences cannot easily be surpassed or be helpful in incidents that have a more urgent character (especially when illegal or uninsured immigrants are concerned). From a gender perspective, female immigrants are more likely to use the public health services in Greece than male immigrants. The majority of them is at reproductive age and, therefore, augmented use is relevant to pregnancy and obstetrical issues⁶. It is very interesting that the majority (80%) of beds in obstetrical hospitals in 2000 were occupied by foreign women (Kaitelidou, 2003). More in-depth research is required in order to understand the cultural differences of various groups of immigrants according to gender, but in general, it is believed that the Greek National Health System (ESY) has not yet done its best in addressing the needs of minorities, irrespective of gender issues.

Gender and geographical inequalities in health

Inequalities in health can have a geographical dimension, as the lack of health services in some rural or remote regions can result in different health outcomes (Whitehead & Dahlgren, 2007)

The Greek National Health System, consisting of numerous hospitals and health centres across the country, covers the majority of the Greek regions. Nevertheless, significant disparities between regions exist as far as the offered health services are concerned. For example, Attica (the periphery of the capital) has a large number of doctors and hospital beds per 100.000 inhabitants, whereas the neighbouring prefectures of the Sterea Ellada region have an importantly lower number of both doctors and hospital beds. Thrace (the region with the largest mortality rates and lower GDP in Greece) is in a better position than Sterea Ellada, but in a worse than Attica (Tountas et al, 2007). In general disparities in existing health services between regions can easily be observed.

Not much evidence exists concerning the geographical dimension of gender relevant services in Greece. The only data available by the National Statistical Service ("ESYE") concern the number of specialised obstetrical- gynaecological hospitals in each region. The regions with the largest numbers of such hospitals are Makedonia (9), Thessalia (7) and Peloponnissos (6). In Athens there are 3, whereas in Crete there is only one and in the Ionian Islands none. Another important factor is that, as far as childbirth is concerned, the vast majority of Greek women prefer private clinics as there is a sense of mistrust towards public hospitals concerning the specific service. Therefore, even where there are public obstetrical hospitals, it is uncertain that women are likely to use them.

Distance and transportation problems have been reported in a study concerning mammography screening in rural Crete (Trigoni et al, 2008). Distance from the screening site and transportation problems have been reported as reasons for non-use and it is quite likely that the same may apply to other rural regions of Greece, concerning not only mammography but also other health services targeted at women. Nevertheless, more research is required in order to be able to draw more specific conclusions.

Gender and inequalities in long-term care

According to the country's latest National Strategy for Social Protection and Social Inclusion, there has been an attempt to move from traditional services of social protection to more modern ones. Moreover, it is being attempted to create new services targeted at new, vulnerable groups in need of social protection and social inclusion. As far as long-term care is concerned, new interventions:

- The creation of a National Network of Centres of Social Support of Persons with Special Needs.
- The creation of 12 new centres of care for disabled persons.
- The Creation of a National Centre of Immediate Social Help.

In addition to the above mentioned actions, the following ongoing interventions exist:

- The development of the Initiative "Help at Home", including 1200 programmes across the country
- The strengthening of social inclusion for vulnerable groups via the development of the "Network of Social Supporting Services" that is being implemented in 130 municipalities across the country
- The development of Day Care Centres for Aged Persons by Municipal Enterprises and NGO's.

Nevertheless, no programme or action could be found in the National Report targeted especially at women as far as long-term care is concerned. In addition to this, specific data concerning the gender-related aspect of long-term care issues are not provided.

Relevant long-term care information was retrieved from a recent national survey, dealing with the issue of persons looking after elderly persons in Greece (Triantafyllou et al, 2006). This survey is very helpful due to the fact that gender issues are addressed. One very interesting element is that the majority of elderly persons receiving help are women (64.5%) residing with the person or persons providing the help (50.7%). Furthermore, only 1.3% of these persons reside in an institution, which means that, in Greece, it is mainly the family that provides help to older people, and especially women: 80.9% of the providers of help were female. Also, the majority of help providers are middle-aged (51.7 years on average) with a medium or lower educational level, while the relationship between the care provider and the care receiver is mainly a child-parent relationship. As far as the possibility of transportation of the older person to an institution is concerned, 81% of the care providers responded that they would not consider it in any case (even if the health status of the person in need deteriorated), which could indicate either that family ties are strong in Greece, or that there is not enough trust in the relevant institutions in Greece (which are mainly private). It could also indicate that Greek families do not have the economic capacity of engaging in such an obligation.

The above evidence can lead to the conclusion that the present situation consists a serious burden on (mainly female) care providers, with serious implications for their professional and personal life, even though the majority (96.8) of them state that they engage in this kind of activity mainly due to sentimental reasons⁷. These matters surrounding the issue of long-term care for the elderly should be addressed with a sense of serious commitment by the Greek state, in order for gender-equality issues to be confronted, especially in an age where the active participation of both sexes to the workforce is being promoted as a priority, both nationally and at the EU level. The framework for long-term care exists (even if it does not yield the best possible results) but it should be further developed and further research should be attempted in order to address, among other things, gender-related inequalities on this matter, as well as issues such as the barriers to accessing long-term care services by both men and women.

In order to address the issue of efficacy in the delivery of long-term care services in Greece (and subsequently their equity perspective), it is important to look at the actual capacities of the elderly to access health services.

According to a recent study, the elderly Greeks pay 7.5% of their annual income for health services (Lambrelli & O'Donnell, 2008). The consequence of this high expenditure for health care is of course that the elderly have to compromise their consumption of other goods and, more importantly, it involves private expenditure on health, with significantly negative implications in terms of equity or financial access in health services for the elderly. Furthermore, Greece has a very high proportion of elderly with destructive private expenditure for health services (that is with private payments that surpass 15% and 25% of their total income). It is important to note, that this kind of private expenditure does not consist of co-payments for public health services provided by the NHS, as these are negligible. On the contrary, they consist of co-payments for medicines, private care and informal ("under the table") payments in the public sector. Another important factor is that destructive payments for health care concern mainly persons with lower income. The above mentioned evidence reveals that financial barriers exist in the domain of long-term care in Greece. This general conclusion, combined with the fact that income elasticity in the use of health services seems to be double for Greek women than

for Greek men (Mergoupis, 2003), can have serious gender-related implications. As for fund-financed health services, in the area of Attica, there seems to be a positive relationship between female gender/old age and health services utilization (Pappa & Niakas, 2006). However, the fact remains that this particular study does not refer to private health expenditure (which amounts for about half of total health expenditure in Greece) and is focused solely in the area of the Greek capital, so further research would be welcome.

In relation to the long-term care services provided by the public sector, institutionally there are no discriminations or access limitations, as long as they are offered to anyone residing legally in the country (according to the latest National Strategy for Social Protection and Social Inclusion). In practice however, there are deviations from this model, since in general there is a concentration of the institutions providing these services in the urban centres and shortages in rural areas. A very characteristic example is the one of the programme "Help at Home" which is not provided in every municipality in Greece. This means that geographical disparities in the provision of long-term care are evident and compromise the efficiency of a series of actions and provisions.

Another important issue is the one concerning the information provided to the persons who could benefit from long-term care provisions, whether they are care-providers or care-receivers. In general, there seems to be a lack of awareness concerning the existence of the relevant services by the people having the right to make use of them. There have also been reported bureaucratic hindrances by persons providing long-term care for elderly people when turning to public services. NGO's have also reported that there are vast areas in which they could take action, which could also imply that the existing public framework is inadequate.

The gender-related issues of access to long-term care are not easily identified in national reports or relevant studies. Also, it is difficult to find specific long-term care programmes targeted at women. The only conclusion that could be drawn from the facts presented above is that any long-term care provisions and services available, are helpful to women, as they alleviate their burden as care-takers, especially for members of their own family. They could also facilitate their participation in the professional and social sphere, contributing thus, to other gender-related equity goals. In addition to that, facilitating financial access of the elderly to health care (there may be complete coverage of the Greek population by the NHS, but quality issues of the services provided remain), as well as limiting geographic disparities in long-term care could prove to be crucial for the amelioration of long-term care provision for both men and women in Greece.

5. Conclusions

Differences in the health status of women and men exist in Greece and are analysed in the first chapter of the present report. An important finding of this paper is that, even though these differences exist (and reflect different healthcare needs of women and men), there are no adequate provisions in order to address this matter decisively in Greece, as far as health promotion, prevention and treatment is concerned.

The national healthcare system of Greece (ESY), which was founded in 1983, is set up to provide healthcare services to the entire Greek population, irrespective of socioeconomic characteristics. The universal (Beveridgean) character of the Greek system has often been

considered as a very important social conquest by the Greek people, but at the same time problems of satisfaction from the quality of the public services arise. Problems of financing are also often put forward, as there are two main deficiencies in this domain. The first consists of the existence of numerous health funds (which compromises the Beveridgean character of the Greek system, and makes it more Bismarckian) with also numerous provisions for different groups of insured citizens (thus giving rise to the existence of inequalities). The second deficiency involves the remarkably high level of private expenditure for healthcare in Greece, which reflects the dissatisfaction from the national healthcare system (and which also gives rise to inequalities, especially when financial access is considered).

Due to these special characteristics of the Greek national healthcare system, important inequality problems arise. The same conclusion applies regarding long-term care, as the financial and territorial dimension of access issues concern older people in Greece too, and women especially.

As far as gender issues go, even though there are different needs of women and men in the health sector, there are few health policies that are addressed especially to women, and those that exist, are either fragmented, promoted by NGO's or there is a territorial aspect to them. Furthermore, the matter of health inequalities in Greece does not consist a political priority, nor is much scientific importance given to it, mainly due to lack of relevant data.

Notes

1. Unequal access can take three distinct forms : geographical, economic and cultural (often referred to as "institutional racism").
2. <http://www.who.int/gender/genderandhealth/en/index.html>.
3. Just a decade before (in 1997) Greece's population was at 10,744,649 people, a fact that cannot be attributed to the fertility rates in Greece (which are rather low in comparison to EU's average) but to the significant arrival of immigrants (mainly illegal) since the early nineties.
4. Institute of Social and Preventive Medicine (2006), *Hellas Health* 1.
5. Institute of Urban Environment, Panteion University, *Report on the Problems Faced by the Public Administration while Being of Service to Immigrants*, Athens, October 2003.
6. National Centre for Social Studies (EKKKE), *Migration and Health*, Assessment of the Actual Situation, Athens, 2005.
7. Other reasons include a sense of duty (89.3%) and a sense of obligation (91.4%).

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