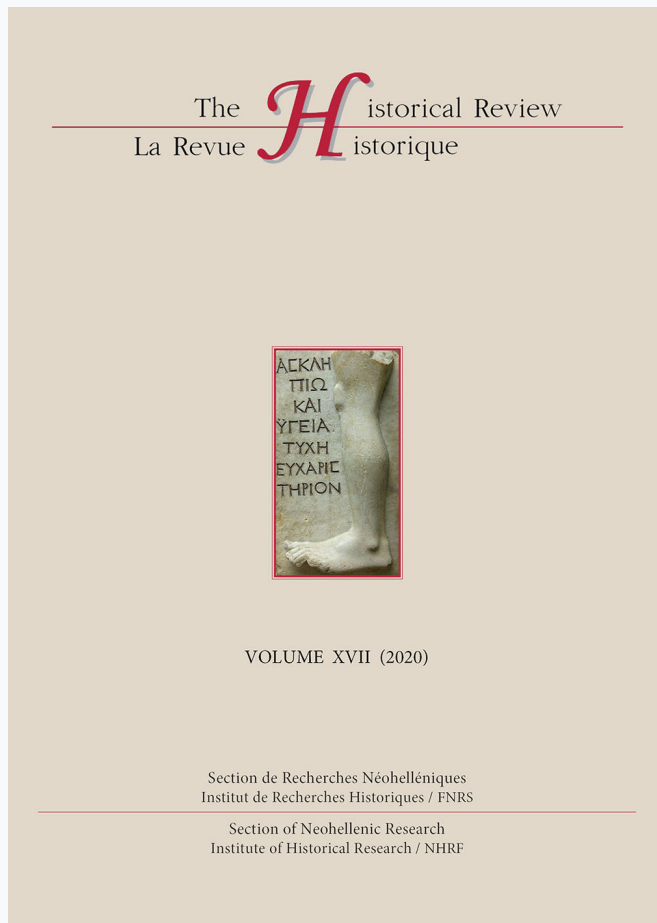


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THE TRIALS AND TRIBULATIONS OF THE NATIONAL HEALTH SYSTEM (ESY) IN GREECE: A CHRONICLE OF UNFULFILLED PROMISES

Anastas Philalithis

ABSTRACT: The creation of the National Health System (ESY) in the 1980s is a major landmark in the development of the welfare state in Greece during the *metapolitefsi* (regime change) period. An ambitious effort to reform the fragmented, ineffective health services of the post-World War II period, it achieved a major reorganisation of public hospitals and the establishment of rural health centres providing primary health care. Yet its promise of high-quality services for all was not fulfilled, since vested interests blocked its full implementation. While the fiscal crisis of the 2010s was the catalyst for the unification of the health insurance funds, the creation of integrated primary health care in towns failed once again. This article examines the achievements and failures of the reform in light of the political and social factors that shaped this era.

The creation of the National Health System (Ethniko Systema Ygeias,¹ ESY) in the 1980s is often hailed as one of the most important steps in establishing a welfare state in Greece. It has also been the object of severe criticism, with accusations that it is disorganised, dysfunctional, wasteful and ineffective. In order to seek the truth about these opposing viewpoints (and any others that fall in between), it is necessary to understand how the health services functioned before the ESY was created, how the political debate about the reform fashioned the decisions that were taken, how different stakeholders vied for influence and privileges, how it was implemented and how it evolved over the years. Further, the analysis must be framed within the political and social circumstances that prevailed at the time, since all health systems are both a reflection of a country's politics and a defining feature of its political system. This article aims to attempt this historical reckoning, trying to show that the development of the health reform in Greece was moulded by the interaction between the intentions and proclamations of politicians, the vested interests

* The author thanks Athanasios Athanasiadis, PhD, and Agalos Fotopoulos, MD, for their comments on an earlier draft of the paper. The author alone is responsible for the final text.

¹ Some characteristic terms will also be given in Greek, so that Greek-speaking readers can easily recognise them.

of professional groups, syndicates (*syntechnies*) and the private sector and the hopes and expectations of the public.

The Health Services after World War II

When Greece emerged from the ravages of the Nazi occupation and the strife of civil war, it embarked on a concerted reconstruction effort, assisted by funds from the Marshall Plan. Successive governments increased public investment in infrastructure projects, encouraged the private sector to expand and used the public sector to provide services as well as to support the networks of political patronage and clientelistic favours that dominated politics since the time of Greek independence. The country witnessed a period of strong economic growth, averaging 7 percent in the 1950s and 1960s,² even though the economy could not absorb all the available workforce, many of whom emigrated to Western Europe, mainly to Germany. Poverty rates dropped and living standards improved rapidly.

Health was a major component of the reconstruction effort. Studies were carried out by the international agencies on the health status, health-related habits and the health services of Greece.³ A campaign, led by the World Health Organization (WHO), with the participation of the Ministry of Health⁴ and the Athens School of Hygiene, was launched to eradicate malaria, an endemic disease that was a major cause of disability and mortality in Greece since ancient times (Lord Byron succumbed to it in 1825). The campaign, which ran from 1946 to 1960, relied on the extensive spraying of rural areas and houses with DDT, an insecticide that kills the larva of the anopheles mosquito, in conjunction with the epidemiological surveillance, detection and following up of cases and the draining of swamps and other areas of stagnant water. Although

² Nikolaos Karamouzis and Tasos Anastasatos, “Η ανάπτυξη της Ελληνικής οικονομίας: Πηγές, προοπτικές και ο ρόλος των επενδύσεων και των εξαγωγών,” *Οικονομία και Αγροές* 6, no. 3 (2011): 1–23.

³ Leland G. Allbough, *Crete: A Case Study of an Underdeveloped Area* (Princeton: Princeton University Press, 1953); Richard H. Blum and Eva Blum, *Health and Healing in Rural Greece* (Stanford: California University Press, 1965).

⁴ Since it was first established in 1917 as the Ministry of Medical Care (*perithalpseos*), the Ministry of Health has been renamed several times, sometimes because it was combined with different portfolios, for example, welfare or social security, sometimes for symbolic reasons only. For the sake of simplicity, we will refer to it as the Ministry of Health. See Ministry of Health, *100 χρόνια του Υπουργείου Υγείας* (Athens: Ministry of Health, 2017); Theodoros Dardavesis, “Η ιστορική πορεία του Υπουργείου Υγείας στην Ελλάδα (1833–1981),” *Ιατρικό Βήμα* (October–November 2008): 50–61.

DDT can still be detected in the soil of the sprayed areas, the campaign was rightly hailed as a spectacular success, with the last indigenous case of malaria being recorded in 1976.⁵

The eradication of malaria coincided with the introduction to medical practice of immunisation for many of the “childhood” diseases (measles, diphtheria, polio, etc.), leading to a rapid decrease in mortality from infectious diseases, which was further enhanced by the improved standard of living. This was the period of Greece’s epidemiologic transition: the phenomenon whereby the main causes of death in a population shift from infectious diseases to so-called chronic diseases (principally cardiovascular diseases and cancers). However, the Greeks continued for a long time to adhere to the traditional elements of their lifestyle: strong family ties and social networks, the Mediterranean diet⁶ and a substantial proportion of the population working in agriculture (including many of those living in rural areas who were officially registered as small shopkeepers or municipal workers). These elements were enhanced by a drastic reduction in illiteracy and a considerable improvement in housing conditions, even for poorer income groups, which was the consequence of *antiparochi*, a policy whereby a piece of urban land was exchanged for two or three apartments in an apartment building built by a construction company. The advantageous social determinants of health were reflected in high levels of life expectancy for the Greek population, exceeding those that would be expected from the overall level of the economy (and the inadequacies of the health services, as will be discussed below), a phenomenon that was later named the “Greek health paradox”⁷ (fig. 1, table 1).⁸

⁵ Leonard Jan Bruce-Chwatt and Julian de Zulueta, *The Rise and Fall of Malaria in Europe: A Historico-Epidemiological Study* (New York: Oxford University Press, 1980).

⁶ Ancel Keys, Alessandro Mienotti, Mariti J. Karvonen et al., “The Diet and 15-year Death Rate in the Seven Countries Study,” *American Journal of Epidemiology* 124, no. 6 (1986): 903–15; Antonia Trichopoulou, Tina Costacou, Christina Bamia and Dimitrios Trichopoulos, “Adherence to a Mediterranean Diet and Survival in a Greek Population,” *New England Journal of Medicine* 348, no. 26 (2003): 2599–608.

⁷ Anastas Philalithis, “If I Were Minister of Health: The Greek Health Paradox and the Health Policy Conundrum,” *Towards Unity for Health* 4 (2001): 13–15.

⁸ OECD Health Data, “OECD Health Statistics 2019: OECD,” [Oecd.org](https://www.oecd.org/health/health-data.htm), accessed 3 August 2019, <https://www.oecd.org/health/health-data.htm>; WHO HFA Database, “WHO European Health Information at Your Fingertips,” [Who.int](https://gateway.euro.who.int/en/datasets/european-health-for-all-database), 2019, accessed 3 August 2019, <https://gateway.euro.who.int/en/datasets/european-health-for-all-database>.

Table 1.
Selected mortality indicators, 1970–2015

Year	Greece	WHO_Euro	EU15	UK	France	Spain	Bulgaria
Age-standardised death rate (SDR), all causes, all ages, per 100,000 population							
1970	874.8	1029.7	1079.5	1099.2	970.5	1035.6	1089.7
1990	739.9	955.2	780.2	819.6	689.4	735.1	1138.3
2010	558.0	786.0	529.9	553.1	500.6	487.0	970.3
2015	536.9	718.3	507.3	539.6	456.7	462.1	914.6
Infectious and parasitic diseases, all ages, per 100,000 population (SDR)							
1970	22.9	13.3	15.3	7.3	14.8	23.5	18.5
1990	4.6	9.9	5.8	4.0	8.7	8.9	5.9
2010	5.4	12.5	8.8	6.1	9.6	8.9	6.6
2015	15.0	12.3	9.6	6.3	8.1	8.7	4.9
Diseases of circulatory system, all ages, per 100,000 population (SDR)							
1970	301.4	519.9	474.1	557.6	344	457.2	559.1
1990	370.8	466.2	326	363.1	205.6	287.6	691.4
2010	228.9	363.2	164.8	164.2	113.9	137.6	621.7
2015	188.3	314.9	145.6	134.7	97.2	122.4	564.6
Malignant neoplasms, all ages, per 100,000 population (SDR)							
1970	136.2	181.8	196.7	216.9	192.6	159.9	147.4
1990	158.9	188.3	199.9	220.2	201.2	175.9	152.4
2010	149.0	157.9	160.7	170.4	162.0	152.4	156.4
2015	153.0	151.3	152.1	162.0	152.7	141.6	163.4
Motor vehicle traffic accidents, all ages, per 100,000 population (SDR)							
1970	11.9	15.3	22.3	13.8	23.5	14.7	13.0
1990	20.9	17.3	14.2	9.1	16.8	19.3	15.5
2010	13.4	9.4	5.6	3.7	6.5	5.4	7.4
2015	7.9	8.4	3.8	2.4	4.3	3.7	5.9
Suicide and self-inflicted injury, all ages, per 100,000 population (SDR)							
1970	3.4	18.2	13.3	7.9	15.9	4.8	13.0
1990	3.2	15.4	12.2	7.8	19.0	7.1	14.1
2010	2.9	11.7	9.1	6.4	14.8	5.8	9.3
2015	4.2	10.5	8.8	7.2	12.1	6.4	7.8
Infant deaths per 1,000 live births							
1970	29.6	19.1	21.9	18.5	15.1	20.8	27.3

1990	9.7	15.2	7.6	7.9	7.3	7.6	14.8
2010	3.8	7.3	3.6	4.3	3.5	3.2	9.4
2015	4.1	6.9	3.3	3.9	3.3	2.7	7.7
Maternal deaths per 100,000 live births							
1970	28.3	31.1	34.8	18.0	28.2	33.1	44.7
1990	1.0	22.5	7.8	7.6	10.4	5.5	20.9
2010	5.2	10.3	5.1	5.0	8.5	4.1	8.0
2015	4.3	11.5	4.4	6.4	4.9	2.1	12.0

Note: Greece is compared to the EU average before 2004 (EU15), the members of the WHO Regional Office for Europe (WHO_Euro), France and the UK (as two large countries with a strong tradition in healthcare organisation) as well as Bulgaria (another Balkan country) and Spain (another Mediterranean country).

Source: WHO HFA Database, 2019.

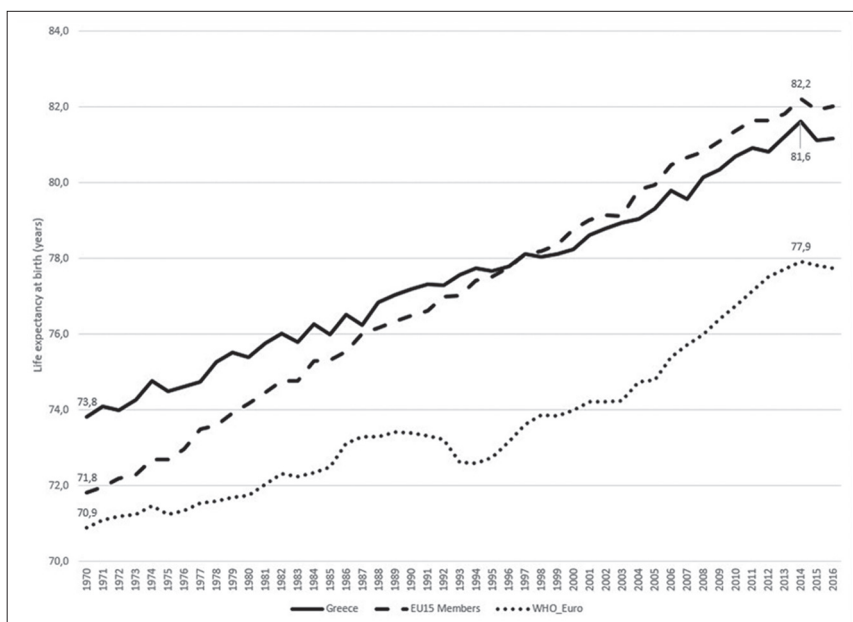


Figure 1. The loss of the Greek paradox: Life expectancy at birth (years) in Greece, the EU15 and members of WHO Euro (WHO HFA Database, 2019).

Note: In 1970, life expectancy in Greece was 73.8 years, two years more than the EU15, that is, the countries that were members of the EU before 2004. At its peak in 2014, life expectancy had improved to 81.6 years, but this was 0.6 years less than the EU15, because the rate of improvement was slower.

The measures to reorganise the health services and hospitals in particular constituted the second aspect of the reconstruction effort.⁹ In 1953, landmark legislation was enacted (Law 2592/1953) that included provisions for the regionalisation of health services, the reorganisation of public hospitals and their designation as legal entities of public law (NPDD), the creation of sanitary stations and rural health posts (*agrotika iatreia*) in rural areas.¹⁰ Although the regionalisation of health services was never implemented,¹¹ the significance of the provisions for hospitals is reflected in that, for the next 30 years, public hospitals were known as “Law 2592 hospitals”. Yet, this designation included hospitals of widely divergent standards: from a few large hospitals in Athens and Thessaloniki, including those which accommodated the university departments of the respective medical schools, to the understaffed, poorly equipped and malfunctioning hospitals of the regions. The hospital sector also included a number of large non-profit hospitals in the two main urban centres, designated as legal entities of private law (NPID), which were administered by charitable foundations, scientific societies or the trustees of the bequests of deceased donors. Most NPIDs had a good reputation, but all were dependent on government subsidies to cover their costs. Finally, a large number of small, mostly inefficient, privately owned, for-profit hospitals, known as *klinikes*, functioned in the two main urban centres and in the regions.¹²

Another aspect of the reconstruction effort was the reorganisation of the social security organisations, each with its associated health insurance fund (HIF), that, in accordance with the Bismarck model of social security, covered specific occupational or professional groups, some of which had been established as far back as the late nineteenth century, others in the 1930s. Thus, Law 1811/1951 reorganised the Civil Servants Health Fund, which was run as a service by the Ministry of Health and financed directly by the Ministry of Finance; Law 1846/1951 reorganised the Social Insurance Foundation (IKA),

⁹ Nikolaos Louros, *Η υγειονομική οργάνωση της χώρας: Ένα σχέδιο* (Athens: Papadoyannis, 1945).

¹⁰ Xenofon V. Peloponnisios, *Οργάνωσις και νομοθεσία της εν Ελλάδι νοσοκομειακής περιθάλψεως* (Athens: s.n., 1961).

¹¹ Athanasios Athanasiadis, Stella Kostopoulou and Anastas Philalithis, “Regional Decentralisation in the Greek Health Care System: Rhetoric and Reality,” *Global Journal of Health Science* 7, no. 6 (2015): 55–67.

¹² Anastas Philalithis, “Η κοινωνική αναγκαιότητα για σχεδιασμό των υπηρεσιών υγείας στην Ελλάδα,” *Ιατρικό Βήμα* 4 (1984): 65–68; Philalithis, “The Imperative for a National Health System in Greece in a Social and Historical Context,” in *Socialism in Greece*, ed. Zafiris Tzannatos (Aldershot: Gower, 1986), 145–68.

which is the largest in the country, covering all white- and blue-collar workers in the private sector; other laws reorganised existing or created new social security organisations and their associated HIFs, covering specific occupational groups, such as self-employed shopkeepers and tradesmen, workers in the large public utility companies, in banks, even in a single large hospital, as well as specific professional groups such as doctors, lawyers and engineers. The last group to be covered were the farmers, for whom insurance was provided by Law 4169/1961, which created the Agricultural Insurance Organisation (OGA).¹³ It is noteworthy that OGA was created by the government of the (right-wing) National Radical Union (ERE) in an effort to stem the rise of the (left-wing) United Democratic Left (EDA), which had won second place in the 1958 elections, becoming the main opposition party in parliament.¹⁴

The HIFs mainly followed the Bismarck model in the delivery of healthcare, especially of ambulatory, out-of-hospital care: all but two of the HIFs provided ambulatory care through contracted specialists who received the insured in their private premises and were paid on a fee-for-service basis, wholly or partly reimbursed by the patient's HIF. One exception was OGA, which will be described below, and another was IKA, which employed salaried specialists in its own premises, called *polyiatreia*, in the "morning shift", while the specialists had their own private practice in the "evening shift", where they often looked after the same patients whom they had seen in the morning. It is interesting that the *polyiatreia* were reminiscent of the Semashko model of healthcare that prevailed in the Soviet Union and the Eastern bloc after World War II, whereby ambulatory care was delivered by specialists working in health system premises called *poliklinika*. As regards hospital care, the HIFs reimbursed hospitals with a flat rate per diem that was considered sufficient to cover the cost of hospitalisation in the private *klinikes*, but fell short of the actual costs in the NPDD and NPID hospitals, the balance between real costs and fees paid by the HIFs being covered by government subsidies, as has been mentioned already. This mixture of financing differs from the strict Bismarck model, whereby there are no government subsidies, but the total cost of ambulatory and hospital care is covered by the money raised from the contributions of employers and employees or of the self-employed, as the case may be. Another point worth highlighting is that the benefits provided by different funds varied considerably, so much so that some HIFs, such as those covering employees

¹³ Christos Andricopoulos, "Farmers' Social Insurance in Greece," *International Social Security Review* 29, no. 1 (1976): 18–48.

¹⁴ Aris Sissouras, *Τα μετέωρα βήματα του ΕΣΥ: Τριάντα χρόνια Εθνικού Συστήματος Υγείας. Ανάλυση της υλοποίησης και μαθήματα πολιτικής υγείας* (Athens: Kastaniotis, 2012).

of banks or of public utility services, were popularly known as the “privileged” or “noble” funds.¹⁵

This system of occupation-based social security organisations lacked the tools to provide cover to people living in rural areas.¹⁶ In an effort to alleviate the problem, Law 3487/1955 reorganised the rural health posts, and, as an incentive to physicians to staff these posts, Greece became one of the first countries in the world to recognise general practice (GP) as a speciality (Decree 3366/1955). This had no effect since, by the 1980s, fewer than ten physicians had taken up the speciality. Nor did the creation of OGA provide a solution to the problem, since the staffing of the rural health posts remained the responsibility of the Ministry of Health. The solution enforced by the colonels’ junta¹⁷ was to impose one year’s obligatory service in rural areas on all new medical graduates (Law 67/1968), handing responsibility for all the acute and chronic health problems of the rural population to young inexperienced physicians, who performed their duties grudgingly.

It is evident that during most of the 1950s and until the fall of the junta in 1974, health policy was limited to the day-to-day management of current affairs, without any substantial, concerted measures to develop the health services provided by the public sector. Total health expenditure on health was less than 4 percent of GDP for the whole of this period, a sum well below that of most Western European countries, where it ranged from 5 to 6 percent of GDP. In addition, private, out-of-pocket expenditure on health was, at about 55 percent of total expenditure, one of the highest rates in Europe along with Switzerland (table 2). The balance was split almost equally between funding from taxation and funding from social security contributions. All physicians, irrespective of whether they worked for social security, in public hospitals, in university departments or in the military, had the right to out-of-hours private practice. Some were, at the same time, heads of a unit in a public hospital and partners in a private *kliniki*.¹⁸ The multiple conflicts of interest that dominated the health

¹⁵ Yannis Tountas, *Υπηρεσίες Υγείας* (Athens: Odysseas, 2008).

¹⁶ Christos Zilidis, *Αξιολόγηση των πρωτοβάθμιων υπηρεσιών υγείας του αγροτικού πληθυσμού* (Athens: Agricultural Bank of Greece, 1989).

¹⁷ The colonels’ junta seized power in April 1967 in a coup d’état that installed a military dictatorship and suspended parliament and the democratic process. In July 1974, the junta instigated a coup d’état against the democratically elected government of Cyprus, provoking an invasion by Turkey, leading to the junta’s collapse and the restoration of democratic government in Greece.

¹⁸ Mamas Theodorou, Markos Sarris and Sotiris Soulis, *Συστήματα υγείας* (Athens: Papazisis, 2001); John N. Yfantopoulos, *Τα οικονομικά της υγείας: Θεωρία και Πολιτική* (Athens: Typothito, 2003).

sector were accepted as a natural way of doing things. Further, as the payment system did not have effective cost-containment procedures, the fee-for-service payments for ambulatory care and the per diem reimbursements for private hospitals were susceptible to the practice of supplier-induced demand. Finally, politicians of all hues were always willing to intervene on behalf of their voters to arrange a visit to a well-known hospital specialist, who might have owed his appointment to this or another politician, or to arrange admission to one of the crowded reputable hospitals of the two largest urban centres.

Table 2.
Total health expenditure and private-sector health expenditure, 1970–2014

Year	Greece	WHO_Euro	EU15	UK	France	Spain	Switzerland
Total health expenditure as % of GDP							
1970	5.5		5.5	4.5	5.4	3.5	5.3
1990	6.7	5.3	7.5	5.8	8.4	6.5	8.0
2000	8.0	6.2	8.7	7.0	10.1	7.2	9.9
2010	9.9	8.0	10.5	9.6	11.7	9.6	10.9
2014	8.3						11.3
Private-sector health expenditure as % of total health expenditure							
1970	57.4		25.4	13.0	24.5	34.6	49.7
1990	46.3	23.0	22.7	16.4	23.4	21.3	47.6
2000	40.0	24.0	28.7	20.9	20.6	28.4	44.6
2010	30.0	27.6	23.1	16.5	23.1	25.8	34.8
2014	40.4						38.3

Note: Greece is compared to the same countries and groups as table 1, with Switzerland however replacing Bulgaria.

Source: WHO HFA Database, 2019.

Because the public perceived that hospital care in the regions was inadequate, all those who could travel did so, seeking care for even the simplest of conditions in the more reputable hospitals of Athens and Thessaloniki. Likewise, all who could afford to travel abroad for treatment did so, with large numbers of Greeks seeking care in other European countries (of the West or the East) or in the United States. Inequalities were rife: differences in income that determined the ability to pay for out-of-pocket healthcare and to travel to the main urban centres or abroad were compounded by inequalities due to geography or to the different coverage provided by the multiplicity of HIFs. Certainly, criticism

was levelled at the system: the problems were described and solutions were proposed.¹⁹ An example of one such solution was the Experimental Sanitary Unit of Thessaly (PYM), established in 1959 as a pilot project that integrated preventive and curative medical services with public health measures.²⁰ In spite of its ambitious goals, none of the lessons drawn from this project had an impact on the rest of the health services. Of particular interest is the case of Loukas Patras, professor of social policy at the University of Thessaloniki and minister for health (1968–1970) in the junta government, who in 1968 made a proposal for the reorganisation of the health services, including the unification of the HIFs. This immediately provoked negative reactions, was denounced as too drastic a measure and was withdrawn without further ado.²¹

In the best spirit of *laissez faire* politics, healthcare was abandoned to the entrepreneurial private sector, albeit with financial support from the public purse through direct payments and indirect subsidies, with the result that by the fall of the junta in 1974, healthcare in Greece was in a dire state, even drawing criticism from abroad that elicited rebuttal.²² In effect, all the governments of this period, whether of the traditional right, of the centre or of the military dictatorship, let the welfare state that flourished during the postwar era in Western Europe to bypass Greece.²³

Putting Health Reform on the Political Agenda

The fall of the junta in the wake of the Turkish invasion of Cyprus in the summer of 1974 ushered in a period of optimism, in spite of the Cyprus tragedy: the restoration of democracy was accompanied by expectations that Greece was entering a new era and the *metapolitefsi* (regime change) was perceived as signalling a period of democratic governance, economic prosperity and social reforms for the whole of the country.

The newly elected New Democracy (ND) government (1974–1977) started with the adoption of a new constitution and prioritised the restoration of

¹⁹ Nikolaos Louros and Evangelos Tsoukatos, *Πορίσματα της Επιτροπής Κοινωνικών Ασφαλίσεων: Εισηγήσεις επί της γενικής περιθάλψεως του πληθυσμού* (Athens: s.n. 1963); Nikolaos Zakopoulos, *Η δημόσια υγεία στην Ελλάδα* (Athens: s.n., 1965).

²⁰ Ministry of Health, *100 χρόνια*.

²¹ Loukas Patras, *Σχεδιασμός Κοινωνικής Πολιτικής* (Athens: Ellinikos, 1969).

²² Anastas Philalithis, "Reciprocal Treatment for Britons in Greece," *British Medical Journal* 282 (1981): 826; Spyros Doxiadis, "Reciprocal Treatment for Britons in Greece," *British Medical Journal* 282 (1981): 995.

²³ Mick Carpenter, "On the Edge: The Fate of Progressive Modernization in Greek Health Policy," *International Political Science Review* 24, no. 2 (2003): 257–72.

democratic institutions. Confirmed in power in the 1977 elections, it focused on preparing the country for accession to the European Economic Community (EEC), a goal that was achieved when Greece became the tenth member of the bloc on 1 January 1981. However, any tentative measures in the area of social policy were blocked by the resistance of the conservative circles that prevailed within the party, exemplified by developments in the area of health policy.

Health policy was pushed onto the political agenda a few months after the *metapolitefsi*, when junior doctors in public hospitals, under the leadership of the newly created Union of Hospital Doctors in Athens and Piraeus (EINAP), went on strike in the spring of 1975, demanding the right to be paid while undergoing specialist training.²⁴ Until then, this was considered an extension of their medical education and hence was unpaid. In response, the Ministry of Health passed Law 121/1975 that created salaried positions for trainees (or interns, to use US terminology) in the public and non-profit hospitals. The need to re-examine health policy was recognised and the Ministry of Health commissioned the Centre of Economic Research and Planning (KEPE), a government think tank, to prepare a report on the health services. The landmark report, published in 1976, described the problems that existed and put forward three alternative solutions: (a) the creation of a unified, centrally financed, health system, (b) the unification of the HIFs, or (c) the adoption of measures to improve healthcare through specific interventions and better coordination between different bodies.²⁵ The report clearly stated that the choice between the three options was a political matter and, in the first instance, the latter option was chosen: specific proposals were announced, but never came to fruition.²⁶ Still, in a move to decentralise specialised hospital care, two new medical schools were inaugurated in Patras and Ioannina in 1977, with plans to construct associated university hospitals.

When, after the 1977 elections, Professor Spyros Doxiadis, an eminent paediatrician of international renown, was appointed minister for health (1977–1981), he immediately set out to prepare the ground for a major reform of the health services. A committee was formed (the Filias committee) as a channel for formal dialogue with stakeholders in the health sector,²⁷ new regulations for specialist medical training were introduced, the Athens School of Hygiene

²⁴ Costis Chlouverakis, *Γιατροί και άρρωστοι: Δοκίμια για την κρίση της ιατρικής* (Athens: Diogenis, 1975).

²⁵ Centre of Planning and Economic Research, *Πρόγραμμα οικονομικής και κοινωνικής ανάπτυξης 1976–1980: Υγεία* (Athens: KEPE, 1976).

²⁶ Anastas Philalithis, “Ριζικό και τολμηρό ή ανεπαρκές και διστακτικό βήμα: “Τα νέα μέτρα για την υγεία;” *Πανιατρική Υγειονομική Επιθεώρηση* B2 (1977): 11–15.

²⁷ Sissouras, *Τα μετέωρα βήματα*.

was reorganised, negotiations with the EEC regarding the mutual recognition of doctors' qualifications were successfully completed,²⁸ a fifth medical school was planned for Heraklion and KEPE was commissioned to prepare a second report, this time on the regionalisation of the health services.²⁹ Finally, a bill was published that put forward the plan for the reorganisation of the health services.³⁰ Its proposals included the creation of a National Health Council, the decentralisation of the health system with the creation of health regions, the reorganisation of public hospitals and the introduction of geographical full time for senior hospital doctors, that is, physicians working in public hospitals would be obliged to limit their private practice to certain hours within the premises of the hospital. As it appeared following the adoption by WHO member states of the 1978 Alma-Ata Declaration on primary health care (PHC), as the means to achieve "Health For All by the Year 2000" through comprehensive and integrated services that would provide prevention, cure and rehabilitation,³¹ the plan included the creation of health centres to provide PHC in rural areas (on whose location the University of Patras was commissioned to carry out a study).³² The health centres were broadly based on the UK's Beveridge model of general practice, but without any reference to the gatekeeping functions of British GPs.

The bill was received with hostility from all sides: the opposition parties to the left of ND rejected it as being too conservative, while the more conservative elements within ND rejected it for being too radical. Indeed, the Athens Medical Association, expressing the views of these elements, as well as of the medical establishment, denounced the bill as Marxist in ideology, basically because of the limitations on private practice. The internal opposition was too strong to overcome and there was a token tabling of the bill to parliament in spring 1981, a few months before the scheduled elections, when it was already too late for it to be approved and enacted.³³

²⁸ Anastas Philalithis, "Η ιατρική στην Ελλάδα μετά την ένταξη στην Ευρωπαϊκή Οικονομική Κοινότητα" (PhD diss., University of Athens, 1978).

²⁹ Centre of Planning and Economic Research, *Η περιφερειακοποίηση των υπηρεσιών υγείας* (Athens: KEPE, 1979).

³⁰ Spyros Doxiadis, *Μέτρα προστασίας για την υγεία* (Athens: Ministry of Social Services, 1981).

³¹ Anastas Philalithis, "Υγεία για όλους το 2000 και Πρωτοβάθμια Φροντίδα Υγείας: ουτοπία, παγίδα ή εφικτός στόχος," *Ιατρική* 42 (1982): 257–64.

³² Sissouras, *Τα μετέωρα βήματα*.

³³ Lycourgos Liaropoulos, "Πολιτική υγείας: Το νομοσχέδιο Δοξιάδη," *Ιατρική* 61 (1992): 367–71; Philalithis, "Imperative."

The Enactment of Law 1397/1983 Establishing the National Health System

The Panhellenic Socialist Movement (PASOK) won the elections of October 1981 having campaigned for *allaghi* (change), an overarching slogan that raised expectations for sweeping changes in all fields of government. Indeed, in its first term it did follow a different policy to its predecessors: in economic policy it raised wages and pensions and nationalised many companies that were close to bankruptcy, averting an increase in unemployment; in foreign policy it made openings towards the nonaligned countries; although its promise to leave the EEC was never really countenanced, it negotiated a package of financial support from the EEC for development policies, known as the Integrated Mediterranean Programmes; it passed legislation to recognise the fighters of the resistance against the Nazis during World War II; it instituted reforms in family law, the rights of women, abortion, education, including a new framework law for universities, social security, health and safety at work and, of course, healthcare.

Its first minister for health was Paraskevas Avgerinos (1981–1984), a surgeon who, being a member of PASOK’s political bureau, had the political authority to overcome any potential objections. In fact, PASOK had already prepared a detailed health plan (the so-called “Green book for health”), which had restricted circulation because it was deemed too radical.³⁴ He immediately set up a committee to make proposals for the reform of the health services. Its proposals, published in 1982, incorporated many of the elements of the Doxiadis bill, but they went further in three crucial aspects: (a) the new project would be called the National Health System (ESY), promising it would provide high-quality care to all, without economic, social or occupational distinctions, (b) all HIFs would be unified into a single health body (*eniaios foreas ygeias*) and PHC established in both rural and urban areas, and (c) limitations would be placed on the private sector, including a freeze on the expansion of the private hospital sector and the introduction of full and exclusive (*pliris kai apoklistiki*) practice for all physicians working in the ESY. The first aspect proved to be of paramount importance because it inspired and mobilised public opinion in favour of the reform: the promise of equal access without obstacles to high-quality care gave the reform an ideological basis, consistent with the ideology of a party that cared for the unprivileged.³⁵ It is worth noting that, contrary to popular lore, article 1 of Law 1397/1983 does not mention “free services for all”, but “high-quality services

³⁴ PASOK Health Committee, *Εισήγηση για το κυβερνητικό πρόγραμμα: Υγεία (Το πράσινο βιβλίο της υγείας)* (Athens: PASOK, 1980).

³⁵ World Health Organization, *Highlights on Health in Greece, 2004* (Copenhagen: WHO Regional Office for Europe, 2006); Yannis Tountas, Panagiota Karnaki and Elpida

for all". The second aspect raised strong objections from multiple stakeholders, provoked a heated debate and was stalled from early on in the process, as will be explained later. The last aspect, and in particular the changes in the terms of service of physicians, was the other most hotly debated issue, since it was immediately rejected by the professional and academic establishment, including medical circles within PASOK. In contrast, it was fervently supported by EINAP and younger doctors, dividing the previously united medical body.

The first part of the reform, enacted in December 1982 (Law 1278/1982), replaced the Supreme Health Council (AYS) that had been in place since 1922 with the Central Board of Health (KESY) as the highest advisory body to the Ministry of Health. In fact, the terms of reference of the board endowed it with strong powers, since its agreement (not only its opinion) was required before the minister for health could issue ministerial decrees on several key issues, creating a mutual veto that proved untenable in the long run. Just as important was the fact that the board was conceived as a body that would embody PASOK's proclamations about community participation in decision-making, since it included representatives of the government, health-service professionals and public bodies, that is, the users of the service. The latter were represented by members nominated by the confederations of municipal authorities (KEDE), civil servants (ADEDY), workers (GSEE) and farmers (PASEGES). In practice, most of these bodies nominated as their representative physicians from within their ranks, who then just expressed their own professional views. Further, the composition of the board was such that its majority would tend to support the policies of the government.³⁶

The debate between the supporters and detractors of the reform in medical circles raged on, and in early 1983 further developments seemed to be on hold. Although the bill to create the ESY was widely known to be ready, its submission to parliament for ratification was repeatedly postponed with rumours blaming the influence of the medical establishment and those physicians who were close to the leadership of the government. However, opposition to the reform was also expressed by the HIFs, especially by those known as "privileged", voiced by their administrations, by the medical staff they employed and by the insured. The gist of their arguments was that if they lost their independent status, the property of their fund would be confiscated

Pavi, "Reforming the Reform: The Greek National Health System in Transition," *Health Policy* 62 (2002): 15–29.

³⁶ Anastas Philalithis, "Community Participation in Health Care Planning: The Greek Experience," in *Advisory Systems in Health Care Planning* (Madrid: Ministry of Health and Consumer Affairs, 1986), 59–63.

and they would end up as OGA. In fact, the administrations were afraid that they would lose the power of patronage and the independence to run their own finances, the medical staff were afraid that they would lose the opportunities to draw their clientele from the insured, and the insured were convinced that they would lose any extra benefits provided by their HIFs. In essence, it was a classical reaction of corporate, syndicated stakeholders (*syntechnies*) resisting the loss of privilege and financial gain.³⁷ Another source of resistance came from the private hospital sector, whose further expansion was banned, but at this juncture they lacked the political influence to obstruct the reform. Actually, when the freeze on further expansion of the private *klinikes* was enforced, it had the unforeseen effect of a rapid expansion of private diagnostic centres all over Greece.³⁸

At the same time, the Ministry of Health opened up a debate with local communities all over the country about the exact locations of the rural health centres. Although the bill had not yet been tabled in parliament, local communities and municipalities were invited to comment on the locations of the health centres as proposed in the University of Patras study, to identify specific sites where the health centres would be constructed or suggest whether any existing buildings could be suitably modified. This move rallied wider public support for the ESY, since local communities had a tangible, even if vaguely understood, object to identify the “prize” of the reform: a health centre on their doorstep to serve local needs.

The bill was eventually submitted to parliament in the summer of 1983, accompanied by a substantial explanatory report that set out the political, social and scientific arguments underpinning the reform. The opposition parties were divided in their stance, with ND vehemently opposing the bill, while the left parties provided their qualified support. More important were the objections that were raised within PASOK itself.³⁹ During the debate in parliament, the speaker,

³⁷ Michael S. Mitsopoulos and Theodore Pelagidis, “Vikings in Greece: Kleptocratic Interest Groups in a Closed, Rent-Seeking Economy,” *Cato Journal* 29, no. 3 (2009): 399–416.

³⁸ Yannis Tountas, Panagiota Karnaki, Elpida Pavi and Kyriakos Souliotis, “The ‘Unexpected’ Growth of the Private Health Sector in Greece,” *Health Policy* 74 (2005): 167–80; Gavriil Kouris and Anastas Philalithis, “Ο μεταβαλλόμενος ρόλος του κράτους στο Ελληνικό σύστημα υγείας: Ο ιδιωτικός τομέας υγείας σε ρόλο οδηγού;” in *Κοινωνική Μεταρρύθμιση και Αλλαγές στο Μείγμα “Δημόσιου”-“Ιδιωτικού” στο πεδίο της κοινωνικής πολιτικής*, ed. Maria Petmezidou and Christos Papatheodorou (Athens: Ellinika Grammata, 2010), 164–201.

³⁹ Paraskevas Avgerinos, *Η Αλλαγή τέλειωσε χωρίς* (Athens: Estia, 2013), 145–211; Sissouras, *Τα μετέωρα βήματα*.

Ioannis Alevras, a venerable and influential member of PASOK, descended from his podium and spoke “as a simple member of parliament”, in order to express his total disagreement with the provision to pool the financial resources of the HIFs into the single health body. It so happened that Alevras was previously a bank employee, who had served as president of the Confederation of Bank Employees’ Unions (OTOE). This episode threatened to develop into a major rift within the ruling party, with two politically strong members of the party clashing in public. The rift was avoided since the minister for health decided to back down on the proposal: the clause concerning the unification of the HIFs into the single health body (paragraph 4 of article 16) was modified by a clause that appears two paragraphs later, stating that the incorporation would require the approval of the governing body of each HIF in question. Given that requirement, unification was dead. The rest of the bill was ratified without further surprises and the historic Law 1397/1983, creating the National Health System, was published in the *Εφημερίς της Κυβερνήσεως*.

The Challenges of Implementation

The next challenge was implementation, a matter that is not self-evident, considering that many previous reforms never went beyond the stage of parliamentary approval.

Hospital reorganisation and staffing

According to the new law, all public hospitals had to be reorganised in order to achieve a decentralised, regionalised hospital system. The aim was to create an integrated hospital network, which would serve the needs of the population as close to their residence as possible, in relationship to the required medical specialisation and the availability of advanced, expensive technology. Each prefecture would have a fully staffed and equipped general hospital providing secondary care, while more specialised, tertiary care would be provided by the larger hospitals in Athens and Thessaloniki, as well as by the three new university hospitals that were planned for Patras, Ioannina and Heraklion. Another designation was that of special hospitals, which mainly referred to psychiatric hospitals. This reform included the non-profit hospitals, most of which enjoyed a reputation for providing high-quality care. However, in order to continue to receive the necessary government subsidies, they would have to join the ESY, changing their status from a non-profit NPID to a publicly owned NPDD. This also entailed changes in their administrative boards, a majority of whose members would be appointed by the Ministry of Health.

In spite of efforts to renegotiate particular aspects of the law, they all accepted the inevitable, albeit reluctantly, since none was viable without government subsidies.

The next step was the restructuring of all hospital medical posts according to a basic organogram that would then be individualised for each hospital, depending on the designation of the hospital as secondary, tertiary or specialised, according to its infrastructure and medical equipment and, to some extent, according to local circumstances. This would be followed by a call for applications for all medical posts, the hiring of the most qualified applicants by specially appointed selection committees, and those selected would be appointed to serve as directors (consultants in British terminology), A (senior) Registrars or B (junior) Registrars, under the new terms of full and exclusive practice. Negotiations around the specifics of the restructuring were immediately initiated between the Ministry of Health, the Central Board of Health, local groups of doctors, the mayors of the towns where the hospitals were located and PASOK cadres from all over the country. It soon became evident that the restructuring entailed a redistribution of all existing hospital posts, without substantial overall increases. As a consequence, many posts would have to be moved from the centre to the periphery, creating great insecurity among hospital staff. The result was that the junior hospital doctors, represented by EINAP, reversed their position and, from being the most fervent supporters of the reform, they went on strike, expressing their rejection of the process. In January 1984, during the strike, Avgerinos was replaced by Georgios Gennimatas as minister for health (1984–1987). Gennimatas, an engineer, was also a member of PASOK's political bureau and had served until then as interior minister, introducing several reforms that were quite popular. He adopted a two-pronged approach to the problem: on the one hand, he initiated a dialogue with the junior doctors, attending public meetings where he would address their concerns and, on the other, he sought additional funds from the Ministry of Finance in order to increase the number of medical posts in the hospitals and to safeguard the special salaries that the hospital doctors would receive under the new terms of service. His approach was successful, the strike was called off and the task of selecting and appointing the medical staff of some 130 hospitals all over Greece was completed after the 1985 elections that renewed PASOK's mandate.⁴⁰

However, it must be noted that the issue of the terms of service of ESY doctors remained contentious. First, in spite of the special salary that doctors were paid in contrast to other categories of civil servants, for a long time the doctors claimed

⁴⁰ Theodorou, Sarris and Soulis, *Συστήματα υγείας*; Yfantopoulos, *Τα οικονομικά της υγείας*.

and the state tolerated additional payments for on-call shifts that existed on paper only and were never actually realised (*plasmatices efimeries*). Secondly, criticism was raised (and which still persists) that some ESY doctors do not honour their full-time contracts and demand additional, unofficial payments from patients or their relatives, the so-called *fakelaki* (little envelope). It is, by definition, impossible to estimate how extensive this illegal and unethical practice is,⁴¹ but it is certainly one of the factors that contributes to the public's persistent discontent with the deficiencies of the ESY.

PHC in rural areas

Meanwhile, the effort to construct the first 165 health centres in rural areas got under way, while the pre-existing rural health posts were merged into them, so as to constitute an integrated, unified service. The aim was to provide comprehensive, 24-hour coverage to wider catchment areas, including ambulatory care and basic diagnostic services.⁴² Trained, specialised GPs would gradually fill the posts in the health centres, rendering the obligatory one-year service in rural areas redundant. Although training in general practice was reorganised and expanded, the salary scale of GPs was raised to be equivalent to that of hospital physicians and other incentives were given to fill the posts in remote areas, at the time of writing the aim of terminating the obligatory service has only been partially achieved.⁴³ Dentists, nurses, midwives, social workers and other health professionals were also appointed as part of the multidisciplinary health team. One controversial aspect of the reform involved assigning jurisdiction for the health centers to the hospitals: the proponents of this arrangement argued that hospitals were the only local body with the

⁴¹ Christos Zilidis and Anastas Philalithis, "Μέτρηση των ιδιωτικών δαπανών υγείας στην Ελλάδα: Μεθοδολογικά προβλήματα και εμπειρικά δεδομένα," *Κοινωνία, Οικονομία και Υγεία* 1 (1992): 19–38; Zilidis and Philalithis, "Θεωρητικά προβλήματα στη μεθοδολογία ανάλυσης των στοιχείων των Εθνικών Λογαριασμών σχετικά με τις δαπάνες υγείας," *Κοινωνία, Οικονομία και Υγεία* 3 (1994): 1–13; Kyriakos Souliotis and John Kyriopoulos, "The Hidden Economy and Health Expenditures in Greece: Measurement Problems and Policy Issues," *Applied Health Economics and Health Policy* 2 (2003): 129–34.

⁴² Evangelos Moraitis, Toula Kouri-Zarafoniti and Bodosakis-Prodrimos Merkouris, "Κέντρα Υγείας: Ο νέος θεσμός για την Πρωτοβάθμια Φροντίδα Υγείας," *Πρωτοβάθμια Φροντίδα Υγείας* 1 (1986): 5–23.

⁴³ Anargiros Mariolis, Constantinos Mihas, Alevizos Alevizos, Vasilis Gizlis, Theodoros Mariolis, Konstantinos Marayiannis, Yannis Tountas, Christodoulos Stefanadis, Anastas Philalithis and George Creatsas, "General Practice as a Career Choice Among Undergraduate Medical Students in Greece," *BMC Medical Education* 7 (2007): 15.

knowhow to manage health services, while its detractors argued that putting primary care under secondary care was akin to having the wolf look after the sheep.

It must be noted that PHC was not merely an issue of buildings and personnel. It was a major component of the reform, since it epitomised the way that the ESY would cover even the remotest parts of the country, provide 24-hour coverage, meet the needs for first-instance care and, in accordance with the Alma-Ata Declaration, provide prevention, cure and rehabilitation. Invited to support the process, the WHO Regional Office for Europe organised an international network for PHC in southern Europe, where experts from Italy, Spain, Portugal and Greece met to exchange experiences.⁴⁴ Also, it supported a series of meetings and workshops all over the country where the concept and content of PHC were discussed. This process consolidated the understanding and support for PHC within the health professions and the public at large and contributed to PHC becoming the flagship of the reform.

The Insurmountable Hurdle of the Urban Health Centres

The next step of the reform was the creation of health centres in urban areas: Law 1397/1983 laid out the legal framework and the infrastructure of the IKA *polyiatreia* was there, ready to be integrated into the ESY. So, the Central Board of Health, in consultation with the Ministry of Health, prepared a detailed plan of how this should go into effect.⁴⁵ At that juncture, Georgios-Alexandros Magakis, a law professor respected for his stance against the junta, was appointed minister for health (February 1987–September 1987). He received the report and passed it on to the prime minister, asking for the go-ahead to implement it. In lieu of an answer, at the next reshuffle Magakis was replaced by Ioannis Floros (September 1987–November 1988), a cardiologist who immediately let it be known that the report would not be implemented.⁴⁶ He also annulled the plans for the regionalisation of the ESY, which was envisaged in the law establishing

⁴⁴ Escuela Andaluza de Salud Pública, *Nuevas perspectivas en promoción de salud: ponencias y comunicaciones* (Granada: Escuela Andaluza de Salud Publica, 1989).

⁴⁵ KESY (Central Board of Health), Special Committee, *Για ένα ενιαίο και ολοκληρωμένο σύστημα Πρωτοβάθμιας Φροντίδας Υγείας: Η ένταξη του ΙΚΑ στο ΕΣΥ* (Athens: KESY, 1987).

⁴⁶ Anastas Philalithis, “Δύο χρόνια ΕΣΥ: Απολογισμός και προτάσεις για άμεσα αποτελέσματα,” *Ελευθεροτυπία*, 25 January 1988, 15–16; Philalithis, “Scope and Limitations of Public Health Reforms: The Greek Case,” *Contemporary European Affairs* 2 (1989): 117–26.

ESY, presumably because the governing party could not ensure the control of the majority of the regional health boards, whose composition was, at a local scale, similar to that of the Central Board of Health.

In actual fact, what happened is that the refusal of doctors working in IKA to give up their evening private practice was too strong to overcome, especially since they were supported by the unofficial alliance of stakeholders that has already been described. They all felt that if IKA were successfully integrated into the ESY, preserving their positions and privileges would become untenable. In particular, they feared that the urban health centres, based on the Beveridge model, would, sooner or later, take on a gatekeeping role, limiting unrestricted access to specialists providing ambulatory care on a fee-for-service basis. In conjunction with PASOK's overall shift to a less radical political profile after the 1985 elections, the reform process was halted.⁴⁷

Other aspects of health policy

Three other aspects of the reform process, and two areas of inertia, are worth a brief mention:

First, mental health services were dominated since the nineteenth century by large psychiatric asylums, with completely inappropriate, even inhuman, conditions. The first steps towards their deinstitutionalisation were taken with the financial support of the EEC (EC Regulation 815/1984), in conjunction with the establishment of psychiatric units in general hospitals and the creation of intermediate care facilities in the community. In spite of considerable achievements over the years, exemplified by the Psychargos project (1997–2006), mental health reform is still a work in progress.⁴⁸

Second, the area of the regulation of therapeutic medicinal products was placed on a new basis with the creation of the National Organisation for Medicines (EOF) under Law 1316/1983.

Third, emergency, prehospital care was modernised with the creation of the National Centre for Emergency Care (EKAV) with Law 1579/1985, in

⁴⁷ Aristomenis I. Syngelakis, "Ενάντια στην παλίρροια του μονεταρισμού: Η τομή του ΕΣΥ ως ορόσημο του ανολοκλήρωτου εγχειρήματος οικοδόμησης του κράτους πρόνοιας στην Ελλάδα," in *ΠΑΣΟΚ 1974–2018: Πολιτική οργάνωση, ιδεολογικές μετατοπίσεις, κυβερνητικές πολιτικές*, ed. Vasilis Asimakopoulos and Chrysanthos Tassis (Athens: Gutenberg, 2018), 774–822.

⁴⁸ Panagiotis Chondros and Stelios Stylianidis, "Psychiatric Reform in Greece," in *Social and Community Psychiatry: Towards a Critical Patient-Oriented Approach*, ed. Panagiotis Chondros and Stelios Stylianidis (Berlin: Springer, 2016), 77–91.

conjunction with the acquisition of new ambulances and with the appointment of medical and other health professionals with appropriate training.

Fourth, a policy for the development of human resources has been completely lacking during the entire period under consideration (table 3).⁴⁹ Other than the creation of medical and nursing schools and the hesitant measures to train more GPs, medical, nursing and health professionals' education has been left to the relevant departments of the universities and technical education institutes; the number of doctors in the country has increased to non-sustainable figures; the number of nurses has never increased to a level of sufficiency; speciality training for physicians, very loosely monitored by the Central Board of Health, is still organised in a way that was adequate in the 1950s; and speciality training for nurses is, in its current state, a futile exercise.

Finally, an integrated public health policy in the sense of population-based health promotion and disease-prevention measures was not incorporated into the reform process, probably contributing to the slower rate of improvement of health indicators, compared to other countries in Western Europe. Nor does the creation of the Greek centre for disease control and prevention (called KEEL under Law 2071/1992, renamed KEELPNO under Law 3370/2005 and now EODY according to Law 4600/2019) compensate for this deficit. Another tentative step was the recognition of social medicine as the medical specialisation of the multidisciplinary field of public health with Law 1397/1983, but nothing was done to further its cause.⁵⁰ It was subsequently renamed to public health medicine (Law 3370/2005), once again without any follow up. It remains to be seen whether the recent effort to reestablish it, under the name of public health–social medicine (Ministerial Decree G5a/64843/2018) will fare any better.

A thorough analysis of each of these issues goes beyond the scope and space available for the current article and, important as they are, they have been left out.

⁴⁹ Anastas Philalithis, “Η ανάπτυξη των ανθρωπίνων πόρων στη υγεία,” in *Πολιτική Υγείας στην Ελλάδα: Στο σταυροδρόμι των επιλογών*, ed. John Kyriopoulos (Athens: Themelio, 1995), 63–75.

⁵⁰ Anastas Philalithis, “Can Social Medicine Within a National Health System Supersede Traditional Public Health? The Case of Greece,” in *Public Health and Industrialized Countries*, ed. Pierre Duplessis (Québec: Les Publications du Québec, 1989), 289–312.

Table 3.
Human resources and hospital beds, 1970–2014

Year	Greece	WHO_Euro	EU15	UK	France	Spain	Bulgaria
Physicians per 100,000 population							
1970	162.2			94.4			186.3
1980	243.4	238.3	254.8	131.7		183.5	246.0
2000	432.8	272.0	305.7	195.8		316.6	336.9
2010	612.6	300.2	350.6	271.7	316.2	379.9	371.1
2014	625.5	322.4	368.6	280.7	321.5	381.9	399.9
Nurses per 100,000 population							
1980							
2000	292.8	678.0	837.2	949.4		373.4	435.9
2010	362.4	731.7	917.6	1012.5	928.6	537.1	465.0
2014	344.0	740.9	934.8	872.6	1029.1	535.8	486.5
Dentists per 100,000 population							
1980	79.3					10.5	54.6
2000	113.2	46.8	61.6			43.7	83.0
2010	129.7	51.7	66.8	52.1	65.7	60.4	84.8
2014	125.0	53.3	70.8	53.8	65.9	72.0	98.0
Pharmacists per 100,000 population							
1999							16.5
2004	85.5	47.5	75.8	61.5		81.3	
2010	98.7	50.8	79.6	65.3	108.7	93.3	
2014	105.3	56.6	90.3	82.8	109.4	118.0	
Hospital beds per 100,000 population							
1970	621.3					466.6	
1980	622.9					535.5	
2000	471.7	698.4	617.1	409.8	822.3	368.6	741.1
2010	440.7	589.0	510.7	295.3	662.2	315.2	649.5
2015	419.6	553.2	491.6	274.1	640.9	298.2	715.2

Note: Greece is compared to the same countries and groups as table 1.

Source: WHO HFA Database, 2019

Institutional Stagnation and Investment in Infrastructure

The next major legislative initiative was Law 2071/1992, which was voted in by the ND government. In spite of the fire and fury against the ESY when it was instituted in 1983, the new law essentially reiterated most of what was already in force, adding a substantial chapter on mental health. It was a recognition that the ESY was, for all its shortcomings, successful and popular. It also demonstrated that an undeclared consensus had been reached on the basic elements of the organisation of the health services in the country. Of course, specific provisions of the law were modified, reflecting the different ideology of the ruling party: it gave ESY doctors the option of a part-time contract and a private practice in parallel with their state appointment; it shifted responsibility for the health centres in rural areas from hospitals to the directorates of public health in each prefecture; and it repealed the freeze on further expansion of the private hospital sector.⁵¹ The first provision received little acceptance from the doctors since only very few opted for the part-time contract, indicating de facto that the full-time contract, with its official remuneration and opportunities for unofficial payments, was preferable. Assigning the jurisdiction for PHC to the public health directorates reflected ND's more centralising tendencies, but it had the adverse effect of hindering their development, since the directorates lacked the required expertise. When PASOK was returned to power in 1993 it rescinded these two changes, but allowed the third, regarding the private hospitals, to stand, recognising that the private sector fulfils an important role in the provision of care.⁵²

The new PASOK government did not limit itself to the above measures. It was apparent that, in spite of the progress achieved, fragmentation of care persisted, people were dissatisfied with the deficiencies in the services and complaints were voiced about the unofficial, out-of-pocket payments.⁵³ The government embarked on a review of the situation, first with reports drawn up by Greek experts and then by a committee of seven renowned academics from different European countries who were invited to study the Greek health

⁵¹ John Kyriopoulos and George Tsalikis, "Public and Private Imperatives of Greek Health Policies," *Health Policy* 26 (1993): 105–17.

⁵² Yannis Tountas, Helga Stefansson and Spyros Frissiras, "Health Reform in Greece: Planning and Implementation of a National System," *International Journal of Health Planning and Management* 10 (1995): 283–304.

⁵³ Lycourgos Liaropoulos, Olga Siskou, Daphne Kaitelidou, Mamas Theodorou and Theofanis Katostaras, "Informal Payments in Public Hospitals in Greece," *Health Policy* 87 (2008): 72–81; Olga Siskou, Daphne Kaitelidou, Vasiliki Papakonstantinou and Lycourgos Liaropoulos, "Private Health Expenditure in the Greek Health Care System: Where Truth Ends and the Myth Begins," *Health Policy* 88 (2008): 282–93.

services and make appropriate recommendations. Their report, published in 1994, came to the conclusion that it was necessary to extend to urban areas a family physician-based PHC system.⁵⁴ Additional recommendations referred to reforming the finances of the system, decentralisation, orienting medical education towards PHC and the training of managers. However, the rhetoric about reinvigorating the ESY and strengthening PHC never translated from words to deeds, and the highly publicised report was shelved. The next minister who attempted to break the impasse put forward a plan to create PHC networks in towns that would link together all the services run by different providers in the same area, without encroaching on the administrative and financial status of each provider.⁵⁵ This scheme was enacted in Law 2519/1997, only for it to be abandoned when the said minister was replaced in the next reshuffle, and his successor bluntly stated that the prerequisites for establishing a system based on general practice did not exist. He did not indicate whether any steps would be taken to fulfil these prerequisites, while the ND opposition, in a shift from its traditional position, declared that the healthcare system needed a “new” PHC reform.⁵⁶

In spite of the institutional stagnation of this period, in the 1990s there was considerable progress in improving the public hospitals in the country, financed by the EU’s National Strategic Reference Framework, of which Greece was a beneficiary. New hospitals were built all over the country: tertiary-care university hospitals in Athens, Thessaloniki, Alexandroupoli and Larissa and secondary-care general hospitals in several provincial towns that are the seats of prefectures. Other hospitals were refurbished or extended or they acquired new diagnostic and curative devices, intensive care units and other types of medical equipment.⁵⁷ Meanwhile, total expenditure on health had risen to 8.0 percent of GDP by the end of the decade, but the mixture of about 40 percent

⁵⁴ Brian Abel-Smith et al., *Report on the Greek Health Services* (Athens: Pharmetrica, 1994).

⁵⁵ Evangelos Moraitis, “Δίκτυα πρωτοβάθμιας φροντίδας υγείας: Εφικτή λύση ή ουτοπία;” in *Δίκτυα ολοκληρωμένης φροντίδας στην Υγεία*, ed. Evgenia Georgousi, John Kyriopoulos and Tryfon Beatzoglou (Athens: Themelio, 2000), 36–51.

⁵⁶ Anastas Philalithis, “Η χαμένη ψυχή του ΕΣΥ,” *Ελευθεροτυπία*, 15 December 1999; Philalithis, “Η γενική ιατρική σήμερα και οι προοπτικές της στην Ελλάδα,” in *Proceedings of the Educational Meeting of General Practice “G. Papadakis”* (Piraeus: Nikaia Regional General Hospital–Agios Panteleimon, 2001), 179–85; Tountas, Stefansson and Frissiras, *Health Reform in Greece*.

⁵⁷ Ellie Tragakes and Nikolaos Polyzos, “The Evolution of Health Care Reforms in Greece: Charting a Course of Change,” *International Journal of Health Planning and Management* 13 (1998): 107–30.

private and 60 percent public, almost equally split between taxation and the HIFs, remained unaltered (table 2).

By this time, the “Greek health paradox” had vanished (fig. 1): while life expectancy continued to improve, the rate of improvement in Greece was lower than that in the members of the EU before 2004 (EU15), with the result that the latter group surpassed Greece. Currently, most worrying are the facts that Greece continues to have a high consumption of tobacco, in spite of several anti-smoking laws, and child obesity is at a record level,⁵⁸ with worrying effects on mortality from diseases of the circulatory system.⁵⁹

The Attempt to Re-establish and Upgrade the ESY

When PASOK received a new mandate in 2000, Alekos Papadopoulos (2000–2002), a lawyer with a good track record as a reformer and as an efficient manager when he served as finance minister and interior minister, was appointed minister for health. In a brief space of time, he put forward a plan to re-establish and upgrade the ESY: the plan included a new regionalisation scheme; a reorganisation of the management structure of the hospital system; changes to the terms of service of university medical staff from part- to full-time; and the introduction of the geographical full-time concept that allows all ESY doctors and university staff to see private patients within hospital facilities. He also revived the proposals to pool the finances of the HIFs, under a new name (Organisation for the Management of Health Resources) and to integrate the network of IKA polyclinics into the ESY, converting them into urban health centres. Essentially, he was picking up the threads of the reform from where it had been dropped in 1987.⁶⁰

The first part of the plan regarding regionalisation and the terms of service of university staff and hospital physicians were voted through in Law 2889/2001.⁶¹ The provisions for decentralisation denoted a significant departure from what was, until then, conventional thinking about how it should be done: the country was divided into 17 regional health systems (PESY), into which all public hospitals were incorporated, with about 7 to 12 hospitals corresponding to one PESY. The governance of the PESY was assigned to a board chaired by a

⁵⁸ Panagiotis Mpogiatzidis and Kyriaki Stefanidou, “Συγκριτική μελέτη κυριότερων αιτιών θανάτου και παραγόντων κινδύνου υγείας στην Ελλάδα και στην Ευρωπαϊκή Ένωση,” *Αρχαία Ελληνικής Ιατρικής* 36, no. 4 (2019): 526–33.

⁵⁹ Maria Vassilaki, Manolis Linardakis and Anastas Philalithis, “Burden of Heart Disease in Greece: Time to Act,” *Public Health* 128 (2014): 940–43.

⁶⁰ Sissouras, *Τα μετέωρα βήματα*.

⁶¹ Tountas et al. “Reforming the Reform.”

director general appointed by the minister for health while the boards of the individual hospitals were replaced by management councils, consisting of the hospital governor and the medical, nursing and administrative directors of the hospital. The new structures were launched amid a lot of publicity, stressing that they would render the health services more responsive to local needs and would facilitate coordination among local hospitals, while emphasising that merit and managerial competence rather than party political allegiance (as has been the practice since time immemorial in Greece) would be the criteria for selecting those appointed to lead the system, at both regional and hospital level. The minister for health himself stated that the directors general of the PESY would be the equivalent of “a local minister for health”, fuelling the expectations of the public as well as the health service staff.⁶² At the same time, the provisions for full-time contracts for university medical staff received a mixed reception: the medical schools of Athens and Thessaloniki refused to comply with the new arrangements, while the five medical schools of the regions accepted them.

The second part of the plan, regarding the unification of HIFs and the creation of health centres in urban areas based on the Beveridge model, proved, once more, unenforceable. The usual alliance of vested interests behind the numerous HIFs and the private and semi-private providers of the fragmented PHC services in towns resisted any change to the status quo, as they had often done before. It is worth noting that the impasse in the health reform came very soon after the rejection of the pension system reform, which the same government had proposed, by a similar, even broader, alliance of trade unionists and corporate interests.⁶³ Having scored once, they scored again. Papadopoulos resigned soon after.⁶⁴

His successor focused on overcoming the resistance of the university medical staff of Athens Medical School, by the unconventional method of allowing a partial deferment of the application of the law concerning their terms of service. He also passed a law on the reorganisation of public health (Law 3172/2003)

⁶² Vassilios Aletras, Nick Kontodimopoulos, Athanasios Zagouldoudis and Dimitris Niakas, “The Short-Term Effect on Technical and Scale Efficiency of Establishing Regional Health Systems and General Management in Greek NHS Hospitals,” *Health Policy* 83 (2007): 236–45.

⁶³ Tasos Giannitsis, *Το ασφαλιστικό (ως ορφανό πολιτικής) και μια διέξοδος* (Athens: Polis, 2007).

⁶⁴ Elias Mossialos, Sara Allin and Konstantina Davaki, “Analysing the Greek Health System: a Tale of Fragmentation and Inertia,” *Health Economics* 14 (2005): 151–68; Gavriil Kouris, Kyriakos Souliotis and Anastas Philalithis, “Οι υγειονομικές μεταρρυθμίσεις στην Ελλάδα,” *Διοικητική Ενημέρωση* 39 (2006): 82–90.

and another on PHC (Law 3235/2004).⁶⁵ The former had no impact on how public health services are staffed and organised, while the latter had none on how PHC is organised, being, in effect, a statement of intentions rather than a policy for reform.⁶⁶

At the same time, discontent was expressed with the decentralisation process and the functions of the PESY. They were accused of just adding another level of bureaucratic interference in the management process; the hospital governors preferred to deal directly with the Ministry of Health while the latter did not resist this tendency to bypass the regional structures that it had created; the health professionals and administrative personnel working in the hospitals took exception to the fact that they were answerable to a regional authority that could monitor and control their daily functions much more closely than the Ministry of Health in the remote capital; the local politicians resented that any favours to their political clientele had to pass through the regional director general. Yet, in spite of the criticism, not only were the PESY left in place; their competences were extended (Law 3106/2003) with the incorporation of a number of entities of the welfare services that were under the responsibility of the under-secretariat for welfare of the Ministry of Health, rendering the system even more dysfunctional.⁶⁷

Back to Business as Usual, with Two (Expensive) Differences

In 2004, ND was returned to power, for a period of five years. During this time, the predominant feature of its tenure was the day-to-day running of the health services,⁶⁸ while recent reforms were mostly revoked or ignored, all accompanied by the usual rhetoric regarding the necessary improvements.

⁶⁵ Christos Lionis, Mariza Tsiraki, Vassilios Bardis and Anastas Philalithis, "Seeking Quality Improvement in Primary Care in Crete, Greece: the First Actions," *Croatian Medical Journal* 45 (2004): 599–603; Kyriakos Souliotis and Christos Lionis, "Creating an Integrated Health Care System in Greece: A Primary Care Perspective," *Journal of Medical Systems* 29 (2005): 187–96.

⁶⁶ World Health Organization, *Highlights on Health in Greece, 2004*; Tountas, *Υπηρειακές Υγείας*.

⁶⁷ Elias Mossialos and Sara Allin, "Interest Groups and Health System Reform in Greece," *West European Politics* 28 (2005): 420–44; Athanasios Athanasiadis, Nikoleta Ratsika and Constantinos Trompoukis and Anastas Philalithis, "The Health Decentralization Process in Greece: the Insiders' Perspective," *International Journal of Health Governance* 23 (2018): 316–29.

⁶⁸ Konstantina Davaki and Elias Mossialos, "Plus ça change: Health Sector Reforms in Greece," *Journal of Health Politics, Policy and Law* 30 (2005): 143–67.

Thus, the policy of decentralisation was downgraded in a series of steps: First, the regional health systems (PESY) were renamed regional health directorates (DYPE), their functions were limited to a minimal, coordinating role, and the hospitals and welfare entities were reinstated as independent legal entities of public law, directly answerable to the Ministry of Health (Law 3329/2005).⁶⁹ In a second step, their number was reduced from 17 to seven, and their role limited even further. Although there was bold talk of disbanding them altogether, they survived, probably because they were considered useful as the local overseer of the implementation of the directives of the Ministry of Health. During the same period, amid the usual rhetoric of applying bold reforms, a new law on public health was enacted (Law 3370/2005), basically to replace the one passed by the previous government, and with the same unimpressive results, and a new law on PHC was drafted and publicised, but never submitted to parliament.⁷⁰

The main mark that this period left on the health services was an explosion of public expenditure on pharmaceuticals, which more than doubled from 2.43 billion euros in 2004 to 5.09 billion in 2009, mainly as a result of the revocation of the list of restricted medications, upward repricing of medicines and aggressive marketing practices by the pharmaceutical industry.⁷¹ The drug bill pushed up public expenditure on health to 6.6 percent of GDP (and total expenditure to 9.9 percent of GDP), with the concomitant result that private expenditure on health fell to 30 percent of the total, including about 3 percent of the total that was paid to private insurance firms (table 2).⁷² Another noteworthy episode was how the impending H1N1 influenza epidemic in 2009 was handled, for which a great number of vaccines were ordered so as to inoculate the whole population of Greece amid lots of related publicity.⁷³

⁶⁹ Athanasios Athanasiadis, “Περιφερειακή οργάνωση των υπηρεσιών υγείας: η Ελληνική πραγματικότητα” (PhD diss., University of Crete, 2019).

⁷⁰ Christos Lionis, Emmanouil K. Symvoulakis, Adelais Markaki, Constantine Vardavas, Maria Papadakaki, Natasa Daniilidou, Kyriakos Souliotis and Ioannis Kyriopoulos, “Integrated Primary Health Care in Greece, a Missing Issue in the Current Health Policy Agenda: A Systematic Review,” *International Journal of Integrated Care* 9 (2009): e88; Charalampos Economou, “Greece: Health System Review,” *Health Systems in Transition* 12, no. 7 (2010): 1–180.

⁷¹ Elias Mossialos et al., *Ενδιάμεση έκθεση της ανεξάρτητης ομάδας εργασίας ειδικών εμπειρογνομόνων στον τομέα της υγείας* (Athens: Ministry of Health, 2011).

⁷² Olga Siskou, Daphne Kaitelidou and Charalampos Economou, “Private Expenditure and the Role of Private Health Insurance in Greece: Status Quo and Future Trends,” *European Journal of Health Economics* 10 (2009): 467–74.

⁷³ Anastas Philalithis, “Η γρίπη, τα εμβόλια και τα τριχίλιάρια της υγείας,” *Ελευθεροτυπία*, 12 August 2009, 21; Vana Sypsa, Stefanos Bonovas, Sotirios Tsiodras, Agoritsa Baka, Panos Efstathiou, Meni Malliori, Takis Panagiotopoulos, Ilias Nikolakopoulos and Angelos Hatzakis,

Fortunately, the epidemic was not as serious as originally feared, and most of the vaccines were discarded. Presumably, the cost of procuring them was never recovered.

The Fiscal Crisis, the Memorandums, the Unification of the HIFs and the Integration of IKA into the ESY

Soon after PASOK won the 2009 elections, it was revealed that the country, which was already in recession from 2007, had a sovereign debt that was unserviceable, since its total debt had reached 299.7 billion euros (130 percent of GDP) and its budget deficit was 15.6 percent of GDP. The government had no choice but to seek the assistance of its EU partners, and a bailout by the European Commission, European Central Bank (ECB) and International Monetary Fund (IMF) (subsequently dubbed the troika) was arranged. The terms of the bailout were set out in a memorandum of understanding that listed the details of the economic adjustment programme: it imposed a drastic fiscal adjustment programme, with accompanying austerity measures, as well as a series of reforms that had to be undertaken in order to make the economy more competitive. As the economy remained in recession, a second bailout was required in 2012, together with a concomitant memorandum. In the same year, the European Stability Mechanism (ESM) was added to the country's creditors, being the fund created by the eurozone countries in order to provide financial assistance to its members. The period of the first two memorandums (2010–2014) was a period of unrest in Greece: the austerity and the reforms in every sphere of government activity fuelled large and small protests, strikes and demonstrations, on occasion accompanied by violence. Government instability ensued, with a series of coalition governments from 2011 to 2014, both before and after the two general elections that were held in 2012, which returned hung parliaments.

The reforms impacted on the health sector.⁷⁴ Among the fiscal adjustment measures foreseen in the first and second memorandums was the obligation to reduce public health expenditure to no more than 6 percent of GDP and

“Estimating the Disease Burden of 2009 Pandemic Influenza A (H1N1) from Surveillance and Household Surveys in Greece,” *PLoS ONE* 6, no. 6 (2011): e20593.

⁷⁴ Charalampos Economou, Daphne Kaitelidou, Alexander Kentikelenis, Anna Maresso and Aris Sissouras, “The Impact of the Crisis on the Health System and Health in Greece,” in *Economic Crisis, Health Systems and Health in Europe: Country Experiences*, ed. Anna Maresso et al. (Copenhagen: WHO/European Observatory on Health Systems and Policies, 2015), 103–42; Charalampos Economou, Daphne Kaitelidou, Marina Karanikolos and Anna Maresso, “Greece: Health System Review,” *Health Systems in Transition* 19, no. 5 (2017): 1–192.

to reduce staff costs through restricting the replacement of those leaving the service for any reason, including retirement, to a 5 to 1 ratio. Other reforms aimed at cost containment, including reducing the pharmaceutical bill to two billion euros, introducing electronic prescriptions, encouraging the prescription of generics instead of original patent drugs⁷⁵ and limiting expenditures for laboratory tests and pharmaceuticals with the introduction of clawbacks and rebates on the respective bills.⁷⁶ As regards hospital care, a system for their reimbursement, based on diagnostic related groups (DRGs, or KEN in Greek),⁷⁷ was introduced, changes to the procurement system for hospital supplies were made and neighbouring hospitals were merged into one legal entity, with the aim of reducing overlapping services and improving productivity; most of these reforms had scant results in actual practice.⁷⁸ The memorandums did not include

⁷⁵ Mary Geitona, Dimitrios Zavras, Magda Hatzikou and John Kyriopoulos, "Generics Market in Greece: the Pharmaceutical Industry's Beliefs," *Health Policy* 79 (2006): 35–48; Vassiliki Tsiantou, Dimitrios Zavras, Hara Kousoulakou, Mary Geitona and John Kyriopoulos, "Generic Medicines: Greek Physicians' Perceptions and Prescribing Practices," *Journal of Clinical Pharmacy and Therapeutics* 34 (2009): 547–54; Thanos Balasopoulos, Antonios Charonis, Kostas Athanasakis, John Kyriopoulos and Elpida Pavi, "Why Do Generic Drugs Fail to Achieve an Adequate Market Share in Greece? Empirical Findings and Policy Suggestions," *Health Policy* 121 (2017): 265–72.

⁷⁶ Olga Siskou, Daphne Kaitelidou, Panagiota Litsa, Georgia Georgiadou, Helen Alexopoulou, Panagiotis Paterakis, Sotiria Argyri and Lycourgos Liaropoulos, "Investigating the Economic Impacts of New Public Pharmaceutical Policies in Greece: Focusing on Price Reductions and Cost-Sharing Rates," *Value in Health Regional Issues* 4 (2014): 107–14; John N. Yfantopoulos and Athanasios Chantzaras, "Drug Policy in Greece," *Value in Health Regional Issues* 16 (2018): 66–73; IOBE Health Economics Observatory, *The Pharmaceutical Market in Greece: Facts & Figures 2018* (Athens: Foundation for Economic & Industrial Research (IOBE) and Hellenic Association of Pharmaceutical Companies (SFEE), 2019).

⁷⁷ Nikolaos Polyzos, Haralampos Karanikas, Eleftherios Thireos, Catherine Kastanioti and Nick Kontodimopoulos, "Reforming Reimbursement of Public Hospitals in Greece During the Economic Crisis: Implementation of a DRG System," *Health Policy* 109 (2013): 14–22.

⁷⁸ Nikolaos Polyzos, "A Three-Year Performance Evaluation of the NHS Hospitals in Greece," *Hippokratia* 16 (2012): 350–55; Panagiotis Mitropoulos, Ioannis Mitropoulos and Aris Sissouras, "Managing for Efficiency in Health Care: the Case of Greek Public Hospitals," *European Journal of Health Economics* 14 (2013): 929–38; Daphne Kaitelidou, Maria Katharaki, Maria Kalogeropoulou, Charalampos Economou, Olga Siskou, Kyriakos Souliotis, Konstantinos Tsavalias and Lycourgos Liaropoulos, "The Impact of Economic Crisis to Hospital Sector and the Efficiency of Greek Public Hospitals," *European Journal of Business and Social Sciences* 4 (2016): 111–25; Angeliki Flokou, Vassilis Aletras and Dimitris Niakas, "Decomposition of Potential Efficiency Gains from Hospital Mergers in Greece," *Health Care Management Science* 20 (2017): 467–84; Panos Xenos, John N. Yfantopoulos, Milton

any restrictions on private expenditure on health. On the contrary, they imposed a five-euro fee on non-emergency visits to hospital outpatient departments and a one-euro fee for each prescription. This provoked passionate protests by a public used to free access to public hospitals. When a 25-euro fee for non-emergency hospitalisations was announced, the public outcry was even more vehement, forcing the government to abandon it and to raise the equivalent amount of money by increasing the levy on cigarettes.⁷⁹

A major problem that appeared during this period was that of the uninsured. As has been mentioned, coverage for healthcare is dependent on the occupation-based social security organisations, supplemented by coverage of non-working dependants through the insurance of the head of the household. This system was effectively extended to cover the whole of the population in the 1960s and only small pockets of people, such as the Roma, were left out. During the crisis, two groups of people could not get coverage. First, the unemployed: with unemployment shooting up to 27.9 percent at its peak in 2013, those unemployed for more than two years lost their benefit entitlement from the state employment agency (OAED). Second, self-employed professionals, shopkeepers and tradesmen who had fallen behind on their contributions to their social security organisation, thereby losing their entitlement to healthcare for themselves and dependant family members. It is estimated that about 2.5 million people became uninsured during this period, with the result that the risk of becoming destitute if faced with excessive, catastrophic medical expenses became real. An attempt in 2013 to alleviate the problem with a voucher system funded by the EU's National Strategic Reference Framework failed to have any significant impact.

Prominent among the items raised by the troika were the perennially contentious issues of the multiplicity of HIFs and the fragmented, disparate and unequal services they provided, the absence of an integrated PHC system in towns, and the lack of an adequate number of GPs who could staff PHC services for the whole population. In response, a new organisation was created (Law 3918/2011), the National Organisation for the Provision of Health Services

Nektarios, Nikolaos Polyzos, Platon Tinios and Athanassios Constantopoulos, "Efficiency and Productivity Assessment of Public Hospitals in Greece During the Crisis Period 2009–2012," *Cost Effectiveness and Resource Allocation* 15, no. 1 (2017); Panagiotis Mitropoulos, Ioannis Mitropoulos, Haralampos Karanikas and Nikolaos Polyzos, "The Impact of Economic Crisis on the Greek Hospitals' Productivity," *International Journal of Health Planning and Management* 33 (2018): 171–84.

⁷⁹ Ilias Goranitis, Olga Siskou and Lycourgos Liaropoulos, "Health Policy Making Under Information Constraints: an Evaluation of the Policy Responses to the Economic Crisis in Greece," *Health Policy* 117 (2014): 279–84.

(EOPYY), that initially amalgamated the four largest HIFs of the country (IKA, which insures white- and blue-collar workers; OGA, which insures those working in agriculture; OPAD, which insures civil servants;⁸⁰ and OAEΕ, which insures the self-employed).⁸¹ Subsequently, all the other major and minor HIFs were merged into EOPYY, with the sole exception of the HIFs that cover bank employees, numbering about 110,000 insured, and journalists, since they are self-financing organisations. In one stroke, essentially the whole population was covered by a single fund and a basic benefits package was devised to which all were entitled.⁸² In fact, it was clearly set out that all insured persons could use the services of any provider within the system: for example, the IKA facilities were freely accessible to those previously insured with OPAD, and all physicians who were contracted with OPAD could care for patients insured with IKA. A unitary social insurance identification number (AMKA) was issued to all, becoming a necessary requirement to receive benefits and, interestingly, a prerequisite for physicians and other health providers to write prescriptions and receive reimbursements for services provided to EOPYY.

At the same time, EOPYY “inherited” all the outpatient facilities that belonged to the different HIFs, notably the IKA *polyiatreia* (five medium-sized hospitals that had belonged to IKA were transferred to the ESY). Thus, EOPYY became a hybrid organisation: On the one hand, it was the sole purchaser of medical and health services from the public and private sector; on the other, it was a provider of ambulatory services through the IKA *polyiatreia*. Criticism of EOPYY’s dual status was immediately raised, arguing in favour of creating a “clean” separation of the two functions, that is, of installing a purchaser-provider split and creating the conditions for EOPYY to concentrate on the financing of the services and, in due course, on seeking to obtain better services for the insured from the public and private sector.⁸³ The voices of those who

⁸⁰ Kyriakos Souliotis, *Η Δημόσια Ασφάλιση Υγείας στην Ελλάδα: Από το αδιανόητο στο αυτονόητο* (Athens: Papazisis, 2013).

⁸¹ Stefanos Karakolias and Nikolaos Polyzos, “The Newly Established Unified Healthcare Fund (EOPYY): Current Situation and Proposed Structural Changes, Towards an Upgraded Model of Primary Health Care in Greece,” *Health* 6 (2014): 809–21; Nikolaos Polyzos, Stefanos Karakolias, Costas Dikeos, Mamas Theodorou, Catherine Kastanioti, Kalomira Mama, Periklis Polizoidis, Chirstoforos Skamnakis, Charalampos Tsairidis and Eleutherios Thireos, “The Introduction of Greek Central Health Fund: Has the Reform Met its Goal in the Sector of Primary Health Care or Is There a New Model Needed?,” *BMC Health Services Research* 14, no. 1 (2014).

⁸² See *Εφημερίς της Κυβερνήσεως (FEK)*, no. 3054 B, 18 November 2012.

⁸³ Kyriakos Souliotis et al., *Επιστημονική επιτροπή για την υποστήριξη της μεταρρύθμισης της Πρωτοβάθμιας Φροντίδας Υγείας: Βασικά σημεία πρότασης για τη μεταρρύθμιση της Πρωτοβάθμιας Φροντίδας Υγείας* (Athens: Ministry of Health, 2013).

benefitted from IKA's dual role were not to be easily silenced, and they put forward the opposing argument, claiming that the integration of the two functions facilitates the effective management of resources. Eventually, it was decided to proceed with the purchaser-provider split and all IKA facilities and staff working in them were transferred to the ESY. This was legislated with Law 4238/2014 that created the National Primary Health Network (PEDY), merging the *polyiatreia* into the ESY and renaming them. However, the whole exercise was carried out in such a way that it was solely an administrative reform, devoid of any substance as regards the content of care provided. PHC was unified, but was not integrated, once more missing the opportunity to establish a PHC system that promotes family care.⁸⁴

One issue that had to be settled was the status of the IKA doctors working in the *polyiatreia*: as has been mentioned before, their terms of service allowed them to combine their salaried status with their private practice. The new law was clear on this: either they accepted the status and salary of full-time ESY doctors, or they were dismissed. Of the 6,670 doctors who worked for IKA in 2011,⁸⁵ some took the first option, some the second and the rest challenged the government's decision in the courts, claiming that their dismissal was unlawful. In one stroke, the Ministry of Health had achieved two aims: it brought IKA into the fold of the ESY, surmounting the resistance that had held back this reform since 1987, and it contributed to reaching a different goal of the memorandum, that of reducing the number of civil servants in the country. The third group remained in their posts until their claim against the government was eventually ruled by the courts to lack legal justification and they also had to leave the service.

During this period, a heated debate ensued on the consequences of the recession and the austerity measures on health services and on health status, with academics, researchers and observers weighing into the fray with

⁸⁴ Elias Kondilis, Emmanouil Smyrnakis, Magda Gavana, Stathis Giannakopoulos, Theodoros Zdoukos, Steve Iliffe and Alexis Benos, "Economic Crisis and Primary Care Reform in Greece: Driving the Wrong Way?," *British Journal of General Practice* 62 (2012): 264–65; Peter P. Groenewegen and Arnoldas Jurgutis, "A Future for Primary Care for the Greek Population," *Quality in Primary Care* 21 (2013): 369–78; Ioanna Tsiligianni et al., "Greek Rural GPs' Opinions on How Financial Crisis Influences Health, Quality of Care and Health Equity," *Rural Remote Health* 13, no. 1 (2013): 2528; Christos Lionis, "Is There Any Room for General Practice in Greece? A Proposal to Scientific and Academic Stakeholders," *Hippokratia* 18 (2014): 383; Christos Lionis and Elena Petelos, "The Impact of the Financial Crisis on the Quality of Care in Primary Care: an Issue That Requires Prompt Attention," *Quality in Primary Care* 21 (2013): 269–73.

⁸⁵ Mossialos et al., *Ενδιάμεση έκθεση*.

opposing positions.⁸⁶ It was argued that hospitals and PHC services were not coping because of budget cuts and reduced staff levels, leading to alarming increases in morbidity and mortality. It was also argued that many people were facing a humanitarian crisis, leading to malnutrition and illness, including an increase in suicides to a couple of thousand. In reality, many of the untoward consequences of the crisis were mitigated by the unrecorded yet very real support exhibited by family and social networks, by the determination of medical and health personnel in hospitals and health centres not to sacrifice standards

⁸⁶David Stuckler, Sanjay Basu, Marc Suhrcke, Adam Coutts and Martin McKee, "Effects of the 2008 Recession on Health: A First Look at European Data," *Lancet* 378 (2011): 124–25; Lycourgos Liaropoulos, "Greek Economic Crisis: Not a Tragedy for Health," *British Medical Journal* 345 (2012): e7988; Nikolaos Polyzos, "Health and the Financial Crisis in Greece," *Lancet* 379 (2012): 1000; Dimitris Zavras, Vasiliki Tsiantou, Elpida Pavi, Katerina Mylona and John Kyriopoulos, "Impact of Economic Crisis and Other Demographic and Socio-Economic Factors on Self-Rated Health in Greece," *European Journal of Public Health* 23 (2012): 206–10; Christos Dervenis, Caterina Kastanioti and Nikolaos Polyzos, "Restructuring the Finances of the Greek Health Care System in the Era of Economic Crisis," *World Journal of Surgery* 37 (2013): 707–9; Marina Karanikolos, Philipa Mladovsky, Jonathan Cylus, Sarah Thomson, Sanjay Basu, David Stuckler, Johan P. Mackenbach and Martin McKee, "Financial Crisis, Austerity, and Health in Europe," *Lancet* 381 (2013): 1323–31; Elias Kondilis, Stathis Giannakopoulos, Magda Gavana, Ioanna Ierodiakonou, Howard Waitzkin and Alexis Benos, "Economic Crisis, Restrictive Policies, and the Population's Health and Health Care: The Greek Case," *American Journal of Public Health* 103 (2013): 973–79; Dimitris Niakas, "Greek Economic Crisis and Health Care Reforms: Correcting the Wrong Prescription," *International Journal of Health Services* 43 (2013): 597–602; Daphne Kaitelidou, Maria Kalogeropoulou, Petros Galanis, Mamas Theodorou, Georgios Charalambous and Lycourgos Liaropoulos, "Impact of Economic Crisis on the Greek Health Care System and on the Population Health," *Value Health* 17 (2014): A446; Alexander Kentikelenis, Marina Karanikolos, Aaron Reeves, Martin McKee and David Stuckler, "Greece's Health Crisis: From Austerity to Denialism," *Lancet* 383 (2014): 748–53; Lycourgos Liaropoulos and Ilias Goranitis, "Health Care Financing and the Sustainability of Health Systems," *International Journal of Equity in Health* 14 (2015): 80; Foteini Anastasiou, Maria Antonopoulou, Ioanna Tsiligianni and Christos Lionis, "Long Term Impact of the Economic Crisis on Health Care in the Greek Setting: The Pandora Box?" *Health Policy* 120 (2016): 860; Dimitrios Zavras, Athanasios I. Zavras, Ilias-Ioannis Kyriopoulos and John Kyriopoulos, "Economic Crisis, Austerity and Unmet Healthcare Needs: The Case of Greece," *BMC Health Services Research* 16 (2016): 309; Athanasios E. Chantzaras and John N. Yfantopoulos, "Income-Related Health Inequalities Among the Migrant and Native-Born Populations in Greece During the Economic Crisis: A Decomposition Analysis," *European Journal of Public Health* 28s (2018): 24–31; Marina Karanikolos, Johan P. Mackenbach, Ellen Nolte, David Stuckler and Martin McKee, "Amenable Mortality in the EU: Has the Crisis Changed its Course?" *European Journal of Public Health* 28 (2018): 864–69.

by providing services beyond their official call of duty, and by initiatives of spontaneous social solidarity, whereby voluntary organisations, NGOs, some municipalities and many informal citizens' groups organised "social clinics" and "social pharmacies", which provided free medical care and free medicines, the latter through redistribution schemes, to the uninsured and the needy. Specific untoward effects were due to inappropriate decisions, such as the restriction on the distribution of free syringes and condoms because of budget cuts, leading to a surge in HIV infections among intravenous drug users,⁸⁷ and the withdrawal of a cancer drug from the Greek market because of unpaid bills, leading to increased risks for the life of patients.⁸⁸ Certainly, a substantial increase in suicide, mainly of middle-aged men, was recorded, but not of the size trumpeted by some quarters.⁸⁹ On the other hand, the pre-existing trend of a reduction in deaths from motor vehicle accidents continued, partly attributed to fewer people choosing to drive their cars to save on fuel, as has happened in other countries in economic crisis.⁹⁰ It is evident that the longer the recession, the worse the impact.⁹¹ Although it is not possible to review all the relevant literature in this article, suffice it to say that at the time of writing, the trend in life expectancy has taken a turn for the worse from its peak of 81.6 years in 2014, but seems to be recovering (fig. 1) – whether the negative trend is described as excessive or not is a matter of judgement.

Finally, another consequence of the crisis was that a large number of mostly young people emigrated to other EU countries, including a significant number

⁸⁷ Economou et al., "Impact of the Crisis."

⁸⁸ Ioanna Tsiligianni, "Politics and Cancer Management: Lessons from Greece," *Lancet* 381 (2013): e4.

⁸⁹ Elias Kondilis, Ioanna Ierodiakonou, Magda Gavana, Stathis Giannakopoulos and Alexis Benos, "Suicide Mortality and Economic Crisis in Greece: Men's Achilles' Heel," *Journal of Epidemiology and Community Health* 67 (2013): e1; Nikolaos Antonakakis and Alan Collins, "The Impact of Fiscal Austerity on Suicide: on the Empirics of a Modern Greek Tragedy," *Social Science and Medicine* 112 (2014): 39–50; Marina Economou, Elias Angelopoulos, Lily E. Peppou, Kyriakos Souliotis and Costas Stefanis, "Suicidal Ideation and Suicide Attempts in Greece During the Economic Crisis: An Update," *World Psychiatry* 15 (2016): 83–84.

⁹⁰ George Michas and Renata Micha, "Road Traffic Accidents in Greece: Have We Benefited from the Financial Crisis?" *Journal of Epidemiology and Community Health* 67 (2013): 894.

⁹¹ Stelios Stylianidis and Kyriakos Souliotis, "The Impact of the Long-Lasting Socioeconomic Crisis in Greece," *British Journal of Psychiatry International* 16 (2019): 16–18; Ilias Kyriopoulos, Zlatko Nikoloski and Elias Mossialos, "Does Economic Recession Impact Newborn Health? Evidence from Greece," *Social Science and Medicine* 237 (2019).

of physicians.⁹² The brain drain has deprived the country of many well-qualified scientists and highly entrepreneurial persons in all spheres of life, undermining the long-term prospects for recovery. On the other hand, the departure of many physicians from the country diminishes the pressures on the services from supplier-induced demand.

The “Defiant Renegotiation”, the Third Memorandum and Another PHC Reform

The January 2015 elections returned another hung parliament, and a coalition government was formed between the Radical Left Coalition (SYRIZA), a party of the radical left, and the Independent Greeks (ANEL), a party of the extreme right, the two united by their populist “anti-memorandum” stance. The new government immediately set out to renegotiate the terms of the bailout, while it took a number of measures which aimed to avert what it described as a humanitarian disaster facing the country, ignoring the fact that they contravened the terms of the bailout and the memorandums. After a tumultuous period of negotiations with the country’s creditors, now renamed the “institutions”, a referendum was called that rejected, on the recommendation of the government, the terms offered by the creditors. However, in view of the danger of Grexit, that is, of a chaotic exit from the eurozone and “return” to the drachma, a government volte-face led to the third bailout and another memorandum. Early elections, in September 2015, returned the SYRIZA-ANEL coalition to power. The coalition lasted until 2018, after which SYRIZA managed to hold on to power until the July 2019 elections, which ND won with an overall majority in parliament.

In the area of health policy, one of the first tangible measures of the SYRIZA-ANEL government was to revoke the five-euro fee for attending outpatients and the one-euro prescription fee. The problem of the uninsured was solved with Law 4368/2016, which provided full healthcare coverage (albeit limited to public hospitals and PHC services) to the uninsured and their dependants, on the sole prerequisite of having an AMKA social insurance identification number, as well as for registered migrants, financed from the general budget of the Ministry of Health. Although this measure was criticised for undermining the basis of the Bismarck-style occupation-based health insurance system in favour of a Beveridge-style tax-based system, it did provide relief to the uninsured.

⁹² Amalia A. Ifanti, Andreas A. Argyriou, Foteini H. Kalofonou and Haralabos P. Kalofonos, “Physicians’ Brain Drain in Greece: A Perspective on the Reasons Why and How to Address It,” *Health Policy* 117 (2014): 210–15.

Reforming PHC was high on the government's agenda and early in 2015 the Ministry of Health appointed an expert committee to make proposals on the subject. As so many reports before, the committee's report recommended creating a GP-based PHC system in towns that would cover the whole population.⁹³ The recommendations of the committee were operationalised by laws 4461/2017 and 4486/2017 that established a PHC system backed by EU funds from the National Strategic Reference Framework: A local health unit (TOMY) was established as the basic unit of the new system in urban areas, to be staffed by GPs, internists and paediatricians, as well as nurses and other health professionals; the TOMYs in one area were grouped in a PHC Division (TOPFY); the PEDYs were renamed (urban) health centres; and the jurisdiction for all PHC services was assigned to the regional health directorate (DYPE). On the side of the insured, everybody had to register with a TOMY in order to have access to the services of a family physician. The troika's successor "institutions" encouraged the government, believing that it fulfilled one of the reforms that they proposed from the beginning, that is, an integrated, family physician-based PHC system. However, criticism of the new system highlighted several points: The funding was not guaranteed after the end of the EU funds; the full-time and exclusive terms of service and the limited tenure of the physicians rendered the system unattractive; all the private practitioners in contract with EOPYY were left out; and, most importantly, that there were not enough trained GPs in the country to cover the whole population with TOMYs. It was this last issue that proved decisive, since it obliged the government to backtrack on its original intentions and open up the system to private practitioners contracted with EOPYY, who could assume the role of family physician, provided they were GPs, internists or paediatricians. In addition, the Ministry of Health conceded that the new service was not meant to act as a gatekeeping system, but patients continued to have direct access to specialists contracted with EOPYY and to hospitals. In spite of the publicity, and the support of the creditors, the reality is that the new service is, at best, a modest starting point for a system that will take several years to mature and cover the whole population.

Besides these two issues, the prevailing logic during this period was business as usual. The Ministry of Health claimed that it received an ESY that was on the brink of collapse and its policies stabilised the system and put it on the

⁹³ Alexis Benos, Ioanna Antoniadou, Antonis Koutis, Christos Lionis, Thanos Myloneros and Takis Panagiotopoulos, *Βασικές αρχές, θέσεις και προτάσεις για την ανάπτυξη της Πρωτοβάθμιας Φροντίδας Υγείας στην Ελλάδα* (Athens: Ministry of Health, 2015).

way to recovery. Objectively, nothing major was accomplished,⁹⁴ since hospitals and PHC continued to be underfunded, and there was limited replacement of personnel who retired or left the service for any reason. Consequently, the crowding of emergency rooms and long waiting lists for outpatient departments or for an operation remained undiminished. Also, the ministry and the government launched several campaigns against what it claimed were major corruption scandals in the health sector but, by the end of its tenure, almost none of these allegations had translated to specific prosecutions or, even less, convictions.

Conclusion

Major healthcare reforms happen when there is a suitable window of opportunity, that is, when for various reasons a society is willing to accept that a major reorientation of the health services in the country is required.⁹⁵ Such windows of opportunity are fashioned by factors outside the health services, such as a major political or socioeconomic crisis that the country has faced. There must also be a recognition that the health services are failing to deliver appropriate and requisite care.⁹⁶ In the period examined in the current article, Greece went through three such windows: the period after the end of World War II, the period of the early *metapolitefsi*, that is, after the fall of the colonels' junta, and the period of the fiscal crisis.

The postwar period witnessed an attempt to reorganise the healthcare system and the social security organisations with their health insurance funds, but the reforms were abandoned soon after. The health services reverted to autopilot, with the Ministry of Health providing no leadership, no vision and not even the managerial capacity required to keep the health services abreast of developments in medical science and technology.

In the early period of the *metapolitefsi*, a reform of historic proportions was achieved, with the creation, with Law 1397/1983, of the National Health System (ESY). It took the serendipitous coincidence that the Ministry of

⁹⁴ Vasilis Venizelos, “Αναζητώντας το Χαμένο Χρόνο’ ...στην Υγεία. Συνέντευξη με τον Γιάννη Κυριόπουλο,” *Healthview*, 8 July 2019, accessed 8 August 2019, <https://www.healthview.gr/70213/anazitontas-to-xameno-xrono-synteneyxi-giannhiw-kyriopoylos/>.

⁹⁵ Anastas Philalithis, “Κοινωνικές κρίσεις και υγειονομικές μεταρρυθμίσεις στην Ελλάδα,” in *Economics and Health: Proceedings of the 1st Greek Conference on Health Economics* (Athens: Centre for the Social Sciences in Health, 1989): 445–50.

⁹⁶ Gavriil Kouris, Kyriakos Souliotis and Anastas Philalithis, “Οι ‘περιπέτειες’ των μεταρρυθμίσεων του Ελληνικού συστήματος υγείας: Μια ιστορική ανασκόπηση,” *Κοινωνία, Οικονομία και Υγεία* 1 (2007): 35–67.

Health had at its helm three enlightened and capable persons in succession, from the two large political parties that dominated political life in Greece for 40 years:⁹⁷ Spyros Doxiadis, whose vision for better health services combined with his technical expertise to prepare the ground for the changes that followed; Paraskevas Avgerinos, whose ideological commitment to equal health services of a high standard for all combined with his astute political acumen to overcome the millstones of conflicting and opposing interests as they expressed their opposition to the reform both outside and within parliament; and Georgios Gennimatas, whose rhetorical skills, combined with his managerial competence, enabled the implementation of the first phase of the reform.

Yet, not everything was achieved, and the ESY was left unfinished, like a three-legged stool hovering on just two of its legs: the reform of the public hospitals and of rural PHC could never be fully functional as long as the third component, urban PHC, was not implemented.⁹⁸ But the vested interests who thrived on the grey zones of the finances of the fragmented ambulatory care in towns blocked this crucial step. Likewise, they blocked the creation of a single fund for the payment of health services, in lieu of the multitude of health insurance funds that nourished this grey zone of financing and the networks of patronage and privilege that accompanied them.⁹⁹ Paraphrasing Adam Smith's well-known adage, it was the "invisible hand" of interweaving favours (*diaploki*) that dictated their stance.¹⁰⁰

The third window of opportunity was the period of the fiscal crisis, the three bailouts and the memorandums, when Greece's creditors asked, inter alia, two self-evident questions about the healthcare system, one regarding the multitude of HIFs and the other regarding the absence of a family physician-based PHC system in urban areas. The creation of EOPYY in 2011 answered the first question, almost without a whimper, when it was realised that the publicly funded HIFs were effectively broke. Part of the answer to the second question came with the creation of the PEDY in 2014, which disbanded the bastion of

⁹⁷ Anastas Philalithis, review of *Τα μετέωρα βήματα του ΕΣΥ*, by Aris Sissouras, *Metarithmisi.gr*, 18 November 2013, <http://metarithmisi.gr/post/27514/ta-meteora-bimata-tou-esy>.

⁹⁸ Sissouras, *Τα μετέωρα βήματα*.

⁹⁹ Savvas Avgoustatos and Charalampos Economou, "Greece," in *Study on Corruption in the Healthcare Sector* (Luxembourg: Publications Office of the European Union, 2013): 242–46.

¹⁰⁰ Anastas Philalithis, "Η Δημόσια Ασφάλιση Υγείας στην Ελλάδα: Από το αδιανόητο στο αυτονόητο, του Κυριάκου Σουλιώτη – Βιβλιοπαρουσίαση," *Αρχαία Ελληνικής Ιατρικής* 31, no. 5 (2014): 637–39.

resistance of the IKA physicians' syndicate. However, the issue of a family physician-based PHC system in towns remains pending: this was attempted with the creation of the TOMYs in 2017, but they have only been applied on a limited scale, and their future remains uncertain.

From October 1944, when the first postwar Greek government assumed office, to the July 2019 elections, there have been 107 changes of minister for health, with an average tenure of 8.5 months.¹⁰¹ Some observers blame the brevity of the ministers' tenure for the lack of continuity in health policy. A more careful reading of events leads to a different conclusion: leaving aside the numerous political upheavals of this period, on several occasions the change was made precisely in order to rescind the policy of the outgoing minister.

Throughout the 75 years of the development of the health services in Greece that this article covers, there is one more issue of paramount importance to the users of the health services: the burden of high out-of-pocket costs, both authorised and unauthorised, that the patients and their households are required to bear:¹⁰² accounting for about 40 percent of total expenditure on health, they remain among the highest in Europe and even in the OECD. None of the governments that came to power during this period countenanced taking any measures to redress this injustice, whose impact is mostly felt by the poorest households.¹⁰³

Time and again, the reports of specialised scientists who analyse the healthcare system reach the same conclusion, the politicians express the intention to heed their advice, and the public sense that what is proposed promises a significant improvement of their repeated experiences of dealing with, and paying for, the available dysfunctional healthcare services. Yet, after more than 35 years of striving, the quest for equal services of a high standard for all remains unfulfilled.

Postscript: The Covid-19 Pandemic (10 September 2020)

In late December 2019, China reported to the WHO that several cases of acute respiratory syndrome in Wuhan city, capital of Hubei province, were due to a

¹⁰¹ Ministry of Health, *100 χρόνια*.

¹⁰² Kyriakos Souliotis, Christina Golna, Yannis Tountas, Olga Siskou, Daphne Kaitelidou and Lycourgos Liaropoulos, "Informal Payments in the Greek Health Sector Amid the Financial Crisis: Old Habits Die Last," *European Journal of Health Economics* 17 (2016): 159–70.

¹⁰³ Lycourgos Liaropoulos and Ellie Tragakes, "Public/Private Financing in the Greek Health Care System: Implications for Equity," *Health Policy* 43 (1998): 153–69; Ilias Kyriopoulos, Zlakto Nikoloski and Elias Mossialos, "The Impact of the Greek Economic Adjustment Programme on Household Health Expenditure," *Social Science and Medicine* 222 (2019): 274–84.

novel coronavirus. Within a few short weeks the Covid-19 pandemic wreaked havoc worldwide, causing deaths and illness almost everywhere.¹⁰⁴ In its wake, it has exposed the weaknesses of the most robust healthcare systems, devastated strong and weak economies and had untold psychological and social consequences; the political repercussions have yet to unfold. Given the enormity of the event, it is necessary to consider how Greece coped with the pandemic, looking briefly at how events unfolded and commenting on specific aspects.

The first wave of the pandemic left Greece almost unscathed: on 4 May, when the general lockdown was called off, it had recorded only 146 deaths (14 per million) and just over 2,600 confirmed cases (250 per million).¹⁰⁵ This inspired a strong feeling of congratulatory self-confidence in the country. Yet, by late July it became evident that a second wave of the outbreak was underway, with new cases exceeding one hundred daily and the number of patients on a ventilator and people dying on the rise again, leading to the reimposition of generalised or local restrictions. At the time of writing, between 150 and 250 new cases were recorded daily, bringing the total to just over 12,000 confirmed cases (1,160 per million), as well as 293 deaths (28 per million).¹⁰⁶

Taking events from the beginning of the outbreak, on 17 February 2020, before any cases were confirmed in the country, the Greek government convened an ad hoc committee of medical experts to advise it on the necessary measures and it was quick to accept their recommendations. The first confirmed case was reported on 26 February and, one day later, carnival festivities were banned. Over the following days, schools, universities, museums, cafés and tavernas were closed, religious services were suspended and public gatherings of more than 10 people were banned, including sports events. The first death was reported on 12 March and a general lockdown was put in place on 23 March. Strict “stay at home” and social isolation orders were issued: only essential services were allowed to continue and everybody who went outside had to carry a signed declaration or obtain prior authorisation through a text message on their mobile phone, stating which one of seven prescribed reasons justified their being outside, or else pay a fine. Travel between prefectures

¹⁰⁴ Johns Hopkins University & Medicine–Coronavirus Resource Center, accessed 10 September 2020, <https://coronavirus.jhu.edu>.

¹⁰⁵ European Centre for Disease Prevention and Control, Covid-19 situation update for the EU/EEA and the UK, accessed 10 September 2020, <https://www.ecdc.europa.eu/en/cases-2019-ncov-eueea>; WHO Coronavirus disease (Covid-2019) situation reports, accessed 10 September 2020, <https://covid19.who.int>.

¹⁰⁶ Greek Government, Covid 19–Greece, accessed 10 September 2020, <https://covid19.gov.gr/covid19-live-analytics/>; National Public Health Organisation, accessed 10 September 2020, <https://eody.gov.gr/category/covid-19/>.

and to all islands was subsequently limited to returning residents and to the delivery of goods. Finally, the country's borders were closed, all but a few incoming flights were suspended and strict restrictions on travellers arriving by land, sea or air were imposed, including a 14-day quarantine of all arrivals.¹⁰⁷

Surprisingly, the acceptance of the lockdown was almost universal. In contrast to the widespread protests against the memorandums of the fiscal crisis over the previous decade, on this occasion the Greeks were willing to follow the leadership of a government that heeded the scientific advice of experts, rather than promise easy, pain-free solutions. Further, it was argued that the experience of austerity enhanced the resilience of the population and made them willing to suffer short-term sacrifices in order to avoid heavier losses.¹⁰⁸ On this occasion, the Greeks prioritised the value of human life above all else, whatever the economic and social costs: the protection of each person's life was equated with the public good.

After seven weeks of quarantine, the pandemic was clearly under control: new cases were in single digits, deaths were down to less than three per day and overall mortality did not show any excess deaths; if anything there was a small decrease.¹⁰⁹ During May and June, stepwise measures to ease the lockdown started to be implemented: shops, cafés, restaurants and hotels were allowed to open subject to social-distancing requirements, religious services resumed with similar limitations, schools opened with small class sizes and attendance on alternate days, limits on travel within the country were lifted and the land and air borders were open again, albeit with restrictions. However, although requirements for social distancing, avoidance of overcrowding and recommendations to wear a face mask whenever necessary remained in force, several instances of large gatherings were observed. Some were organised events, such as local festivals, weddings or parties, and others were spontaneous gatherings in streets, public squares or beaches, mostly involving younger people. Specific clusters were particularly worrying, such as those occurring in popular tourist destinations and in factories where congestion is difficult to avoid. As already mentioned, the reintroduction of restrictions

¹⁰⁷ Covid-19 pandemic in Greece, accessed 10 September 2020, https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Greece.

¹⁰⁸ Eleftheria Kollia, "Τι έκανε τους Έλληνες τόσο ανθεκτικούς στη μάχη με τον κορονοϊό;" *Protagon*, 18 May 2020, accessed 10 September 2020, <https://www.protagon.gr/themata/ti-ekane-tous-ellines-toso-anthektikous-sti-maxi-me-ton-koronoio-44342054760>.

¹⁰⁹ European Mortality Monitoring Project, accessed 23 May 2020, <https://www.euromomo.eu/graphs-and-maps/>.

followed. Nationally, the wearing of face masks indoors became obligatory again and gatherings of more than 50 people in public and private events were banned. In addition, towns, islands or districts with a high epidemic load had to observe a “local lockdown”, such as wearing a mask outdoors, capping gatherings at less than nine people and the closure of bars and restaurants between midnight and 7 am. It became apparent that self-regulation had its limits and that the motive for making sacrifices was probably self-protection rather than to protect others.

Turning to the aspects related to the health services, a major factor in deciding the lockdown was the goal of flattening the curve, that is, delaying an early peak in cases requiring a ventilator, so as to avoid overloading the intensive care units (ICUs) of the ESY. This was deemed crucial in view of the low availability of ICU beds (565 or 5.5/100,000), even for the routine coverage of needs.¹¹⁰ Although this was attributed to the spending cuts of the fiscal crisis, in actual fact the problem predated the crisis and nothing had been done about it. Still, the number of ICU beds was almost doubled to 1,015 and additional medical and nursing staff were recruited. Fortunately, the use of these beds during the pandemic never reached capacity levels, peaking at 92 patients in April. Subsequently, it fell to single digits in mid-June and rose again during the second wave, reaching about 40–45 patients in September. In addition, testing capacity for suspected cases and for contact tracing was boosted from less than a thousand daily in March to more than 12,000 per day in August.

Similar longstanding inadequacies were displayed in PHC provision, since the government advised patients who had mild symptoms to consult “their doctor”, when, as has been described above, the goal of covering the whole of the population with a functional network of family physicians had never been achieved. Also, the crisis exposed the shortcomings of the public health services at central and regional levels¹¹¹ since many of the tasks which they should have carried out were assigned to ad hoc structures under the EODY (whose status was changed once again under Law 4633/2019) and the Civil Protection authority.

In essence, the pandemic revealed the limitations of the policy of “benign neglect” that almost all previous governments had adopted: do not solve a problem that is not urgent, since the political costs of any solution are immediate, while the benefits are long term. It remains to be seen whether the legacy of the

¹¹⁰ Andrew Rhodes, Patrick Ferdinande, Hans Flaatten et al., “The Variability of Critical Care Bed Numbers in Europe,” *Intensive Care Medicine* 38 (2012): 1647–53.

¹¹¹ Anastas Philalithis, Agalos Fotopoulos and Constantinos Trompoukis, “Δημόσια Υγεία – Κοινωνική Ιατρική: Η ιστορία και η σημειολογία του όρου,” *Αρχαία Ελληνικής Ιατρικής* 37, no. 3. (2020): 395–405.

pandemic will extend beyond the temporary measures to strengthen the public healthcare sector: Will the government deliver on its promise to support the ESY and will it realise that its plans to privatise certain facets are off the mark? Will it acknowledge that a recent, much criticised¹¹² law on public health services (Law 4675/2020) has already been shown in practice to be obsolete and will it re-examine it in consultation with the scientific community (whose contribution to the handling of the pandemic it acknowledged)?

A special consideration during the pandemic was the protection of the elderly, whose number as a share of the population is one of the highest in Europe. However, family bonds in Greece remain strong and make it imperative to protect the elderly and other persons at risk. Furthermore, during the fiscal crisis it was the presumably inflated pensions of the grandparents that often kept the family finances afloat. Was it not time to repay this moral debt? Thus, strict protection orders were issued to nursing homes, resulting in very few recorded cases and only two deaths among their residents during the first wave. Unfortunately, in the post-lockdown phase, case clusters did appear in a few nursing homes, on one occasion leading to several deaths.

Another important issue was the huge number of refugees and migrants (about 120,000 at the latest count),¹¹³ many housed in facilities where social isolation and physical distancing are well-nigh impossible. Any outbreak in these facilities could have disastrous consequences. Several clusters that emerged in camps were contained successfully. However, one major incident in Moria camp in Lesbos, the largest such camp in Europe, resulted in a major disaster: when 35 identified cases of infection were ordered to isolate, a fire broke out that completely destroyed the camp. All of its 13,000 occupants were left without shelter, sleeping in the open and under the trees of the adjoining olive groves until an alternative could be arranged. However, the incident did raise awareness about the plight of the refugees and calls for support were raised by the EU¹¹⁴ and UNHCR.¹¹⁵

¹¹² Yannis Tountas and Agis Tsouros, “Η Δημόσια Υγεία στον 21ο αιώνα,” *To Vima*, 7 March 2020, accessed 10 September 2020, <https://www.tovima.gr/2020/03/07/opinions/i-dimosia-ygeia-ston-21o-aiona/>.

¹¹³ UNHCR–The UN Refugee Agency, Fact Sheet: Greece, July 2020, accessed 10 September 2020, <https://data2.unhcr.org/en/documents/details/78445>.

¹¹⁴ “Commissioner Schinas at Lesbos: ‘Moria is here to remind Europe that we need to change,’” Athens-Macedonian News Agency, 10 September 2020, accessed 10 September 2020, <https://www.amna.gr/en/article/486661/Commissioner-Schinas-at-Lesvos-Moria-is-here-to-remind-Europe-that-we-need-to-change>.

¹¹⁵ “UNHCR offers support as large fire destroys asylum center in Moria,” UNHCR.org, 9 September 2020, accessed 10 September 2020, <https://www.unhcr.org/news/press/2020/9/5f588b0e4/unhcr-offers-support-large-fire-destroys-asylum-center-moria.html>.

A crucial aspect of the crisis in Greece related to the tourist industry, which contributes about 20 percent to the country's GDP and which was badly hit. Eventually, the land borders to the north were opened but had to be closed again when the epidemic spiked in neighbouring Balkan countries. The airports were also opened to flights from European countries, albeit with preconditions for arrivals, such as completing a passenger locator form (PLF)¹¹⁶ to identify where the traveller had come from and possibly having a test, either on arrival or in the 72 hours prior to travel. When the surge of the second wave appeared, some countries imposed restrictions on travellers returning home, inflicting further damage on tourism. The sacrifices of the Greeks during the pandemic saved the country's brand name as a tourist destination, but the uncertainties about its prospects remain.¹¹⁷

The economic fallout of the lockdown is enormous. Just after the country had managed to turn the tide of 10 years' recession due to the fiscal crisis, it went into a new downturn, the size of which was estimated to be between 5 and 10 percent of GDP, according to different organisations.¹¹⁸ In any case, several financial support packages were announced. Furthermore, after lengthy and difficult negotiations on 17–21 July 2020, the Special European Council of the EU decided on a multiannual financial framework (1,074.3 billion euros) and an extraordinary recovery effort known as the Next Generation EU (750 billion euros) to support all its member states, including Greece.¹¹⁹ At the same time, the political debate, in Greece as elsewhere, is raging. Opposition political parties voiced criticism of the reasons that allowed the second wave to swell, of how specific issues, such as the reopening of schools, were managed and of the size and timing of the economic support measures.

¹¹⁶ "Protocol for Arrivals in Greece." Gov.gr, accessed 10 September 2020, <https://travel.gov.gr/#/>.

¹¹⁷ Anastas Philalithis, "Η πανδημία του κορωνοϊού: Πρώτες σκέψεις για την επόμενη μέρα," *Nea Kriti*, 27 April 2020, accessed 10 September 2020, <https://www.neakriti.gr/article/apopseis/1575645/i-pandimia-tou-koronoiou-protos-skepseis-gia-tin-epomeni-mera/>.

¹¹⁸ European Commission. European Economic Forecast, Summer 2020, accessed 10 September 2020, https://ec.europa.eu/info/business-economy-euro/economic-performance-and-forecasts/economic-forecasts/summer-2020-economic-forecast-deeper-recession-wider-divergences_en; "IMF Forecasts Devastating Recession for Greece in Coronavirus-stricken 2020, Implosion of 10%," 14 April 2020, accessed 23 May 2020, <https://www.naftemporiki.gr/story/1589831/imf-forecasts-devastating-recession-for-greece-in-coronavirus-stricken-2020-implosion-of-10>.

¹¹⁹ Special European Council, 17–21 July 2020, accessed 10 September 2020, <https://www.consilium.europa.eu/en/policies/the-eu-budget/long-term-eu-budget-2021-2027/>.

Finally, a discussion of the Covid-19 pandemic would not be complete without a reference to its global dimensions, to the role of the WHO, especially after the United States decided to withdraw from the organisation, to the designation of any vaccine produced as a global public good and to the threat of a looming geopolitical conflict. A thorough discussion of these issues is beyond the remit of this article. Suffice it to say that the “new normal” will be very different from the world as we knew it. This brings to mind Rudolf Virchow’s 1848 maxim that “medicine is a social science and politics is nothing else but medicine on a large scale”.¹²⁰ Some 172 years later, this saying has returned with a vengeance, either to inspire us or to haunt us.

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Disclosure

The author worked as an adviser to the minister for health in 1979 and was a member of the executive committee of the Central Board of Health (KESY) from 1982 to 1985. From 1986 to 2019 he served on several committees, boards and councils of the Ministry of Health and of KESY and participated as Greek delegate, invited expert or adviser in councils, committees and workshops of the World Health Organization (WHO) and of the European Commission.

¹²⁰ Johan P. Mackenbach, “Politics is Nothing but Medicine at a Larger Scale: Reflections on Public Health’s Biggest Idea,” *Journal of Epidemiology and Community Health* 63 (2009): 181–84.