

THE PROBLEMS OF THE GREEK HEALTH SYSTEM DUE TO THE ECONOMIC CRISIS

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Abstract

The magnitude and intensity of the impact of the crisis requires alternative policies, which must have a design based on criteria of effectiveness of interventions and equal access so that the patient as a final recipient enjoys high-quality services, even in times of economic crisis. Appropriate transparency and internal control can help optimize the exploitation of scarce resources, making it an antidote to the economic crisis. However, the fist and the will to change are always the basis for the success of any ventures.

Introduction

The global financial crisis has found most of the EU Member States unprepared and frail to meet the demands of the new economic reality, which has affected all areas of public policy. Regarding social policy and health policy in particular, most health systems have faced major reductions in their budgets as a result of the economic crisis. In particular, some governments have reduced the amount of public health resources, either directly or indirectly, by limiting public participation in the provision of specific health services. At the same time, in an effort to reduce the cost of public funding, they have reduced payments to health service providers, or even merged with structures, reducing hospital beds, and reducing jobs for healthcare professionals. An indicative of the impact of the economic crisis on international health policy is that since 2007, 18 of the 28 EU Member States have experienced a reduction in health expenditure (Eurofound, 2013).

In this context, Greece is unable to cope with its fiscal deficit and the current account deficit - also known as the twin deficit - in order to make its debt sustainable and in order to adopt a national plan, which included financing it by an external support mechanism, subject to a series of fiscal adjustment measures (European Commission, 2010). These measures were primarily aimed at reducing public spending through a series of structural reforms in the wider public sector, notably through reducing wage costs, increasing retirement and tax obligations for citizens, and reducing social benefits (Matsaganis, 2011).

The impact of the crisis on the health system

The high private health costs, the high number of physicians and the disproportionate number of general practitioners and nurses which are unevenly distributed in the country, are the some of the main characteristics of the Greek health system over time (Groewnewegen & Jurgutis, 2013). At the same time, high public health expenditures - at least in relation to the strengths of the economy - and inherent structural, organizational and operational problems are observed within the system well before the crisis (Kyriopoulos, 2000). Thus, with the onset of the crisis, these failures gradually worsened the quality of health services provided, while the big rise in unemployment rates and the dramatic decline in family incomes increased the demand for public health services by testing the limits of the system. However, despite the fact that many of the

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measures adopted were necessary to rationalize the health system and address the distortions of the past, speed of implementation, poor planning and the absence of a universal reform request substantially undermined their success and did not allow the system to meet its objectives and citizens' needs.

The Fiscal Adaptation Program, set as primary public spending target 6% of GDP (maximum), thus has reduced the total health financing from €23 billion in 2009 to €14.4 billion in 2015 and the public health expenditure respectively, from €16 billion to €8.7 billion. At the same time, a remarkable decrease was recorded in public pharmaceutical expenditure, which from €5.1 billion in 2009 reached €1.9 billion in 2016 as a result of a series of rationalization measures such as mandatory e-prescription, drug price reduction, callback mechanisms and mandatory rebates, changing the supply system in hospitals and increasing patient participation in costs. In particular, institutionalized patient participation increased to 26.4% in 2014, from 14.8% in 2012, and private participation reached at 29.3% in 2014, from 20% in 2009 (Siskou et al., 2014).

At the same time, social health expenditures show an average annual reduction in the first six years of the crisis of 6.6%, thus shifting the burden on hospitals and pharmaceutical care to the already burdened households (OECD, 2016). However, while public healthcare demand for public health services has increased, public hospital funding has fallen from € 6.9 billion in 2009 to € 4 billion in 2015, and according to the latest OECD data, total public health expenditure per capita in Greece is 52.1% lower than the rest of the European Union (OECD, 2016).

One of the effects of the economic crisis on the health system is that vulnerable social groups (unemployed, elderly, immigrants, etc.), unable to cover their health costs privately, address the public structures and, above all, the hospitals, thus reducing visits to hospital afternoons and private doctors (Economou et al., 2014; Simou & Koutsogeorgou, 2014; Kondilis et al., 2013). More specifically, within five years of the crisis, the proportion of people with low incomes who failed to meet a medical need doubled (from 7% in 2008 to 13.9% in 2013) (Karanikolos & Kentikelenis, 2016).

At the same time, in the context of structural reforms and better management of resources, public hospital structures are merging, which, coupled with reduced public funding for hospitals, appears to have hampered access to health services by restricting their delivery points and on the other hand, their quality, given the great demand and deficiencies that prevail (Minogiannis, 2012; Xenos et al., 2017). Similarly, incomplete reform in primary health care has limited the choices available to citizens because it has led both to a reduction in the number of doctors in public structures and to a sharp reduction in the coverage of care provided by contracted private doctors. With these developments, it is reasonable that the scientific discussion focused on the impact of the economic crisis on health and health services in an effort to look at the extent to which the causal relationship between them is confirmed in the Greek case, of unmet health needs (Liaropoulos, 2012; Kentikelenis et al., 2012).

More specifically, it has been reported that older people and patients with chronic illnesses encounter greater difficulties in accessing treatments and health services, especially when treatment is administered in hospitals (Kentikelenis et al., 2014). In a relevant survey carried out in 2015, about 30% of the population said that while they had a medical need, they did not manage to use a health service compared to the previous year, mainly due to financial difficulties (Zavras et al., 2016).

The most important barriers to access are the difficulty of planning a medical visit due to waiting time or cost, as well as the distance from the hospital where the treatment takes place. Disparities in access to health care have also been reported in patients with cancer. In a related study conducted in 2014, 31% of cancer patients faced problems in access to their treatment in the last year, while 51% failed to schedule a medical visit in time and 44% could not cover the cost of visiting a private individual physician (Souliotis et al., 2015).

In the case of the Greek crisis, although the debate on the extent to which the impact of the austerity policies that have been implemented on the health level of the population is still open, the empirical reality shows areas where budget cuts have direct effect. In particular, a large increase in large-scale epidemics (such as malaria, the West Nile Virus, H1N1) is reported in 2010, with HIV infection among intravenous drug users rising 33 times more from 2010-2013, mainly due to of the reductions in the budgets of the work programs for vulnerable social groups (Bonovas & Nikolopoulos, 2012; Paraskevis et al., 2013).

In addition, economic dysfunction has been found to be negatively related to mental health (Efthimiou et al., 2013; Giotakos et al., 2011; Zavras et al., 2012). Findings suggest that people experiencing financial difficulties are at three times more at risk of experiencing a serious psychological disorder, regardless of their income (Efthimiou et al., 2013). Thus, in recent years, the mental health of the Greeks seems to have deteriorated as there is an increase in the use of mental health services of 120% in just three years (Karanikolos et al., 2013; Anagnostopoulos & Soumaki, 2013; Oikonomou et al., 2012).

Furthermore, men aged 25-44, with a higher level of education, married and working actively, are more likely to develop a generalized anxiety disorder. Also noteworthy is the recent debate over the relationship between the economic crisis and the increase in deaths and the number of suicides. The findings of a study on economic change in Europe over the period 1979-2007 argue that for every single percentage point of unemployment increase there is an increase of 0.79% in suicides and homicides (Stuckler et al., 2009; Falagas et al., 2009).

Moreover, a further study found that a 1 percentage point increase in male unemployment was associated with an increase in suicide by 0.72% (Reeves & Stuckler, 2015). In addition, in a study of the frequency of suicide attempts and its relation to unemployment, it was recorded that the percentage of women was at least twice as large as men, while 15.34% reiterated the attempt at the same time and 75 % within 2 years (Fountoulakis et al., 2015).

However, the prevalence of suicidal ideation and suicide attempt has been reduced in recent years to levels close to the pre-crisis levels despite the increase in depression rates (Economou et al., 2016). At the same time, although a reduction in overall mortality is observed in literature, deaths from adverse events in medical care, digestive disorders and complications during pregnancy and childbirth are statistically significant (Laliotis et al., 2016).

On the other hand, the period of the crisis also shows some positive effects, the reduction of cardiovascular disease by 4.7% on average per year and death from road accidents (Filippidis et al., 2017; McKee & Stuckler, 2016). An important role in this direction has been the gradual reduction of smoking, the increase in exercise and the limitation that this has led to sedentary life as well as the small change in eating habits with the increase in consumption of fruits and vegetables (Filippidis et al., 2017; Tarantilis et al., 2015; Dom et al., 2016).

As a result of the economic crisis, the level of services provided to the patient was altered and decreased. The state, for its part, is committed to maintaining the health status of a free social commodity and its assurance of basic medical care that responds to modern medical data. The need for a fair distribution of limited financial resources becomes all the more pressing in times of economic recession.

New health policies were born in the spirit of the crisis, which aimed, among other things, on limiting pharmaceutical spending and reducing public health insurance. To this end, the state has moved on with the mandatory application of e-prescription to control super-immunity, while setting a limit on permissible drug bundles per month. By creating a protocol that recommends specific pharmaceutical formulations, depending on the patient's history and laboratory test prices, and by adopting a law obliging physicians not to prescribe original but generic medicines, the goal is to greater savings. If the prospect of a generic Greek pharmaceutical industry is added to it, the benefit is double, as this is the attempt to keep capital in the domestic industry for re-use in the Greek market over time.

Also, in the effort to save public spending, insured persons are invited to contribute with higher participation rates while at the same time decreasing drug prices as well as the profit rate of pharmacists. At the same time, non-compensation policies on social security for certain drugs, the so-called "off-list", were needed, while some others now require special confirmation from the medical practitioner in order to compensate or even prescribe only a doctor of specific specialty.

In a further effort to reduce spending, the consolidation in 2011 of most of the insurance funds under a common large body (National Health Service Organization) was attempted to respond in order to have a single administration and central planning-organization. Today, and always in the spirit of saving resources, the insurer of EOPYYY pay for each recipe made 1 € in favor of the insurer in order to ensure the viability of the Agency. Mergers also took place at hospital and service levels or, in some cases, even closure of these units, always aiming to reduce the costs of shrinking administration and staff, reducing fixed accommodation and operating costs (Simou & Koutsogeorgou, 2014).

A significant shortage of Greek health system is the absence of a formal patient information system on the performance of health units. Consequently, neither risk nor comparison can be made. On the contrary, information is made by the mouth to mouth and is not documented. As a result, the user does not facilitate his / her choices and the suppliers have no incentive to improve their performance. Obligatory should be the use of diagnostic and therapeutic protocols. Failure to observe them will also entail similar consequences (Geitona & Kyriopoulos, 2000).

Increasing age limits, the advancement of medical science and technology and the emergence of new diseases by increasing health spending have raised the question of the sustainability of health systems. Greece is one of the countries that spend a lot on health, with the public spending department being considered one of the lowest in the OECD countries. The main sources of financing according to the Geitona & Kyriopoulos (2000), is the social security (mainly contributions from workers and employers) and general taxation and private insurance participates in micro rate, although increasingly growing. Observed the paradox that as it enlarges the concept of health, beneficiaries and scope of the right in the negative, but the positive side, the reasonable of fiscal health related and more the pervasiveness of private sector increased to all degrees of supply (Geitona & Kyriopoulos, 2000).

The multifaceted nature of health in terms of its structure and its impact on other areas necessitates not only the accounting but also the economic valuation of its costs. Examples of the past, particularly in times of financial crisis taught us that cuts in health weaken the system and add the health crisis can have more long-term impact of the financial crisis. Responding to this unfavorable development is the policy of introducing health insurance for the poor, extensive preventive policy, rationalization of the system, and concurrent policies to support the weak. The combination of private and public health services, especially in an uncompetitive environment, raises a two-fold inequality: the downgrading of public sector services and the diminishing of the overall system's efficiency, while increasing its costs.

Disparities in accessibility and the use of health services arise where market forces prevail and where demand and supply balancing are centered. Recognizing the principle of equality in patient access to health goods and services has led to the development of social security and / or the financing of health spending through the state budget. Patient and dysfunctional primary care has led to increased spending on treatment, expansion of the private sector, resulting in higher prices, rising household spending and an increasing gap in access to health services and ultimately a lack of confidence in the public system. It is therefore necessary to reorganize pre-hospital care, which will prevent more expensive therapies, operate competitively towards the private sector, reduce price inflation, exploit medical potential, strengthen household incomes, will smoothly link primary to hospital care and strengthen prevention by providing quality, security and economy (Patelarou, 2011).

The high debt of the state, in relation to insurance funds and providers of health goods and services, reinforces the under-funding of the system, the interrelationships and the possibility of securing it. The debts of insurance funds to public hospitals and the debts of the latter to pharmaceutical companies, as well as parallel exports and the lack of public sector computerization, make it more difficult to measure expenditure. The state must repay its debts to the funds and its suppliers in a timely manner, drawing up true and credible budgets (Patelarou, 2011).

One step towards change is the effort to integrate health funds for reasons of administrative flexibility and economy, strengthening their role in shaping the health market. Their active intervention in the healthcare market would promote healthy competition by choosing the most advantageous service providers. Producers' compensation should also be based on the value of the results achieved. In shaping the competitive market in the health sector, public bodies could also be involved through the creation of market volumes. Thus, with the development of competition and the increase of quality, while price reduction and given the validity of Law 4213/2013, the outflow of resources abroad for the purchase of services and of health goods with potential input from abroad (Patelarou, 2011).

It should be noted that health is an incomplete market, because the physician, because of the authority he possesses, decides on the therapeutic actions, but at the same time provides them. Also, the assumption of health costs by third parties (state or insurance) may lead to an increase in demand for health goods and services. The importance of the supply of goods and the payment of services by a third party often causes a lack of competitiveness but also overexploitation, increasing prices in health services as a result of the reduced price of the patient consumer (Karabelas & Cafcas, 2011).

The reforms that have been made in Greece have focused on the reorganization of primary health care through the establishment of the National Primary Health Care Network (PEDY). At the same time, measures have been taken to compensate for the access problems of uninsured citizens, such as the introduction of the health voucher and the universal access to the PEDY, regardless of the individual's insurance situation.

According to the recent health reforms, the new EOPYY will be called PEDY, ie the Primary Health National Network. Unlike the hospitals that will be the secondary network, EOPYY now functions as a healthcare provider, not as a provider. Essentially it will be an insurance instrument. The staff were made available and will belong to the Greek Government. Those physicians who choose to work full-time should close their surgeries. Apart from the above additional key points of the PEDY are the following:

1. Focus the EOPYY to become more efficient and less bureaucratic in its role as a healthcare buyer in conjunction with the abolition of its role as a buyer.
2. Development of a health care system in Greece, which comes from the services of EOPYY and NHS. The objective is the rational management of structures, human resources, doctors, nurses and other health professionals.
3. The EOPYY service providers are integrated into the structure and operation of DY.Pe. Excludes pharmacies of EOPYY which remain in the organization.
4. In relation to the exercise of the profession of family doctor, the only persons who can practice it are doctors of general medicine, pathology and pediatrics.
5. All staff who are engaged in another occupation are obliged to interrupt activities.
6. The opening hours are from 7am to 7pm. Health structures are shifting from 8am to 4pm and from 11am to 7pm. The timing of medical staff increases, resulting in approximately 30 appointments daily, which in theory will reduce waiting times and long queues in the future.
7. The citizens do not make an appointment, they are addressed to the health facilities of the PEDY during the hours and days of waiting, waiting for the waiting. In each unit, the attending physician will check the incidents and promptly refer the emergency to a qualified

physician. Upon completion of the telephone service, physicians will once again accept the incidents after an appointment other than the emergency, which will take precedence.

8. Prescription to unload the system will refer to family doctors, which will help in the immediate service of the patients. In terms of prescription, the procedures are transparent, speedy and cost-effective.

The PEDY and the DYPE, which are essentially the new health systems in Greece, constitute a clear proposal for the restructuring of health in Greece, but due to a lack of good planning and hasty movements, it lags behind in many areas, negatively affecting health economics, being unfair in relation to its content and function (Bouloutza, 2014).

The PEDY arrangements in relation to hospitals have burdened doctors at the service level while creating an unclear service framework, which also has an increased cost for citizens, since they could not initially find medical care at the polytheists, were all crowded in queues of hospitals, bearing in mind that they are also likely to pay a small fee, but it is difficult for them to deal with in the crisis, but it is difficult for them to face the crisis.

The aforementioned price was not paid in the first place, but there is a general lack of clarity about the future. The main problem is that at present the resources for public hospitals have been reduced, that there is essentially a transition to the other end, from over-employment to underemployment, which poses the risk of primary structures collapsing. The basic financial cost to the insured person is the cost of visiting a private doctor, as with the dismissal of external doctors and the weakening of the health care system, people must, especially those who want constant monitoring, visit private doctors to watch them, which creates an extra cost. At the same time, physicians have an increased cost because they can no longer work in the public sector and have a doctor's office, which greatly reduces their income.

This situation increases on the one hand the cost for the patient who only needs 3 or 4 different doctors to prescribe it, while on the other hand you create a gap in public primary care units, which is likely to be covered by young people and less experienced doctors who will not be so productive until they have the necessary experience, and will also cost the education system.

Another important cost for the patient and more for the National Health System is the prescription ceiling. Specifically, the prescription ceiling imposed on doctors puts a monthly limit on how many prescriptions they will issue and if they overdo it automatically locks for their e-prescription system. The overhead of a general discussion of improving or abolishing it greatly increases the cost of health for the patient and for all involved.

Conclusions

A severe economic crisis such as this one, has a serious impact on the health of citizens by increasing rates of suicide, depression, transmitted diseases such as AIDS while creating uninsured due to the continuous increase in unemployment, burdening the operation of public units' health services due to increased demand, and thus threatens the viability of private insurance companies. Society and the welfare state are experiencing the limits of their resistance on a daily basis by trying to manage rising demand with reduced budgets for health.

On the other hand, this is an important opportunity for national understanding of policies and reforms that have been inactive for decades. The economic crisis is considered to be a catalyst that will promote reforming and improving healthcare changes, which have been postponed for many years before the crisis. In this context, the adverse environment should be transformed into supportive care by means of appropriate modernization steps.

The magnitude and intensity of the impact of the crisis requires alternative policies, which must have a design based on criteria of effectiveness of interventions and equal access so that the patient as a final recipient enjoys high-quality services, even in times of economic crisis. Appropriate transparency and internal control can help optimize the exploitation of scarce

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