interlinks

Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Prevention and Rehabilitation within LTC

Greek National Report

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CMT PROOPTIKI | 50+ HELLAS

Athens, 2010

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SEVENTH FRAMEWORK PROGRAMME

Funded by the European Commission
under the Seventh Framework Programme
Grant agreement no. 223037

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1 Introduction/Background

1.1 Demographic starting point

The percentage of older people in Greek society, as in the rest of Europe, is getting higher and higher (WHO, 2009; Fujisawa and Colombo, 2009). Prevention, public health programs and care have prolonged life, transferring the age of sickness to a later age (Commission of the European Communities, 2008). In 2007 the proportion of over 65 year-olds in the total population was 18.6% amounting to more than 2,082,000 inhabitants (Eurostat, 2008). Life expectancy at birth in Greece in 2008 was 79.52 years, being one of the highest in Europe (WHO, 2008). Since 1998, the total number of residents aged 65 years and over exceeds the total population from 0 to 15 years. The leading causes of death of older people in Greece are cardiovascular and ischemic heart diseases, cancer and respiratory infections, whereas in the sixth position come injuries.

Long-term population projections for 2050 indicate a further increase in the proportion of older people in Greece, and a significant increase in the proportion of the population aged over 80 years, estimating that 58.8% of the population of Greece is expected to be at retirement age in proportion to working age population in the year 2050, and 13.1% is expected to be 80 years of age and over (Huber, 2007).

1.2 Very brief description of how national LTC is organized and delivered; strengths and limitations to be considered

Long-Term Care is defined as: "*The system of activities undertaken by informal caregivers (family, friends and/or neighbors) and/or professionals (health and social services) to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation, personal fulfillment and human dignity*" (WHO, 2000).

Long-term care (LTC), in this paper, includes the range of services provided to people who need assistance for Instrumental and/or Personal Activities of Daily Living (IADL AND PADL) for an extended period of time due to age, chronic conditions or mental disabilities (Grammenos, 2005). This help may be provided through supportive services such as care at home, for people with needs in everyday activities, or in an intensive way through residential, acute or long-term hospital care (Huber, 2007).

According to the Esping-Andersen's typology of welfare state regimes, Greece belongs to the Mediterranean welfare regime or the family-based long-term care model (Reimat, 2009). The main characteristics of this model are the high contribution of the family, which sometimes takes the form of co-residence, and the weak public or private supportive services (Reimat, 2009). Around 80% of older people own their residence, 30% are still living with at least one of their children (co- residence index) and a low percentage (variously estimated as between 1.5%-3.5%) live in residential homes. Nowadays women are entering dynamically into the labour market, especially in urban areas, thus the traditional role of women as unpaid family carers tends to be replaced by paid migrant informal carers (Huber, 2007; Fujisawa and Colombo, 2009). Although private care is costly, as reflected in the

proportion of national expenditure for LTC, it is the obligatory substitute for the insufficient public care services (Huber, 2007; Woittiez et al, 2007; Reimat, 2009).

1.3 Cultural context

Strong family bonds in Greek society are not the only reason for high informal care. Traditionally male children used to live near or in the same house with their parents, as they kept on the culture of farming the land or breeding the herds. In those societies the older people were looked after by their children or children-in-law, with no public care except that of a GP or a hospital. The sudden increase of the population which led to a high rate of urbanization, in combination with the lack of formal structures of LTC in the newly-built cities, left a gap of care in the modern health care system. Although Greece has still a relatively low participation rate of women in the labour market, modern women refuse or are unable to undertake the traditional role of the family carer. Although 30% of older parents live with at least with one of their children, informal care is also sought through migrant women who sometimes live with the older person (Fujisawa and Colombo, 2009). The other solutions for care are through public Help-at-Home services or residential care homes, public or private.

As long-term care is one of the most labour demanding sectors of health care, public expenditures are not focused on long-term care, making the hospital beds for LCT rare and valuable (Reimat, 2009). In a country with a very high ratio of doctors per capita (5.4 practising physicians per 1000 population) and a much lower rate of nurses (3.2 per 1000), and with the greatest proportion of expenses in healthcare coming from private insurance and own contributions (40%) compared with the other OECD countries, it is challenging to alter a medically-centred health system to a patient-driven national network of services (Tountas et al, 2005; Liaropoulos et al, 2008; OECD, 2009, Lionis et al, 2009).

1.4 Brief discussion of current political context: How are issues of LTC/prevention/rehabilitation being discussed?

Greece faces the same difficulties as the other European countries concerning legislation and financing of LTC. Many stakeholders participate in a system where financing leads legislation, depending on professionals' ability and need to supply rather than consumer's needs. There is a loose link between cure and care instead of a bond and a continuity (Lionis et al, 2009). Cure is the primary obligation of the health services, whereas care is provided predominantly by the social services. There are gaps and overlaps between services of the social sector; a variety of services are provided and controlled by authorities in different sectors (institutional, public, private or non-governmental) and at different levels (local, regional, national).

Important steps have been planned using European co-funding and collaboration towards a common European health strategy, although funding problems have limited the implementation of the ambitious plan. Current health policy is orientated towards a flexible, low cost health system that especially supports people with low income, but leaves plenty of opportunities and initiatives to the private sector and the NGO’s (Ministry of Health, 2008).

This paper considers the issues of prevention and rehabilitation in a descriptive way. It will present the current prevention and rehabilitation services of the different LTC structures, making some references to the past and providing insights for the future. From this point of view direct comparisons with other countries will not be sought except in distinctive cases.

Prevention is primary when it avoids the development of disease e.g. through vaccinations, information, lectures, consultations or presentations on subjects around health, as well as by the promotion of active ageing through programs of exercise, dietary advice, stopping smoking etc., as well as excursions, social events or other opportunities for increasing well-being and quality of life. Secondary prevention is the screening of the population for early diagnosis of illness.

Rehabilitation is the restoration of function, which may occur despite physical or psychosocial disability. It intervenes in the disability process of impaired people to prevent them from becoming handicapped. It is implemented, ideally, by a multidisciplinary team coordinated by a physical medicine physician, and including physiotherapists, ergotherapists, social workers, rehabilitation nurses, speech therapists and psychologists.

2 Current mainstream practice of prevention and rehabilitation within LTC in Greece related to different care settings

2.1 Living in the community

Nowadays, a variety of local services on prevention and rehabilitation within LTC exists for older people living in the community. This 'network' aims at the physical, mental and social support of older people and consists of the following services:

2.1.1 The Open-Care Protection Centres for Older People (KAPI)

Their aim is to offer support and protection in the familiar environment of the community and avoid admissions to any kind of institution. The core personnel of a KAPI is a social worker who is the team leader and co-coordinator, a nurse or health visitor, a physiotherapist and/or an occupational therapist and a cleaner. The focus of the work is on the prevention of biological, mental or social problems of older people, so that they may remain active and autonomous in the society. Membership of the KAPI is voluntary and a nominal yearly fee is charged, which may be waived in cases of financial hardship. The co-operation and affiliation with other public, voluntary or non-governmental organizations, is common and desirable in order to focus on and resolve aspects of health promotion and possible problems of everyday life. Primary prevention (including vaccination and information on health issues) as well as secondary prevention (including medical examination and investigation for the early detection of illnesses) should be done systematically in the KAPIs and research is facilitated in the population they serve. Links with the other local health and social care services have also been developed and the various multidisciplinary teams interact so that older people have access to a network of health services, while still living in the community. Rehabilitation is integrated among the services provided.

Staff shortages and insecure and inadequate funding are the main reasons for some KAPIs not providing the full range of services they were designed to offer. Another drawback is based in human psychology; KAPIs are designed and identified as centres for ‘protection’ of older people and many older people choose not to enroll in KAPIs, as they refuse to identify themselves as older people that need protection. The issue of age discrimination is raised and a different approach is now being adopted. By different activities such as story-telling to local nurseries, traffic control to schools etc, KAPIs are now trying to integrate and develop closer links between older people and the younger generations, encouraging the positive interaction between the elders’ wisdom and the impulsiveness of the young.

2.1.2 The Friendship Clubs (LEFI)

The Friendship Clubs give the opportunity to older people to socialise, to learn and have a good time. Staff consists of social workers, physiotherapists, nurses, administrative staff, assistants and technicians. Their program includes groups of active participation, physiotherapy, excursions to historic places and presentations, theatres, museums, exhibitions and other cultural happenings. They offer support and consultation on health, social or personal problems linked or caused by age,

especially to people without family support. They co-operate with public services, Universities and NGO's offering lectures on the prevention of problems relevant to ageing. They were created in areas and neighborhoods that did not have KAPIs such as the Municipality of Athens, where health care is partly provided through the Municipal Health Centres, with the aim of providing recreational and support services in a more economical way. Nevertheless there is a common request of LEFIs to become KAPIs as integrated health needs are not met.

2.1.3 Help-at-Home

Help-at-Home is a social protection program, similar to those of the Scandinavian countries and the UK. It aims at the provision of structured and systematic help and support to older people and people with kinetic disabilities. Figures for 2009 indicate that 120,000 people were supported by 4,500 health and social care professionals. The teams consist of social workers, sociologists and psychologists who supervise the service, evaluate the cases, offering their support and referring them to the appropriate speciality or service; nurses who offer primary care, drug prescription and health supervision; home care attendants who do the shopping, the cleaning and the care of the house. The aim of the team is to support frail people in their own familiar environment, avoidance of hospital admission and securing the quality of life.

The staff of all the above local supportive structures has been recently trained in the management of people suffering from chronic and incurable illnesses, including dementia, in an effort towards higher quality provision of care and the inclusion of a larger population in the above kinds of service. There should be a close co-operation, communication and co-ordination with the local KAPIs and LEFIs, giving a patient-centred characteristic to services that follows the older person through the different stages of health and autonomy in the community environment. However, insecure finance and consequent understaffing are the main barriers for the full and appropriate function of these services in the provision of integrated care for older people in the community, thus restricting prevention and rehabilitation within LTC in the above settings.

2.1.4 NGOs

There are several non-governmental organisations that support prevention and rehabilitation of people within LTC, each one focusing on different aspects of health, including:

- Fifty plus Hellas : supports people over 50 years old with information on health issues and other measures to promote social inclusion and improve their quality of life.
- Hellenic Red Cross: the programs of Gerontology, Home-Nursing and Help at Home of the Hellenic Red Cross were the first to be established as home-care services for older people in Greece and continue to provide both preventive care, long-term care and rehabilitation to people enrolled in these programs. Other activities include the training of volunteers and regular missions on health awareness and early detection of illnesses, focusing on different target groups in a great variety of health subjects.
- TANDEM: focuses on people with mental or physical disabilities and their incorporation into society.
- The Federation of Greek Alzheimer Associations consists of a network of associations focusing on the support of people with Alzheimer disease and their carers.

- Hellenic Foundation of Support for People with Osteoporosis: a newly founded organisation that sensitizes and examines women for osteoporosis free of charge, offers lectures, support and guidance.

The experience and human resources of these and many other NGOs are being targeted by the Ministry of Health for incorporation into future policy for public health (Ministry of Health and Social Welfare, 2008).

2.1.5 Lifelong Learning

Public institutions such as the National Library, The National Lyric Scene and NGOs such as the Civilization Centre "Stavros Niarchos" work on the promotion of active and healthy ageing. Following the idea of continuous and lifelong learning, not only do they offer unlimited access to material and knowledge, but also through organised seminars, they aim to become centres of spiritual growth, recreation and relaxation. Some of the free educational programs they offer include gardening lessons, literature lessons, drawing and music lessons.

The above services and programs are free and aim to support and improve the life quality of people of all ages, including older people.

2.2 Different kinds of intermediate care settings (intensive home interventions, day care, short-term in patient care)

In Greece there aren't many kinds of intermediate settings as yet. The existing policy of reducing length of hospital stay to cover the demand without developing new public hospital beds and reducing the private ones, has left a gap in care (Tountas et al, 2005; Boutsoli, 2007). Despite the existing respective coverage from the private sector, this gap in care will inevitably lead to alternative kinds of care and the development of intermediate care settings (McKee, 2004).

As for intensive home interventions, there are only private services that offer full hospital care at home, such as from "IATRIKO KENTRO ATHINON" and "YGEIA" that set up a hospital environment with laboratory and radiology support in the very bedroom of the client. Full nursing supervision is offered, including ICU equipment if needed, and constant telemedicine services are provided. These services are covered only by some private insurances or by out of pocket payments.

Only a few public hospitals have nursing home-care services, although physicians and nurses do offer such services privately. The aim of the public interventions is to support the patient at home, to support the family, to avoid hospital readmissions and prevent complications. The legislative framework supports the development of home-care services; however specific laws regulating financial matters are making the social security organisations hesitant towards these services. In 2009 most of these matters have been solved; however a subsequent development of such services is still suspended due to staff restrictions (Mpoutsi, 2005; IKA, 2009; Klothos, 2009). An important exception is a new kind of preventive and supportive monitoring to patients with pulmonary problems living in the community, provided by the large public hospital 'Sotiria'. Using telemedicine equipment, nurses and health visitors monitor around 50,000 patients, using an electrocardiograph, a spirometer and a pulse oximeter connected to a laptop. The service aims to prevent hospital

admissions through the provision of monitoring, continuous care and rehabilitation of the patient at home from an early stage of the disease. Inclusion priority is given to socially sensitive groups of patients and especially to older people within LTC (National Documentation Center, 2008).

Public Day-care services exist since 2001, called KIFI (Centres of Daily Care for Older People) and consisting of nurse-led units aiming at the amelioration of the quality of life of older dependent people or people with physical disabilities and their families. Apart from nurses, the KIFIs employ social workers and assistants, trained volunteers and staff from the local KAPIs such as physiotherapists and occupational therapists. There is communication and cooperation among KIFIs, KAPIs, Local Health and Social services as well as with the National Centre of Social Solidarity (EKKA). The average stay in a KIFI is 8 hours, from one to three times a week, but transportation to and from these day-care centres is not included in the service. Public information on the numbers of existing KIFIs, the services offered and the numbers of older people using them is not easily available, although each Municipality gives information on the local services offered through their web sites.

Short-term in-patient care is performed in all public and private acute-care hospital settings for the cure of an acute problem or as an extension of stay of outpatient clinics to patients who need some kind of monitoring for some hours. The service is provided in certain hospitals mainly for rehabilitation and will be discussed below.

2.3 Acute care/hospital settings

Hospital beds in 2000 were 36,700 public and 15,800 private (Tountas et al, 2005).

Acute care in hospital settings is the traditional way of health care in Greece. Primary prevention in the form of vaccination or information on health subjects used to be done in the hospital setting, whereas limited rehabilitation and long-term care used to be done in hospital-like institutions. Currently, prevention and rehabilitation centres, mainly specialized in cancer and drug addiction, are organised as different departments in an acute care or hospital setting. There is not an obvious link between prevention of illness and acute tertiary care/hospital setting apart from the outpatient department where the medical doctor of each specialty follows up an already symptomatic patient. In rural areas where the primary and secondary health care centre is the only health care provider, it is the responsibility of the centre to address issues regarding prevention within the population of its territory (Boutsioli, 2007; Lionis et al, 2009).

Regarding rehabilitation and physical medicine, such services are provided within hospitals with in-patient and outpatient treatment facilities. There are private physiotherapy and rehabilitation centres, throughout Greece, which cover fully or partly the needs. In rural areas mostly private centres cover the needs of the population and the social security fully or partly covers the cost.

The most complete rehabilitation Centre in Greece is the National Institute of Rehabilitation in Ilion-Athens and a smaller one in Patras. It offers treatment for muscular disorders, chronic pain, spinal problems, joint disorders, sports injuries and all the conditions and diseases that need in-hospital care in the phase of rehabilitation. At the tertiary level, these concern diseases of the nervous system, the musculo-skeletal system, the cardiovascular system and poly-systemic diseases. The departments include relevant medical specialties specialized laboratories, a social service, a physiotherapy department, a psychological support team, an occupational therapy department, a biomedical and technological rehabilitation unit, speech therapy department, dieticians, a training

department for people over 16 in carpentry, shoemaking, knitting and, finally, there is a centre of evaluation of drivers with special needs. There is no age or disease discrimination and older people with strokes constitute a proportion of the patients.

Greece has a long way to go towards adequate rehabilitation services, since a total of 200 public rehabilitation beds are insufficient to cover the spectrum of rehabilitation needs from people with injuries to people with strokes or other problems within LTC. Although not all of the cases need in-patient rehabilitation, the need is still not covered by the existing structures and out-of-pocket payment is necessary as social security covers only part of the expenses. For example IKA (the major public Insurance Fund) pays only for a set of 20 physiotherapy sessions. With so few public beds it would be expected for the patients to rotate at a quick rate. However, the outcomes for people who need in-hospital rehabilitation may vary from those whose functional abilities will be fully restored to those with residual minor or major disabilities, who are thus classed as LTC patients. The latter are the most complicated, labour demanding and most expensive patients, who are very difficult to discharge when social problems arise. For their return home or to a LTC setting, special arrangements need to be made and/or informal carers need special training in how to support the patient after discharge. Again the public Insurance Funds do not cover fully the expense e.g. IKA covers only the equipment and one nurse shift per day for a maximum of six months, so that a fully dependent person will need to pay out of pocket expenses, or to have a member of the family trained to care for her/him for the rest of the day and night.

There is a serious gap in care and rehabilitation after discharge from the acute hospital setting for people that are still not or will never be autonomous again, when there is no family to carry the burden, pay the expenses and support this person, as there are no well equipped and relevant structures to accept such patients.

2.4 Care homes (residential and nursing care facilities)

In a rapidly ageing population, mainly private or limited public residential and nursing care facilities provide a variety of services to cover the needs of non-autonomous older people. People who are obliged or choose to spend the rest of their lives in these facilities due to their physical, mental or social needs, are under the prevention and rehabilitation services of each institution. National standards or guidelines on prevention and rehabilitation have not been set, thus a variety of services in different degrees may be provided.

Things become complicated when nursing care or specialist medical care is needed. The above institutions are classed as social care facilities, but have an obligatory ratio of nurses, as well as cooperating with relevant medical specialists, physiotherapists, occupational therapists and other health care personnel. However, if a resident suffers from a contagious illness, tuberculosis, cancer or needs specialised medical treatment, he is referred to the hospital and for some institutions it is forbidden to accept such residents (Presidential Decree 385/1990). When it comes to discharge from hospital, the people with complicated problems and no robust family support have nowhere to go unless they can afford private care. The view of the hospital is that the acute treatment is over and the person occupies a bed in the acute setting that should be used to cure another patient who needs it. The view of the residential care institution is that it cannot respond to the complicated care needs of such a resident (Paparrigopoulou, 2007)

Institutions founded by the Church or other NGOs offer care and rehabilitation to people with severe chronic or incurable mental and physical diseases, with programs that may include training in handicrafts, gardening, social and psychological support, sport facilities, and vacation programs. They usually include a physiotherapy program and volunteers are welcomed to enrich their services. Some relevant colleges and universities have incorporated educational visits to such institutions in their curriculum.

3 The "good practice discourse": How and by whom is good practice defined? How are good practice criteria and models developed, disseminated, implemented?

The supervision of the services provided within LTC exists throughout all levels of public administration, although not as a systematic or obligatory evaluation of quality. Methods of supervision and feedback include the following: Firstly patients opinions may be recorded in different surveys; secondly, the team–leader of the service sets the goals;, thirdly the local authorities provide the license to run the service and set the minimum standards, and finally the Ministry of Health and Social Solidarity supports, checks and regulates all the services in order to plan and apply the governmental policy according to national and European norms and guidelines. Nevertheless, these evaluations are not yet publicly available and quality criteria are not obligatory, but may be adopted voluntarily e.g. by legally registered residential care homes belonging to the Greek Care Homes Association (P.E.M.F.I). International organisations like OECD, WHO, EU, may also evaluate and define good practice by using international standards or criteria, which are usually adopted by the Ministry of Health and Social Solidarity, as they should follow a common European agenda.

The telemedicine unit of "Sotiria" was distinguished with the e-Inclusion award in 2008 and three other programs are described in the National evaluation report of Health PRO elderly for their success.

3.1 Living in the community (care at home)

3.1.1 Action program for older people

An initiative of the physiotherapist and occupational therapist of a KAPI has been to implement a program of physical exercise based on similar programs of the General Secretariat for Sports. It has gained not only the recognition of the people involved, but has also produced significant measurable results, and is projected as an example of good practice. Within the program of a KAPI, lectures and discussions about the role of exercise and health related problems are performed; in the second phase two 45-minute sessions twice a week complete the program. The program is evaluated every 5 years and the results show a 30% reduction of the need for physiotherapy, improvement of the joint functional ability, body balance and neuromuscular control, an overall increase of the quality of life of the participants, increase of their social activities and improved psychological status (Kalokairinou et al, 2008).

3.1.2 The involvement and role of older volunteers in promoting healthy diet for the prevention of cardiovascular diseases

The aim of this project was to initiate the Senior Health Mentoring concept, to train older people to become educators to their peers on health promotion and disease prevention issues. The Ageing Well UK Core Training Pack was modified to suit the Greek population and an English partner counseled the whole project. The result of the program, apart from the three booklets that were published concerning the training package and the satisfied participants, is the creation of the infrastructure so that knowledge and information on prevention and rehabilitation may be distributed to and accessed by older people through their peers. Interest in the program was

expressed by other KAPIs and the same program is implemented following the three booklets' instructions (Kalokairinou et al, 2008).

3.1.3 The role of health education in improving compliance for the prevention of cardiovascular diseases.

The project aimed to educate and persuade older people prone to cardiovascular disease to change their life-style (nutrition, exercise) or intervene on their risk factors (diabetes, dislipidaemia) so as to decrease the prevalence of cardiovascular diseases. The program was applied to the members of two KAPIs and two other KAPIs were used as control. Six months later smoking and body weight were reduced in the intervention group and compliance with secondary prevention (measurement of blood sugar and blood pressure) was increased. Data on morbidity and mortality due to cardiovascular diseases was not yet available, but the project was received with enthusiasm by the KAPIs employees, by older people who participated, by local authorities and the Ministry of Health (Kalokairinou et al, 2008).

There have also been many lectures and public campaigns aimed at women concerning **osteoporosis** and the needed **prevention, early diagnosis and treatment.**

3.1.4 Network of Offices of Social Supporting Services in Crete

According to the good practices of the European co-funded program "Ygeia kai Pronea 2000-2008", around 150 social services were developed throughout the island of Crete. Prevention for older people within LTC is a major part of their responsibility and activity. For better coordination, the upgrading of services and the more complete coverage of peoples' needs, these services were organized as a network through the Social Support Bureaus (KYY) developing channels of communication, co-operation and support and constituting a model for the organization of similar Networks in each Region of Greece. The objective of the networking was to upgrade Primary care services in rural areas mainly for vulnerable social groups at a local level in the Region of Crete (http://www.ygeia-pronoia.gr/home.asp?pg=Dhmosiothta_KP). This need is strongly advocated in the peer review of Lionis et al (2009) on the integration of Primary Health Care.

3.1.5 The EUropean NEtwork for Safety among Elderly (EUNESE)

A seven-step guide to successful interventions for injury prevention among older people (65+) was developed by the Centre for Research and Prevention of Injuries (CEREPRI), Department of Hygiene, Epidemiology and Medical statistics of the School of Medicine of Athens University. This guide, which includes three pilot intervention projects is available at http://www.euroipn.org/eunese. The pilot intervention in Greece concerned the virtual modeling of a safe household environment for older citizens.

3.2 Different kinds of intermediate care settings (intensive home intervention, day care, short-term in- patient care)

In a newly developed network of primary services, the different kinds of intermediate settings that need to exist for the complete support of people within LTC, and through these structures the exercise of prevention and rehabilitation, is still in its infancy in Greece. The development of additional methods of support to cover the needs of older people (Day Centres for social and nursing care, respite care, mobile care units, long-term social and nursing care centres and centres for the care of active dementia sufferers) is still needed.

3.2.1 Creation of a Day-care centre (KIFI) specialized in care of Alzheimer patients in Thessaloniki

The Centre is specialized in the care of older people suffering from Alzheimer disease. The pioneering concept of developing a specialized day-centre was supported by local authorities and organizations. The federation of Greek Associations of Alzheimer disease and related disorders (GAARDA) undertook the scientific supervision of the program, providing training, support and continuous evaluation of the program. Innovative follow-up 'tools' have been developed with important results showing improvement in the intellectual and memory functions of dementia patients. GAARDA also delivers quality day care through 3 day-centres, offering discussion groups, seminars for caregivers and professionals, memory training for patients presenting with early-stage disease, music therapy for patients at all stages, speech therapy and physiotherapy. One of GAARDA's objectives is to raise money in order to build a Clinic where patients in the late stages of AD will get the care they need and it recently obtained some financial support from the Ministry of Culture for this. The Athens Alzheimer Association runs a similar program for the past two years via a Day-care centre in Athens.

3.2.2 Tele-medicine unit of a public hospital

The telemedicine Unit of "Sotiria" Hospital, that monitors the health status, performs clinical tests, takes a complete care at home of old people, was distinguished with the e-Inclusion award in 2008. Nurses and health visitors use advanced technological equipment to file and transmit medical bio-signals, with innovative wearable systems. Teleconferences with physicians at the base-hospital and real time interaction among health professionals and the patient have made possible the follow-up and monitoring of 50,000 patients at home.

3.3 Care homes (residential and nursing care facilities)

Dance and drama therapy run in the residential care home, Aktios (www.aktios.gr) has improved both the mood and satisfaction of its residents, as well as their Instrumental activities of daily living, enhancing their autonomy and reducing their dependency. These activities, among others are carried out in an effort to achieve further development and enhancement of the individual and social skills of the residents. The programme's creation is based on previous individual assessments of the residents, on the levels of communication, functionality and daily living and self care abilities.

Participation in the programs is voluntary, in a closed group with the same participants, which facilitates the expression and the dynamics of the group. The aim of the therapy is socialization, strengthening of movement, initiative undertaking and recognition and expression of one's own feelings. The aim is achieved through free movement and choreography, music, sound production even by using certain objects such as sticks, clothes, balloons etc. In the same vein, drama therapy sessions help old people to cope with their current situation by reviving or replaying roles, imaginary or not. The sessions give them the opportunity to take part in their own stories through different roles, making them realise their own feelings and enhancing their own self-understanding. Again objects such as hats, clothes, masks or wigs help the participants achieve a more dramatic and intense role-play.

The specific therapy programs have become very popular and other residential homes have asked to include them in their programs.

4 Special topics

4.1 Social inequality: equal access, age, gender and diversity issues

Greece is divided into 52 health regions. Although there is a central policy, health provision is adapted to the regions' special characteristics and needs. Prevention and rehabilitation within LTC is provided differently in urban and rural areas giving a fragmented image of LTC benefits and services (Kaye, 2007). The mixture of private and public providers that may supply such services is denser in urban areas than in rural areas, especially in islands or in mountainous regions (Tountas et al, 2005; Kontodimopoulos et al, 2006). Major barriers preventing equal access to existing health care services may be lack of information on available support, low quality or inadequate coverage, the bureaucratic complex procedures to get free access to them and their high financial costs (Commission of the European Communities, 2008).

Regarding the issue of equal access, non-discrimination in age, gender race or religion is a priority for past and the current health care policy (Ministry of Health and Social Welfare, 2008). However, data on non-discrimination is not available, as this data is not collected due to confidentiality and the current non-discrimination policy according to which provision of service is free-to-user, and the only priority criterion set is low income (European Foundation for the Improvement of Living and Working Conditions, 2007).

The only reported issue of inequality regarding prevention and rehabilitation within LTC is the unequal opportunities of access of the same services for people living in rural areas or remote islands. In urban areas, older people have access to public hospital outpatient departments and the primary health care facilities of their public Insurance Fund, whereas those with private insurances or who can pay have a choice of private polyclinics, private health-care professionals and diagnostic centres that also provide medical consultations. Older people in rural areas served by the network of Primary Health Centres have access to relatively comprehensive primary health care services; however, in many remote rural areas the only health-care provider is a single, newly appointed and less experienced medical doctor, who has among others the duty of primary care and coverage of the local population, sometimes without laboratory support. For secondary prevention or rehabilitation elder people may need to travel to the closest city (Tountas et al, 2005; Lionis et al, 2009).

Another indirect but major inequality of accessing prevention and rehabilitation services within LTC is finance. In Greece there are 34 different insurance funds providing a wide variety of services with different systems of co-funding that facilitate or block access to those services. A partially successful effort of the government to unify these different funds has provoked a major reaction of the wealthier funds opposing this decision. Finally, the illegal but widespread practice of under-the-counter payments to health care providers to ensure speedier, better or a more personal service has become increasingly 'accepted' as a norm of health care over the past years, along with similar practices in many other areas of public service (Liaropoulos et al, 2008).

4.2 Involvement of older people in developing prevention and rehabilitation

The involvement of older people in developing prevention and rehabilitation is effected through two social roles. The first one is the role of the consumer, who needs, requests and either freely receives, co-pays or pays the full cost for such services. The second role is the administrative one, as older people, being represented in the board of KAPIs have a voice and may decide on the provided services and their development. Lastly, as seen in the good practices section, older people may acquire a third role, as they become the co-providers of such services, being actively involved as health mentors in health promotion (Kalokerinou et al, 2008).

4.3 Quality assurance

Quality assurance measures, not only in terms of patient satisfaction but also as the existence of multiple and multilevel mechanisms of controlling and ensuring quality of the services provided, are obligatory to provision of effective and efficient services. Prevention and rehabilitation in Greece are still in their infancy and mainly provided through contracts of the public health insurance system with public or private health-care providers, as well as to people that can afford such services with out-of-pocket payments. The system currently uses the 'fire-extinguisher' model of examining complaints and setting fines rather than guiding, facilitating and systematically controlling provision of services (Tsamis, 2003; Kazepidis, 2006; Scordilis, 2008). Although, specific standards for services concerning prevention and rehabilitation have not yet been set, such mechanisms are described in the National Action Plan for Public Health. Quality assurance is one of the aims of the National Action Plan. As it is described, the standards of health care provision are set in order for a continuous system of qualitative care and rehabilitation to be provided throughout the health units of the National Health System (Ministry of Health and Social Welfare, 2008).

4.4 Informal carers' needs and contributions

Informal family carers in Greece carry the biggest burden of LTC: it is an accepted norm within the cultural context of Greek society and any sensitivity towards the public support of family carers has not been developed (Woittiez et al, 2008). However, the social phenomenon of 'abandoning' older people in hospitals, residential homes or other institutions is continuously increasing (Dama, 2005). A characteristic example drawn from cancer research shows the lack of carers' support in end-of-life care, which may reflect their overall lack of support. Although 70% of patients with cancer express the wish to die at home, there is an increasing trend for people to die in hospital, from 50.8% in 1993 to 56.8% in 2003 (Mystakidou et al, 2009). The application of the National Strategy for Public Health is expected to reduce indirectly the costs of care for chronic illness and disability; however it does not include any of the supportive services and benefits for carers seen in the UK, Ireland, the Netherlands and most other EU countries (Ministry of Health and Social Welfare, 2008).

The network of community care and support services for people with LTC needs is expanding, although still very limited, and carers are becoming more familiar with the available types of services and increasingly seeking their support. Although utilisation is still low, with less than one third of carers using a support service in the first half of 2008, it is greater than the 10% of use in 2005 (EUROFAMCARE, 2005; Commission of the European Community, 2008). Very few services are aimed at or technologically equipped for systematic and regular use for respite care, socio-psychological support and information specifically intended for informal carers in Greece. Information, advice and socio-psychological support are usually sought from the Medical Doctor of the patient in public or

private facilities. A common practice is the use of the hospital as a substitute for missing rehabilitation and respite care, or a place to leave a person in LTC when the carers leave on holiday.

Finally, the rapidly increasing use of privately paid migrant care workers can be considered a major resource for family carers with the means to pay, who are not able to supply the hands-on care required by their family members with LTC needs. The employment of a legal or non-legal worker to live in with the older person, or work on a daily basis, represents a flexible solution to individual care needs, which remains under the supervision of the family, despite the obvious drawbacks of this type of informal care. The issue is explored further in the Greek National Report on Informal Care and the European Overview paper on Informal Care in the LTC system.

5 Governance and financing

The Greek National Health System, as it was established in 1983 and reformed in 2001, aimed to increase public health resources, organize a decentralized health care administration, develop primary care services, amend hospital care and control the private health sector (Tountas et al, 2002; Tountas et al, 2005). Evaluations of the National Health System in 2007 by Tountas et al and by Aletras et al have concluded that there was more to be done and the initial goals had not been met. Taking into consideration the European policy for a socio-economic balance, with qualitative public services, with controlled and rationalized expenditure, meeting the public needs for increased investments in healthcare and welfare services, and taking into account the aging of the population and the characteristics of contemporary diseases, the Greek Ministry of Health and Welfare released in 2008 a National Action Plan for public health (Aletras et al, 2007; Contiades et al, 2007; Ministry of Health and Welfare, 2008).

The National Action Plan for Public Health aims to change the focus of the services from treatment to prevention and from hospital to home care, by using more effectively the available human and economic resources. Specifically, it refers to taking measures towards prevention and rehabilitation for people within LTC, by preventing accidents, long-term or short-term effects and complications of their frail health status and it proposes measures towards the support of older people with LTC needs for the improvement of their functionality and increasing their autonomy, thus increasing their quality of life (Ministry of Health, 2008).

Although, in 2009 it is still too soon to obtain published results, some constraints of the application of this strategy in the field of LTC are obvious and expected. The disproportionately high number of physicians compared with nurses and other health care providers can be expected to oppose any changes towards a less medically centred system, an obstacle that is re-enforced by the continuing provision of the major part of the public health budget to the secondary/hospital health care sector, rather than its re-distribution to primary health care. On the other hand, the current existence of an oligopoly in the private health-care market may stand in favour of such changes as a big part of the private sector may be willing to re-enter the health care market through new services on prevention and rehabilitation, or intermediate care settings (Tountas, 2005; Boutsioli, 2007).

It seems that the new policy tries to exploit the paradox of having public health-care with universal coverage throughout the country, and at the same time the highest private expenditure amongst all the EU countries (Siskou et al 2008). Many authors agree that under-financing of the public health sector causes the high expenditure in private health care and Greece has indeed the fifth lowest expenditure in health care by public resources among all OECD countries (Tountas et al, 2005; Siskou et al, 2008; Contiades et al, 2007; Liaropoulos et al, 2008; OECD, 2009). The above numbers indicate an almost certain turn in health policy from the family regime towards the liberal welfare regime, where private services dominate and public services act only as a ‘safety net’ for the poorest. The call from the government to the private sector and the NGO’s to take action, seems to be a repetition of the policy that it is preferable to have services at a cost to the user than not to have services at all.

Another way the national Action Plan for public health supports cost and finance for prevention and rehabilitation within LTC, is by distributing it to different stakeholders (Reimat, 2009). The ministries of: Health and Social Welfare, Interior Public Administration and Decentralisation, Defence, Education and Religion, Rural development and Food, Trade Industry and Tourism, Work and Social Protection are asked to contribute human and economic resources, as they already do (Ministry of

Health and Social Welfare, 2008). A characteristic example is the transfer of the functional and maintenance costs of KAPIs from the Ministry of Health and Social Welfare to the local municipalities and the Ministry of Internal Affairs. This tactic, although spreading the cost to the different stakeholders, also fragments the health care authority, provision, control and responsibility, making impossible a centrally guided, target orientated National Health Service provision, of uniform standard and equal access. It gives the image of a patchwork of services, with a variety of health and care provision, rights and degree of benefits or allowances that differ depending on the geographical area, the Health Insurance Fund that each person belongs to, which in turn depends on the past or present professional occupation of the user.

Another important financial support to facilitate health change and establish prevention and rehabilitation health-care services within LTC, is by co-funding (75%) from the EU; precedents in this area have been established in the funding of similar programs such as Help-at-Home and «Psychargos». The participation of NGO's and volunteer contributions have been used in the past and are considered an important asset in the National Action plan for Public Health (Ministry of Health and Social Welfare, 2008).

Neither policy nor any associated supportive measures for the families and informal carers that carry the main burden of LCT care, have yet been defined.

6 Final comments: characterizing the evidence base and summing up

A wide variety of sources were used for the appropriate information to be obtained. Relevant literature was found in international papers and research by organisations where data for Greece was compared with other countries. Articles written by Greek authors in peer-reviewed journals were also found concerning legislation and finance. Some discussed the gaps or proposed changes in the existing system. The official sites of the Ministry of Health and Social Welfare and Social Security Organisation provided the existing structures of prevention and rehabilitation within LTC or what should exist and defined the future policy. Articles in newspapers and blogs were taken into consideration to provide an insight into the quality of services provided, the existing problems and the gaps in care.

In summary, Greece in common with the rest of Europe faces the continuous ageing of its population. There have been serious steps towards the creation of an effective, flexible and efficient health system; however the full reform has not yet taken place. The low proportion of nurses and the under-provision as well as the under staffing of services, is a common European problem which Greece has partly solved by the use of immigrants who undertake the role of informal carers. Services for supporting people in the community have only recently been developed, though services supporting carers are still rare. Prevention services are more developed than rehabilitation services, which are still out of the focus of current policy. Good practices exist; what it still missing is the system that will incorporate and spread these good practices throughout the health and LTC sectors.

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8 Annex

The Greek National Expert Panel (NEP)

We tried to include members from 2 main categories:

- Academic + researchers, who have a thorough knowledge of several scientific domains, e.g. medicine, social policy, nursing, social workers, e.a.
- Professionals, who work on the field mainly in care related domains and could transfer their valuable everyday experience.

The communications were made through e-mail.
We adapted the standard letter and we sent at about 25 invitations with the InterLinks presentation attached. We got back 15 positive answers. The Greek National Expert Panel met on the 13th of September and apart of the discussion done on this day, individual opinions and remarks were sent to CMT Prooptiki. In the next table the names, position and workplace of the NEPs is presented:

Name, title	*Position, Workplace, other details*	*www*
Ms Ioanna Troumousi	Red Cross Greece – director of the project "help at Home" (NGO)	**www.redcross.gr**
Dr Lefki Mougia	Hellenic Association of gerontology and Geriatrics (NGO)	**www.gerontology.gr**
Ms Lena Margioti	Project "help at Home" of Athens Alzheimer's Association (NGO)	**http://www.alzheimerathens.gr/index.php?option=com_content&view=article&id=198&Itemid=123**
Dr Paraskevi Sakka	Director of Athens Alzheimer's Association (NGO)	
Ms Evi Hatzivarnava	Institute of Social Policy and Solidarity (Public Body)	**www.ikpa.gr**
Dr Liz Petsetaki	National School of Public Health (University)	**www.nsph.gr**
Dr Panayiotis Altanis		
Dr Christos Lionis	Professor of Social Medicine, Medical School of Crete (University)	**http://www.med.uoc.gr/**
Dr Dimitris Ziomas	National Centre for Social Research (Public research Institute)	**www.ekke.gr**
Dr Maria Liapi	Centre For Research On Women's Issues (Research Institute)	
Dr Liz Mestheneos	President of AGE – European Older People's Platform (NGO)	**http://www.age-platform.org**
Ms Maria Karabetsou	Hellenic Association of Ergotherapists (Professional Association)	
Dr Kostis Prouskas	General Secretary of the Greek Care Home Association	**www.pemfi.gr**
Ms Moshoula Besta	Private Office of Advisers to work specialized to nurses and home care assistants	**http://bestcare.gr/intro_en.html**
Ms Myrto Ranga	Psychologist – gerontologist – 50plus Hellas	**www.50plus.gr**