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

Governance and financing of long-term care

Greek National Report

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1 Key contextual factors

Health care in Greece has historically developed into a multi-tier and mixed system of provision, a mosaic of public and private providers of services covering the members of occupational social insurance organizations. Health care provision is mainly focused on acute treatments, whereas preventive and primary care as well as supportive long-term care services are underdeveloped, with the latter until recently not being included in the concept of health provision but classed as social care.

1.1 The health care sector

Before 1983 the health and social welfare system was comprised of two large public insurance funds (namely IKA for urban populations and OGA for the rural areas) and a long list of small insurance funds. The founding stone of the Greek welfare system was the creation of IKA (Social Security Institution) in 1934, which was and still is a vast organisation numbering 331 administrative centres and 364 Health Units. All IKA members (more than 5,500,000 including the ones who are not directly insured) have access to an adequate standard of health care as well as a pension upon retirement. A second milestone was the creation in 1961 of OGA (Agricultural Insurance Organisation), which covers all the country's rural population. Since 1975, the welfare state in Greece has been constitutionally guaranteed (Article 24 of the 1975/19866/2001 Constitution) with Social Security operating through more than 300 funds, providing virtually full coverage, but facing serious problems of financing, leading to government attempts to unify the system by reducing the number to less than 30 (Liaropoulos, 1995). Depending on the occupation or profession and thus the membership of Insurance fund, different population groups have different social contribution schedules and are consequently eligible for different packages of health services (Cabiedes and Guillen, 2001).

In 1983, despite economic problems, the welfare state was expanded. In order to reform the old health care system as well as to restrain the expansion of private practices, the ESY (National Health System) was enacted. The main objectives of the new unified National Health System were to arrest the growth of the private sector and promote the public sector to a dominant position. Its priorities included the equal distribution of health services, adequate coverage of needs, improvement of quality and emphasis on the development of regional capacities for the provision of health services (Kyriopoulos and Tsalikis, 1993). Health was considered a social benefit that should not obey to the laws of market profit. All citizens, irrespective of their economic and social status or location of residence, should have equal rights to access to social and healthcare services. The protection of the health of the population was recognized as an exclusive responsibility of the state, which should be exercised through a decentralized system in the provision of services. The most outstanding changes were the nationalization of independent non-profit hospitals, aiming at establishing a unified public network for hospital care and the closure of many private clinics, thus limiting the private sector. An effort was also made to expand public primary health care, especially in rural areas with the creation of primary health care centres (Venieris, 1997: 81-82).

Changes introduced by the ESY included increasing the number of hospital beds from about 34,000 in 1983 to more than 52,000 today, and increasing the number of doctors -including dentists- to more than 54,000, with a high ratio of doctors/population (4.9/1,000) compared with an average of 3/1,000 in OECD countries (OECD, 2005). On the other hand, there is a staggering lack of nursing personnel with a ratio of 3.9/1000 compared to the OECD average (18 countries) of 8.2/1,000 (OECD,

2000) and with major implications for the LTC sector. However, the 1983 reform was only fully implemented for hospital care, by establishing a unified public network offering services for the whole population. Issues of long-term care were not addressed.

In the reform of 2001 the government restructured the ESY in order to address the problems and malfunctions of the overall welfare system. The Greek government attempted to introduce a new paradigm called managed competition or mixed market, that was already being followed among other European countries. According to this model, the separation of the financing/purchasing and providing functions is introduced while universal access and public finance is maintained, at least in principle (Cabiedes and Guillen, 2001). The ESY was divided into 17 autonomous and independent regional branches, called PESY (Peripheral Health Systems), so that decentralised management and accounting would lead to regionalized, rationally coordinated, needs-led health service provision (Ballas and Tsoukas, 2004). Despite the increased cost in health spending (11.5% in the development and first year operation of the PESY, exceeding 6.6 billion drachmas or 19.4 million euros), the level of public health expenditure was still below the relevant average figure of European countries. Taking into consideration the political and social environment at the time, it is not surprising that the largest part of the public expenditure was directed towards hospital (medical) care and not towards enhancing social care or developing a nation wide network of primary care and LTC services. The ESY is characterized as a highly politicized socio-economic system operating within a highly institutionalized and bureaucratic environment, with limited capacity of independent decision making and managing of the public health services (Ballas and Tsoukas, 2004). The rise of public healthcare expenditure was followed by a proportionally similar increase of private health expenditures, resulting in a more inequitable health system today than it was before the reform. Only two years later in 2005 PESYs were replaced by the Administration of Sanitary Regions (DYPE), which abolished the financial control of the hospitals and the Social Care units.

At present, though coverage is intended for the entire population, access to services is primarily focused on hospital services and clinical care, rather than on services provided through a well-developed primary and LTC sector with gate-keeping capacities. Some efforts were made at creating a more unified network for primary and outpatient care services without much success, resulting in a system that is still fragmented into many social insurance funds, with varying contributions and entitlements. This fragmentation translates into inequalities and organizational and financial difficulties (Cabiedes and Guillen, 2001). The increase in life expectancy and the falling of fertility rates pose new challenges in the social insurance system. These developments progressively affected all the major insurance organizations, decreasing the standards of the services provided, keeping the entitlements at a low level and consequently forcing many Greeks who have the financial means to purchase complementary private insurance or to pay directly for health care services. This has resulted in the ESY being used disproportionately by those with low incomes (older people/pensioners, migrants, the unemployed) whilst those who can afford to pay or have private insurance (working age population, expectant mothers, elective surgery and some mental health services) tend to use the private sector (Mossialos et al, 2005). In the same way, public long-term care services are addressed mainly to those with low income, leaving those who can afford it or their families to pay themselves for such services in the private sector.

The review of the health legislation by a conservative government resulted in focusing on a competitive public private mix of providers. The recently introduced National Action Plan for Public Health, aimed 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 (Ministry of Health, 2008). Although published results and statistical data are not yet available, some constraints of the application of this strategy are obvious and historically expected. The disproportionately high

number of physicians compared with nurses and other health care providers, in addition to the continuing disproportionate funding of the hospital sector, serve as long-term barriers to any changes towards a less medically centred system in the near future. On the other hand, the current balance between a shrinking public sector under economic and fiscal constraints and a growing private health sector may stand in favour of such changes, as the private health sector seeks new opportunities for profitable investments through filling the gaps in the public sector or creating new services (Kyriopoulos and Tsalikis, 1993; Tountas, 2005; Boutsioli, 2007).

In an attempt to overcome medically centred health and social care provision, the introduced National Action Plan for public health implicates and distributes cost and finance 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 (Ministry of Health and Social Welfare, 2008). In the effort to overcome resistance from the medical community, the new Plan is based on the free market, thus further fragmenting health care service provision and crucially weakening the original ESY vision of a centrally guided, target orientated national health system, based on common standards and equal access; it remains to be seen if the new government can plan and implement reforms in line with this vision.

1.2 The social care sector

Long-term care for older people in Greece is based on a mixed system comprising informal and formal care, with legal responsibility for the financial and practical support of dependants placed firmly on the family[1]. State support for non-self-sufficient older people includes limited direct provision via social services, coverage of some of the needs for care through social insurance and very limited support for informal caring via tax reductions, the latter only applying when the older person's pension is minimal i.e. less than 500 euros/month. Formal care is provided by the state, by for-profit and by not-for-profit private organizations. The state provides institutional care through Chronic Diseases Clinics, Psychiatric Hospitals and recovery Centres for Physical and Social Rehabilitation. The non-profit and for-profit private organizations operate residential homes (Elderly Care Units) and some care at home services for older people.

Long-term care was traditionally provided within the family, or in institutions (asylums in the case of psychiatric or communicable diseases) when the family was absent, or unable to provide personal care, or pay for alternative forms of care. Although it was considered socially unacceptable to "abandon" a parent to an institution, it has become a more acceptable and even inevitable solution for many families living in small city flats, leading to an increase in the number of private residential homes for the elderly. Long-term care falls within the social care sector in Greece. The social care sector deals with all the institutions that provide services and care to people with disabilities, long-term illnesses, orphans etc.; long-term care as an individual sector of health or of social care does not exist. Articles describing the Greek health system omit the long-term care sector, referring instead to some services which they include within Primary Health Care, such as Help at Home, devoted to the care of older people on a long-term care basis (Tountas, 2002; Souliotis and Lionis, 2003). In the early 1980s, the state acknowledged the importance of the non-institutionalisation of older people who were generally healthy but faced some problems, mainly social. The first KAPIs (abbreviation for 'Open Protection Centres for the Elderly') originally operated as pilot centres run by volunteer groups using public finance. Their main objective was to maintain older people in their home environment

[1] See WP5 National Report on Informal Care – Greece. Vlantoni D (2009).

for as long as possible and to remain independent, active and participating members of their local communities, through the provision of social support and preventive health-services. In 1982 the local authorities throughout rural and urban Greece assumed responsibility for the expanding network of KAPIs, while the state remained the main financial contributor. Today, there are over 1000 KAPIs throughout the country, although many do not operate to their full capacity due to lack of adequate personnel or lack of financing, reflecting a variable commitment at both national and local level to provide open care services to older people. An additional factor is the lack of evaluation of the effectiveness of the services of the KAPIs in relation to their stated objectives e.g. healthy ageing, social inclusion, prevention of health and social problems and disability.

In 1992 a new pilot project called "Help at Home" was introduced under the auspices of the Ministry of Health, but administered and run by municipalities, often in close collaboration with the KAPI centres. The programme aims to provide care and support at home to non-self-sufficient older people and is now running in more than half of the KAPIs, providing health and care services, counselling and psychological support, as well as aid in everyday tasks (Kyriopoulos and Tsalikis, 1993; Daniilidou et al, 2003). From the outset secure funding was the main problem faced by the service and, following the Lisbon agreement, the aims of the program were revised to include the release of women from caring duties in order to enter the labour force, as well as the creation of jobs in the care sector, thus coming under the joint auspices of the Ministries of Labour and Health. A recent (2008) extensive review of the service indicated the following:

- More than 2,000 jobs were created, but insecure funding problems have seriously undermined the success of the project, with staff remaining unpaid for long periods and with no incentives to improve or expand the service
- The limited resources of the service (also due to lack of secure funding) have meant that staff, of necessity, have to give priority to serving the needs of isolated and poorer dependent older people, so that those with some family support or resources to pay for care (mainly from migrant care workers) are effectively excluded from access to the programme.
- The lack of jobs in the labour market, particularly in rural areas, has meant that women still have no realistic choices and continue to provide care at home in the absence of other alternatives, or pay for private care (migrant care workers).

The above program, although it fulfilled an essential need and became very popular as it is compatible with the cultural characteristics of the Greek society, indicates the problems involved in shifting central administration to Municipal responsibility for care provision in the area of long-term care in the community, unless this shift is accompanied by secure funding, discussed further in section 2.

Currently, recently enacted decrees define the prerequisites for the development and function of the newly established 'social protection units', providing social services relevant to the open or institutionalised protection of older people, those suffering with long-term illnesses or with similar problems. "Care Units for Older People" (MFIs) are residential care homes, which may be developed by individuals, for-profit or not-for-profit organizations, under the control of the prefectoral local organisation (OTA). The foundation and operation of every long-term social care service requires a license provided by local authorities that defines the procedure, the minimal building and safety prerequisites, the size and characteristics of the rooms and the number and kind of the personnel. At the same time, an independent service for the protection of the rights of patients was created within the Ministry of Health and Social Welfare that deals also with the rights of older people as care recipients. In order to ensure quality of care the social prefect, who was the person authorized to

control these services, was replaced by a corps of inspectors of Health and Social Care services in order to unify the criteria and supervision throughout the country, in the margins of the 2001 reform.

In the recent proposal for health, the Greek Economic and Social committee (OKE) points out the non-existence of a public system for pre- and post-hospital care and of rehabilitation services for older people. There is no public system of after-discharge care for people with long-term illnesses, except for 1-2 public hospitals that have developed care at home on a voluntary basis. Protective residential care of older people in the majority is undertaken by the private sector, while there is inadequate control on the quality of care provided, despite the creation of the previously mentioned corps of health inspectors by the Ministry of Health. The committee points out the need for connection of health services with a long-term-care system, and the promotion of quality and effectiveness in care (Economic and Financial Committee of Greece (OKE), 2009).

2 The governance and financing of long-term care services for older people

2.1 Governance

In the reform of 2003 (Law 3106/2003 of the Greek State), all the existing long-term care services and institutions were nationalized and now belong to the peripheral health systems, renamed as Peripheral Health and Welfare Systems (PESYP). The Ministry of Health and Social Welfare regulates and has a central control on all the long-term care services, and in some cases it co-funds the services if needed. The PESYPs act as autonomous, regional, de-centralised units of health and social care provision. Only two years later, with the Law 3329/2005, hospitals and social care units became again financially autonomous with separate budgets and management, but remaining under the control and supervision of the Manager of the administration of the sanitary region (DYPE). The new law enables authorities to design and develop long-term care services; however these services come under the direct supervision of the PESYP and the Ministry of Health, without any central planning, funding, coordination, incentives or encouragement to create such services and develop this sector.

2.2 Finance

Data on the Greek health system are available only for acute care. As long-term care does not fall into the health care sector but into the social care sector, financial data are non-applicable even in recently published papers. Estimates calculate the expenditure for LTC to be approximately 1.4% of GDP (ECFIN, 2009).

The Greek health system is financed both through taxation and social insurance sources, supplemented by a high proportion of private financing. It does not therefore fall neatly into either the Beveridge or the Bismark mode of financing. Reforms of 1983 established a National Health System and attempted to increase the share of state funding of the health care sector (Maniadakis and Yfantopoulos, 1996), but fell short of achieving a full transition from predominantly insurance based to predominantly tax-based financing of health care. The system can therefore be characterized as a complicated mixture of the public integrated model and the public contract model, with the former predominating over the latter (OECD, 1994). Public health expenditure financing is 60% from tax revenues and 40% through social security contributions. However, this constitutes only

56.3% of total health expenditure. Payments from private health insurance account for about 2.3% and the remaining 41.4% from out-of-pocket payments, a significant proportion of which are "informal" (Mossialos et al, 2005). In 2000, taxation and social insurance accounted for 30.4% and 25.9% of total health expenditure. Only approximately 8% of the population has private medical insurance (PMI), which covers services in the private sector. Table 2 shows the sources of revenue for health care in Greece.

Primary care also serves people within LTC through social security polyclinics, health and diagnostic centres, state rural health centres and medical practitioners working in the public and private sectors. It is provided both by the state (for farmers and civil servants) and by social insurance funds (blue and white collar workers) and is also financed by both (about 10 per cent by the state and 50 per cent by social insurance funds). In addition, in view of the significant size of private sector provision and out-of-pocket payments, the voluntary out-of-pocket mode of finance is also relevant in characterizing the system. Private expenditure on health constitutes about 40 per cent of total health expenditure (Liaropoulos and Tragakes, 1998).

Hospital services are delivered mainly through public hospitals (70% of the beds and 80% of admissions), which also offer outpatient clinic services available directly to the public by appointment, as well as for follow-up after inpatient treatment. The introduction of a National Health System in 1983 strengthened the role of the public sector and aimed at the establishment of a comprehensive National Health Service, including both primary and secondary (hospital) care sectors, which was however never realized in practice (Liaropoulos, 1995).

Table 2 Sources of revenue for health care in Greece as % of total revenue (1987, 1992 and 2000) (OECD estimates in brackets)

	1987	*1992*	*2000*
General taxes	33.7	33.3	30.4
Social Insurance	25.4	24.1	25.9
Total public	59.1 (59.9)	57.4 (54.6)	56.3 (53.9)
Private insurance	Na	2.1	2.3
Direct payments	40.9*	40.4	41.4
Total private	40.9 (40.1)	42.6 (45.4)	43.7 (46.1)
Total	100	100	100

Source: Mossialos et al (2005).- Note: *) including Private Medical Insurance.

An important feature of the Greek health system is the existence of a strong subsystem along the lines of the Voluntary Contract Model, which is, in fact a significant 'black' health economy, financed by out-of-pocket private payments. The exact magnitude of this market is strictly a matter of conjecture, although some estimates put it as high as 3% of GDP, or 67% of public expenditure. Every opportunity to overcome the fragmentation of the Greek health care system has been repeatedly lost because of the partial implementation of the reforms (Matsaganis, 1998: 337-338).

Figure 1 depicts health care funding and delivery in Greece. In theory the Ministry of Health is responsible for managing and organising hospital and rural primary care and the insurance funds are responsible for their financing. However insurance funds pay half of the hospital costs, while the Ministry of Health and the Ministry of Finance cover the deficits through taxation. Two main types of coverage are available to the population: the health insurance funds (HIFs) and private medical insurance (PMI). Indirectly, the ESY offers a third type of coverage to the population since anyone can access the public hospitals and rural and semi-urban primary health centres in an emergency, even without any insurance at all (e.g. illegal immigrants, tourists). Some LTC services may be integrated within acute care settings.

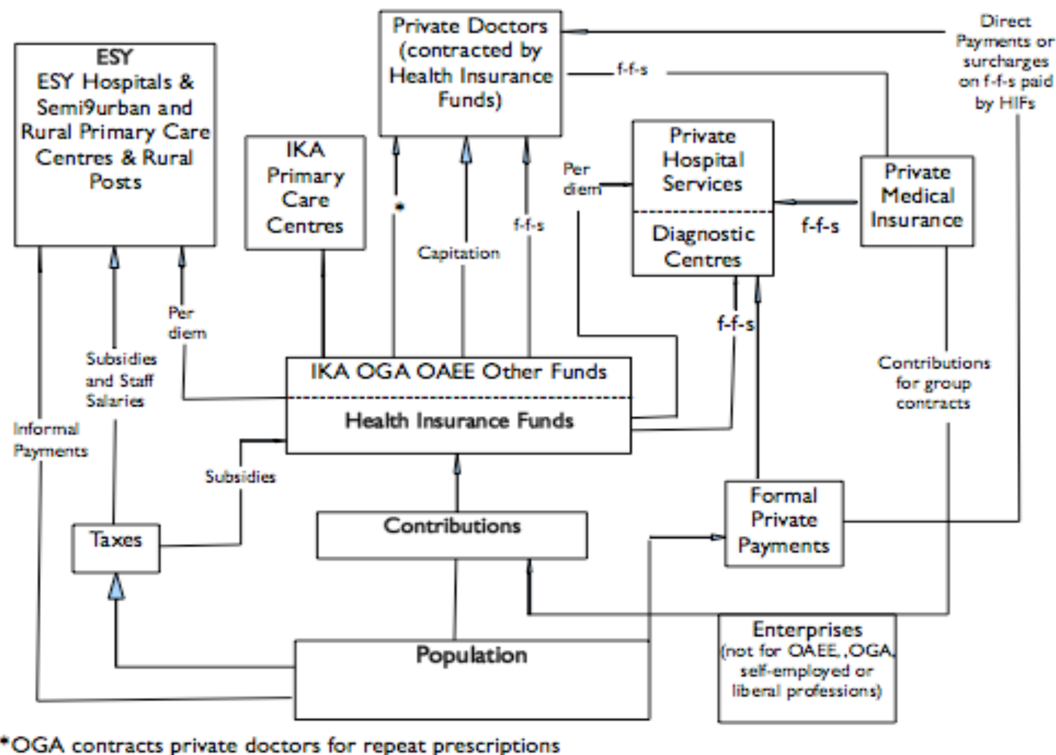

Figure 1: Organisation of the Greek health system: financing flows and delivery of health services source: Mossialos et al, (2005)

The Greek government has attempted over the last 20 years to boost the role of market and competition in health care industries in order to increase efficiency and reduce costs. However the organisation and function of LTC services were only seldom addressed as they are out of the interest of the medically centred health system.

Despite the fact that the private health sector can play a significant role in the financing and delivery of health services in relatively undeveloped health systems, which suffer from limited public expenditures, resource shortages, and quality of care problems, it is questionable whether there would be sufficient motive for profit-making enterprises to invest in LTC services in Greece.

Nevertheless, the Greek private sector is large. Some official estimates offer a figure close to 40% of private expenditure over total health expenditure (Matsaganis, 1998). The lucrative expansion of private professional practices and of the "informal" economy may account for it. Thus, the Greek health care system has remained a three-tiered one, including a large private sector, social insurance health funds and universal access to hospital care (Cabiedes and Guillen, 2001). Private health

insurance is very active in this market and may in fact, be the main source of its financing (Liaropoulos, 1995). The main characteristic of the private health insurance market in Greece is its oligopolistic structure, with the market leader dominating 39% of the market and the three largest (out of 42 companies) accounting for 70.7%. Although reliable official data do not exist, there has been estimation that 10% of the population already has some sort of PHI coverage, and total contributions already amount to 10% of total Social Security contributions. Private health care in Greece has failed so far to act in a complementary way to social health insurance. Informally, rehabilitation clinics or private acute-bed hospitals sometimes substitute for LTC services, providing beds for a period of up to 6 months during which some insurance funds are contracted to cover most of the expenses. After this period the patient is discharged, but may be readmitted to another clinic or hospital in-patient setting for 6 more months. Although this is not the rule, it is a possible alternative when LTC beds do not exist.

Using acute beds for LTC is not however the only reason that led the Greek healthcare system to strive towards cost containment. Spiraling expenditure is attributed to the population ageing and the nature of associated chronic diseases, but mainly to the extensive use of costly biomedical technology, as well as political interventions on the healthcare market in an effort to provide free healthcare (Mossialos et al, 2005). In 2003 alone the total expenditure on health exceeded 15 billion €, constituting the 9.9% of the GDP (Aletras at al, 2007). Nevertheless, the ineffective accounting system, which is used universally in the public sector in Greece, opposes any effective internal or external control over the economics of the health system (Ballas and Tsoukas, 2004).

Fragmented administrative framework, low levels of public expenditure, a significant private sector which is under loose control, inadequate hospital services, skewed numbers of physicians, and a low level of primary health care were all points that the government tried to address through the enactment of ESY legislation, though with limited success (Tountas et al, 2002; Tountas et al, 2005). Taking into consideration the European policy for a socio-economic balance (Aletras et al, 2007; Contiades et al, 2007), with qualitative public services, with controlled and rationalised expenditure, meeting the public needs for increased investments in health and welfare services, the ageing 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 (Ministry of Health and Welfare, 2008).

It appears 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 from 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 call from the last government to the private sector and the NGO's to take action seemed to be consequent upon its policy "that it is preferable to have services that may cost the user than not to have services at all". In the midst of the current financial crisis, it remains to be seen whether the present government can implement the basic reforms needed in the health sector, whilst it seems likely that the social and long-term care sectors will again remain the losers in the funding stakes.

3 Key barriers to joint working

3.1 Structural

Whereas the system is highly centralized, with the Ministry of Health and Welfare exercising strong control over activities in the health sector, it has nonetheless been characterized by the absence of a steering mechanism where change is concerned. As a result, change in the health system is not the result of rational planning, but rather an ad hoc process arising from partially implemented legislative acts in combination with the behaviour of diverse actors operating autonomously within the system (Tragakes and Polyzos, 1998). Currently, services used by older people are characterized by fragmented administrative framework, low level of public expenditure, a significant private sector, inadequate hospitals, skewed manpower (high number of physicians to very low number in nurses and other health professional to support social care, and primary care services), a low and non-comprehensive provision of primary care and fragmented LTC services not connected with the health-care system of the country (Tountas et al. 2006). In a medically centred health environment, with an antagonistic culture, fragmentation of services and lack of communication act as barriers to joint working for the benefit of the person in need.

Lack of infrastructure, understaffing in the administrative sector and lack of organisation and continuity of care, transfers to the patient and the family the responsibility and obligation to find and follow any possible pathways towards investigation, diagnosis, treatment and follow-up. The freedom of choice, which derives from the obligation to pay for services and the lack of an authorized gatekeeper, who will guide or refer the person to the appropriate services, do not facilitate patient pathways. Since these pathways are unidentified by authorised professionals and services, older people and their families are left in the position of having to find their own solutions to their own LTC. The over development of health systems and infrastructures, private and public, in comparison with the less profitable, less medically centred, less developed social supportive care systems, confuse health care providers and consumers alike; it creates dead-ends due to lack of appropriate LTC services, as well as lack of formal links between services, so that people needing care often have no other choice than to occupy an acute sector bed as temporary respite, albeit for a limited time, as well as for emergencies (Triantafillou and Mestheneos, 1994).

3.2 Procedural

The reform initiative in 2001 required hospitals to operate as administrative and economic decentralized units, under the control of newly established Regional Health Systems. In addition Professional Managers were appointed and signed 'efficiency contracts' committing them to run the hospitals efficiently and effectively. However an analysis by Aletras et al, (2007), indicates that technical and scale efficiency has been reduced following the policy changes. Reform planning in Greece, until recently, was a top-down process with legislation being formed by groups in the Ministry of Health and Welfare or in the government planning agencies, working in relative isolation from stakeholders and resulting in many parts of the legislation not being implemented. In part the failure to pass legislation was also due to a lack of political will and a lack of a commitment to change the health sector. The degree of achievement depended on the consensus among the numerous actors involved in the process of change and to the technical institutional and administrative feasibility of the reform plan (Tragakes and Polyzos, 1998).

Problematic administration, low productivity and inadequate Primary Health Care are considered some of the causes that maintain the Greek National Health System in a state of continuous crisis

(Tountas et al, 2002). The transition of authority from the Ministry of Health and Social Welfare to local authorities and DYPEs, have created a procedural mix-up on the services provided, and in the legal status of the care providers. The most striking example is that a health care professional (under the auspices and supervision of the Ministry of Health) may offer care at home, but the same professionals, being allocated to the local municipality, are legally not allowed to enter a home nor to offer services, as they are now considered employees of the local authorities.

3.3 Financial

Ironically, the 1983 reform plan and its subsequent partial implementation coincided with the first period of major economic retrenchment that appeared in Greece in its post-war history. The government of the time was highly committed to change; however the large increases in public expenditure for social purposes (including health) that occurred during the 1980s were financed by borrowed money that increased the financial external debt (Tragakes and Polyzos, 1998). Economic constraints continue to play a crucial role in any health reform implementation, but they are not the only factors responsible for the failure of many attempts to improve the Greek National Health System. Salaries constitute the largest proportion of the budget of the Ministry of Health and Social Welfare, with limited allocation of resources going to improve services in general or to develop much needed services in the community or in the long-term care sector. Although administrative control is exercised by the Ministry of Health and the local authorities (DYPEs), no financial incentives and support are provided for individuals to develop LTC services.

3.4 Professional

Poor planning and implementation capabilities, technical and institutional constraints along with the powerful doctors' and their unions' control of managerial and political structures, impose obstacles to every attempt at system reform (Tragakes and Polyzos, 1998). Seen in the context of bureaucratic clientelism and political populism, the failure of every reform attempt may be explained as follows: the logic of underlying robust reforms does not correspond with the underlying logic of the broader socio-economic system. Effective opposition has not been difficult to mobilize, because the medical profession has historically controlled the ESY and managed to appropriate the constitutive symbols of ESY ('egalitarianism' and 'democracy') to avoid subsuming itself under formal organizational authority. The dominance of medical unions over the running of hospitals (enforced both by law and by the close links of the unions with the political parties), in combination with the lack of an independent managerial elite in Greek hospitals (a natural consequence of bureaucratic clientelism), has successfully opposed effective ESY management reform (Ballas and Tsoukas, 2004). Main professional barriers to the development of a comprehensive LTC sector include: the low status and lack of public jobs for nurses and associated health and social care personnel; the non-recognition of the medical specialty of geriatrics; the lack of professional career structures in this sector. The current high levels of unemployment amongst doctors and nurses could be used as an opportunity to develop appropriate LTC services that are responsive to the ever increasing needs for care of an ageing Greek population.

3.5 Issues of status and legitimacy

Despite the establishment of the National Health System (ESY) in the early 1980s, the institutional framework remained largely unchanged due to opposition from interest groups and high running costs, thus allowing the powerful stakeholders to preserve their privileges. Not until almost two decades later was reform attempted in order to rationalize and modernize purchasing and delivery. The ambitious reform attempt of 2000 tried to rationalize change at institutional level; however the

initial goals of the reform became stuck on the reactions of the stakeholders, producing a different legislative outcome (Mossialos and Allin, 2005). Consumers, voters and taxpayers had no voice in the formation of any legislative acts. As health care is considered the most critical with a large budget and more powerful stakeholders, it concentrates all the attention of every reform attempt. In contrast social care change takes place in a quieter and slower manner, and continues to leave the main responsibility for the provision of everyday LTC needs to the informal care and NGO sectors, mainly through family support. Absence of legislative framework to support LTC is one of the main barriers that still exist. The current legislation is rather control-focused, based on securing some minimum standards, instead of being flexible and based on promoting development.

4 Key enablers

4.1 Shared vision

An examination of Greece's experience with health care reform planning over the past half century reveals a remarkable consistency in reform themes pursued by planners. However, few of the plans resulted in legislation, and of the legislation that was passed even less was implemented. Tragakes and Polyzos (1998) argue that legislative and implementation failures have been due to lack of political will, insufficient attention to consensus forming mechanisms and inadequate consideration of the technical, administrative and institutional feasibility of reform plans. Although the health plan reform launched in 2008 focuses on a shared, non-political, rational and pragmatic reform, proof of a shared vision is still not evident. Despite the macroeconomic constraints and consensus on broader economic policies focusing on the EU, convergence requirements have produced an imperative of change in the health sector and have given rise to mechanisms which facilitate the task of implementation, the same issues that keep coming onto the reform agenda since 1952 (Tragakes and Polyzos, 1998). Implementation seems to be the Achilles' heel of every legislative act.

Since 1990 a new configuration of conditions has appeared. Macroeconomic constraints are of paramount importance, as the EU convergence requirements leave no room for delays. Partial agreement between the two main political parties of Greece concerning the need to meet the convergence requirements has meant that ideological differences between them have been somewhat reduced. This point, together with the prevailing consensus on the imperative to conserve resources in all spheres of social and economic life, has forced a situation where rationalisation of the health sector (as in other social spheres) is deemed necessary. Thus every new article of health care reform legislation shows more continuity in the priorities being set and consistency in the policy orientation, even as governments have changed.

4.2 Clarity of roles and responsibilities

The difference between health and social care is very clearly defined. Medical domination in the field of health services regulates health provision so that physicians often undertake or are called to take on roles of other professions. This situation fosters a professional environment where the tension of multi-professional teams comes into conflict with the personal client relationship, over-financed hospital facilities overwhelm under-financed community health and social care services and expensive specialised treatments are given priority over labour-intensive LTC services. Gaps arising

from lack of coordination between health and social care, namely those located at the boundaries between hospitals and long-term care services, have been recognised by the stakeholders involved and some efforts have been made to overcome them by means of integrating or coordinating health and social care. A LTC system that is connected and integrated within the health system should become a national priority (Economic and Financial Committee of Greece (OKE), 2009). However, lack of funding, lack of legislation and different priorities in health policy do not create the appropriate supportive environment, as roles and responsibilities are not defined. LTC should be the health sector in which Registered Nurses are dominant, as in their professional rights defined by the 351/8-6-1989 Decree, nurses "should cover self-care deficiencies". In spite of this, due to the inadequate numbers of nurses, not only LTC services but also acute hospitals and primary care centres suffer from a lack of nursing personnel, with medical doctors frequently undertaking tasks that in other countries are performed more efficiently by nurses.

4.3 Appropriate incentives and rewards

Monetary incentives and rewards are officially not permitted in health and social care, as services are supposed to be free at the point of use and equally provided to all in need. However informal payments ("fakelakia") continue to be a reality in mainly the public but also the private sectors, given in return for better, quicker, or more personal services and considered appropriate by those receiving and considered a necessity for most of those giving, despite being illegal and constituting non-taxable income.

Political will for change in the health sector has been mobilised by factors external to the sector itself, but political will alone is not enough. Experience now suggests that the presence of other conditions can facilitate the passing of legislation, including the provision of incremental change as this is less threatening to entrenched interests, the incorporation of concessions and compromise elements which will secure the support of other hostile parties, and the selective incorporation of international experiences which are relevant to Greek needs as perceived by the key actors involved in the process of change. These conditions will also facilitate the process of change on the technical, institutional and administrative sides, which in the past have been constraining factors to successful implementation of reforms in Greece (Tragakes and Polyzos, 1998).

4.4 Accountability for joint working

There is no accountability of joint working in Greece. Social and health services are supposed to collaborate in such a way that cure is followed by care, and this co-ordination should be facilitated by the social services of each hospital. However, in Greece the family plays the role, not only of the social services, but also frequently of a nurse. Family members act supportively to the health services by providing 'voluntary' aid to their older relatives or by hiring a private nurse or carer during a hospital admission and then fully undertaking responsibility for the patient's care after discharge. Insufficiency of public LTC services and the absence of a supportive after-discharge national service create problems that the family is called upon to find solutions to. Migrant carers help at home, public home care services are effectively restricted to those without family carers and day-care centres may not be available or affordable for everyone. It is no surprise, therefore, that many seek a temporary solution in frequent readmissions to the hospital.

5 The funding of long-term care services

The growing number of older people has not led to rationing on their healthcare costs, although their use of health care services is higher than that of other age groups; access to health care for >65 year olds is the same as for all age groups and there are no specific barriers or concessions due to age. However, data on health care costs are not available by age group and there is no specific budget allocated to long-term care, either as part of the health care budget or within social care. Since 2003 the statutory long-term care services (Help-at-Home, Day Care Centres, Care units for the chronic sick and limited public Residential Care Homes - MFI) are financed through the local authorities to which they belong and are free to the user, although serious funding problems, particularly with regard to the Help-at-Home services, means that they are obliged to limit service provision mainly to isolated and poorer dependent older people i.e. those without family support and unable to pay for private care. However local authorities are permitted neither to pose taxes nor take payments from the care receivers, leaving them unable to expand social care services, a situation that may change with the planned Municipality reforms.

In the semi-private clinics which provide nursing and rehabilitation for older people, a proportion of the cost may be covered by the insurance funds e.g. IKA will cover some extra nursing care for up to 6 months, but most of the costs are covered by direct, non-reimbursable out-of-pocket payments. Limited tax exemptions have been established in order to help families providing or paying for the care of a dependent older relative whose income of less than 500 euro/month. Other benefits, including therapeutic social tourism and spa-therapies, are offered by social insurance funds, although the latter are more preventive in nature rather than contributing to the provision of LTC (Daniilidou et al, 2003). However, increasing pressure on families responsible for providing informal care to dependent relatives together with the lack of alternative public services, has forced families to find there own solutions to care at home, namely by the use of migrant carers (mainly women). These are employed to live-in with the older person (24 hour care) or on an hourly basis, are often unregistered and untrained, burden the family's budget and are under no statutory control, but nevertheless provide an essential care service which is based on the individual needs of the older person and the family carers.

6 Financial sustainability

Due to the repeated economic crises that Greece has been facing during the last decades and the realization that social problems cannot be solved through economic expansion alone, the possible effects of the changing population structure on the economy, employment, pensions and income distributions are only some of the parameters that affect financial sustainability (Daniilidou et al, 2003). Population ageing has major implications on health and welfare services, employment and society as a whole. The consumption of health and social care services is considerably increased among older people, and those over 65 consume four times more health services than the general population (OECD, 1995). This means that in the context of the new approach of integrated services for older people, the adequacy of provided services must be ensured (Daniilidou et al, 2003).

Since 1990 efficiency increases are placed high on the agenda, as huge deficits characterize the social security accounts and the health insurance funds on which they are financially dependent. The European Union also exerts pressure for control of public expenditure and debt and establishes

conditions for the concession of loans. The attempt to introduce radical reform and retrenchment measures to public health care system was accompanied in the past by long strikes, so that all previous radical changes were in the end abandoned (Cabiedes and Guillen, 2001).

Another Greek paradox is that Greece has one of the most generous and therefore expensive state pension systems among the 30 mostly richer OECD countries. Workers look forward to a pension of 96% of pre-retirement earnings, which is frequently granted at an early age. Recent reforms are slowly taking place so that future pensioners will receive 70% of pre-retirement earnings, and pensions will be granted only at the age of 65 years.

The estimation of the total cost of long-term care is difficult to calculate both in the public and private sector due to the complexity of the funding system, the differences in benefits provided by the different funds, as well as the informal payments. A separate budget for long-term care does not exist and since 2005 most long-term care institutions have independent budgets. Mechanisms of cost control are weak and there is not a clearly defined mechanism for recording and estimating cost and efficiency.

7 Good practice

Integrating health and social care at the local level – the model of the community of Ag. Sophia, Crete. The parish appointed a team consisting of a social worker, a nurse, a home-care assistant and a driver, whose work is self-financed by the parish, with contributions and donations encouraged "in memory" of a deceased family member. Older people are referred to the service by family, neighborhood or by the team itself that actively seek out older people alone and needing help. Initially the family is asked and supported to undertake care, but in the case of non-existence of family or refusal, the team takes over the care. This service is operational for the past 15 years and is highly regarded among residents, as it covers the lack of a formal structure for providing older people with a spectrum of needed services locally. It is noticeable that it has stimulated the community members to work with all involved stakeholders (formal and informal caregivers, NGOs, the church) and at all levels (local, municipal, regional) to develop and operate a network of care provision in the community, based on local and individual needs and finding and using a variety of funding sources.

8 Ongoing tensions

The particular organization of the Greek public health system, its fragmented character, the large weight of the private sector, together with the absence of a family doctor/GP tradition and several cultural obstacles, are all factors hindering the adoption of British-styled managed competition. These specific conditions constitute an uneven playing field, which could prevent the proper and equitable adaptations of any externally proposed changes. Matsaganis (1998) specifies some other priorities in the reform of the Greek Health care system: rationalization of social insurance, imposition of effective regulatory controls on a large and growing private sector and containment of a vast black market operating within the public health sector. These remain the key objectives of health policy in Greece and it is against these that all future reform projects will be judged (Matsaganis, 1998: 346). Meantime few steps have been taken to adopt any of those

recommendations as doctors resist any changes in a system they have learnt to exploit so well (Cabiedes and Guillen, 2001).

Previous experience regarding the conclusive results of all the attempts made to reform the ESY, raise concerns that every next reform is a step towards the gradual privatization of ESY. These concerns are enhanced by the fact that the state and the insurance funds plead inability to pay for the increasing health and care expenses, in conjunction with the ability given to hospitals to provide private services to patients and the DYPEs to create public enterprises independent from the system or contract with private companies, without any control of the Ministry of Health.

Integration of services and connection between cure and care, no matter how cost-efficient, attract low political and organizational support. As non-medical professionals are mostly responsible for such services, medical unemployment restrains the diversion of the system from medical-centred to patient-centred. The fact that low-skilled migrant carers already provide one solution to the care burden of older people, a solution financed by the consumers themselves or their families, makes the need for public action and measures towards changing long-term care service provision seem less imperative.

9 Embedding good practice in everyday practice

As noted by health professionals and verified by the National Expert Panel meeting in Athens (September 2009 – non published data), Greece lacks a mechanism of change for good practices to be spread and embedded into every day practice. The heroism, professionalism, altruism, ambition, love and devotion of certain professionals in health and social care constitute the bright sparkles of good practice in certain services in specific regions. Policy may exist to keep a safe standard of provision; however the current incentives, and the communication network between services at the national level are ineffective in promoting and supporting good practice. If sound provision guidelines were followed, based on evidence-based practices, great improvements could be made. Up to now the vision, the passion and the commitment of certain people is declared in congresses, but the implementation of lasting change faces gaps in legislation, rigid bureaucracy and an overall institutional resistance. Whilst the National Action Plan for Public Health (Ministry of Health, 2008) gives this subject a high priority, it does not define the specific regulations, mechanisms and incentives necessary for its implementation, leaving the way of application to the judgment of every DYPE manager.

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