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Health spending in Greece under restraint measures

Way forward for sustainability of healthcare sector

Healthcare in Greece is facing a crisis. How does health spending compare with other European Union countries and what is the way forward for a sustainable future?

Dionysia Lappou
Assistant Surgeon
Sismanogleio - Amalia Fleming General Hospital
Athens, Greece

dionamare@yahoo.gr

Current situation

Across the Eurozone, there is a need to reduce fiscal debts and deficits, and therefore to reduce annual public spending. This policy is being stifled, however, and the countries that are affected are those in the south. Economic uncertainty, and the application of austerity measures as a precaution, are endangering the viability of the countries in the European Union.

This report sets out the need for the national health systems (NHS) in Greece and other countries of the Organization for Economic Cooperation and Development (OECD) to reduce and secure financial resources, while providing comparative data on the state of national health and assessing what was spent in the period 2000-2012. It also aims to explore the measures that could curb spending in Greece. At the same time, it suggests alternative sources of funding, based on a reformed trend in the healthcare sector, under the supervision of the International Monetary Fund and European partners.

Figures show that after an initial upward trend, health costs in OECD countries tended to decline after the start of the recession, until 2010 (Eurostat 2012; OECD 2012). This suggests that strict supervision, in conjunction with the limitation of resources and rational allocation of these, tends to create an NHS that is competitive and worthy of users' expectations, while contributing to changing a pre-existing culture.

Based on the financing, production and distribution of health services, the basic health systems organisation models are the Anglo-Saxon model, the Continental model, the Scandinavian model and the South African model (Rekliti et al. 2012).

According to the OECD, Greece has a healthcare system based on a mixed and comprehensive national system, contractual insurance schemes and an insurance compensation scheme, which draw on different organisational models. Meanwhile, it incorporates elements and features of the private sector. This set of different systems and different models, combined with a lack of coordination and control mechanisms, has contributed to the creation of difficulties and mismanagement of the healthcare system, as well as to inadequate strategic management and weak implementation of a national policy on health for the past twenty years. The main feature of the insurance system in Greece was the existence of a large number of insurance schemes, covered by the Ministry of Labour and Social Security, most as legal entities under public law and under the supervision of the state, that created inequality both in access and financing of healthcare services (OECD 1992; 2010; Economou 2012; Rekliti et al. 2012).

> "THE ONGOING ECONOMIC RECESSION MEANS THAT 36.2 PERCENT OF THE POPULATION IS DEPRIVED OF RESOURCES FROM THE HEALTHCARE SECTOR AND INSURANCE COVERAGE"

During reforms in Greece from 2010 onwards, the pension funds came under the control of the Ministry of Health and Social Solidarity and the merging of social insurance funds (IKA, OGA, OAEE). The National Agency for Health Care Services was established, which covers 90 percent of the population, with the prospect of a comprehensive assimilation of the remaining funds (Economou 2012; Milona et al. 2012). The Greek NHS initiated changes

from 2011, including direct and indirect taxation and the implementation of closed-consolidated hospital fees. Meanwhile, doctors working in health centres and public hospitals were considered in full and exclusive employment, salaried and dismissed from private practice. Another change was to the pricing of medicines, which came down to EOPPY and the Ministry of Health Care (National School 2011; Economou 2012; Rekliti et al. 2012).

Given the budgetary surveillance within Greece's social policy, because of the large debt and loan crisis in the markets, unemployment and recession are considered negative factors in establishing a social framework. Moreover, there has been an effect on the health of the population and the NHS. Under the terms of the loan agreement with the International Monetary Fund are significant reductions in human, financial and technological conditions, with a focus on hospital expenditure, pharmaceuticals and social health insurance.

The current economic situation, high unemployment, combined with excessive retirement of staff in hospitals, wage cuts, pension changes, the new way of funding hospitals and mergers have imposed further corrective changes in the operation of the National Agency Providers Health services (National School 2012) in order to contain costs and enhance financing and profitability. Health spending (global, public, private, hospital and outpatient) for Greece from the year 2000 can be determined and compared to health costs in other countries of the European Union. This report cites the most important measures that could be implemented to curb health spending, with a main consideration of equality with regard to access to insurance coverage. Finally, based on medical effectiveness, social equity, justice, and economic efficiency in the light of health reforms, it explores the most appropriate source of funding for the NHS to adequately achieve sustainability.

Health spending in Greece and European Union members from the year 2000

Health spending has taken up an increasing amount of Gross National Product (GNP), reaching the rate of 8 percent of GNP in 2000, both for Greece and for the countries of the European Union. The continuous increase in health spending was due mainly to the indiscriminate use of and always evolving medical technology, constant social pressure for improved services and the ageing population of the continent as a whole (Towse and Sussex 2000), without the corresponding upgrade of health. Rising costs coupled with the economic recession led to the crisis in health systems, since it was found that the increase in costs did not result in better health in the population (Souliotis 2000; Souliotis and Kyriopoulos 2015).

For OECD countries up to 2008, and in Greece in particular, the increase in material and human resources in the NHS has created a very high rate of increase in health spending - almost three times the average. This has spurred high participation of the private sector and the transition of healthcare from the public sector to commercialisation (Souliotis 2000; Tountas et al. 2005).

In Greece, in the period 2005-2009, public spending was 17.8 percent of GDP growth while overall health spending rose by 45 percent. Comparatively, for the 2009-2011 period, the public spending proportion of GDP fell to 9.8 percent, along with a reduction of total expenditure at 18.9 percent, as shown in Table 1. According to official OECD figures, as per the table below, up to 2007 the countries allocated on average 8.9 percent as a percentage of their GDP on public and private health spending. Denmark has the highest rate with public expenditure at 8.7 percent of GDP, while private expenditure amounted to 1.5 percent, which was the lowest rate. Greece followed low on the list, with the percentage of private expenditure touching 2.3 percent through private insurance. In contrast to 2009, where public and private expenditure in Greece occupied 10 percent of GDP, for 2012 the rate fell to 9.3 percent, due to the sharp cut in public spending as a measure of fiscal policy to reduce deficits. For the same year, France, Germany, the Netherlands and Switzerland gave more than 11 percent of GDP (OECD 2014).

Restraint measures for health spending in Greece

The ongoing economic recession, high unemployment, the reduced working population and uninsured work has had the effect that 36.2 percent of the general population are deprived of significant resources from the healthcare sector and insurance coverage. Meanwhile, EOPPY seems to need further improvement and adjustment. In light of this, it is appropriate for EOPPY to serve as a medical complex, improve the structure of the holding costs and further strengthen internal competition for

suppliers. It should also boost the individual users' choice and the competitive relationship between primary and hospital care. These perspectives tend to promote higher quality care at the lowest cost (ELSTAT 2014; Kyriopoulos 2014; SEA 2013). Because of economic problems, limited measures exist to curb expenses in order to protect insurance coverage and universal access. Thus, we considered the following:

- Definition and placement of the employed workforce in the EOPPY bodies to be based on the added value that the entity produces to create new conditions of employment stimulus
- The necessity, via detailed knowledge of hospital costs, to redefine the state subsidy of the state provided to hospitals and which is transferred from economic resources to EOPPY. The above redefinition will serve in each incident case and compensation of hospitals can be achieved through the homogenous system diagnostic groups (DRGs model)
- Inspection and evaluation of the production and distribution of care imposed by the introduction of clinical, administrative and nursing audit, as well as ongoing evaluation of pharmaceutical and biomedical technology, and insurance checks
- Social mitigation that has arisen following the global economic crisis. This involves the presentation of different rates in health spending, which is proportional to income, the weak economy and lack of free access to the NHS for the unemployed, the elderly, and those with chronic disease, without endangering insurance
- Finally, the appropriate management of chronic diseases and the national implementation of a screening programme in primary care. This is expected to save financial resources and eliminate any weaknesses in the therapeutic approach (National School 2010; Kyriopoulos 2014; 2015).

Alternative sources of funding the National Health System

The reduction of financial resources for the health sector requires a redefinition of the funding sources to be considered remunerative, with a key parameter being to follow the criteria of medical efficiency, social equity and justice, but also of reciprocity. The EOPYY monopoly exerts its power through the reduction and control of expenditure, which requires:

- The creation of restricted budgets
- The consolidation of internal competition
- The strengthening of funding sources, given the economic situation in the country
- The rapprochement insurance package, based on practical effectiveness. Its viability also requires the delimitation of state subsidy to cover the contributions at roughly the rate of 7.65 percent.

Given that the objective of social policy and social security is to eliminate health risks and prevent economic waste, the degree of insurance coverage is the basic parameter of social negotiation. At the same time, it is appropriate and necessary to redefine the government grant to public institutions, with increased financial resources both for primary and hospital healthcare. Under the suffocating fiscal policy, retesting the design and setup of the Health Charter will help ensure its longevity, and lead to better distribution and proper functioning of health units.

> “ANOTHER SOURCE OF HEALTHCARE FINANCING INCLUDES TAXATION ON HEALTH-HARMING PRODUCTS SUCH AS ALCOHOL, TOBACCO AND SUGARY, FATTY PRODUCTS”

High unemployment rates and changes in employment relationships have led to insecurity with regard to insurance contributions, exacerbating the need for reorganisation. In conclusion, the level of contributions may be set inverse to employee number and the relevant entity-operation to strengthen and stabilise macroeconomic employment, and to achieve payment of the corresponding tax. Control of medical practice under the supervision of experts and the determination of the insurance package based on economic efficiency and clinical efficacy may ensure the redefinition of the insurance package as an additional option to take measures to re-finance the NHS.

Another alternative source of financing includes taxation on products such as alcoholic beverages, cigarettes, and products with high sugar content and saturated fat. The benefit clearly appears double by saving financial resources, and promoting the

health of citizens by avoiding consumption of such products and reducing morbidity and mortality in the country, resulting in the creation of additional economic and clinical benefits.

Finally, the management of chronic diseases, such as diabetes, cancer, heart disease, osteoporosis, etc., combined with the ageing of the population and comorbidity, being the main stress factors of the health system, with the simultaneous establishment of a single national screening programme control, can cause favourable results and significantly reduce the need for clinical monitoring, with the consequent reduction of clinical and economic costs (ESDY 2010; Influenza Pandemic, 2012; own 2017).

Future discussion

The Greek healthcare sector has over the years shown a disproportionate burden on the economy, which has brought with it a continuous decline in the public sector. Meanwhile there has been a growing economic burden on citizens, with additional payouts for ensuring higher quality health services. The total health expenditure showed an upward trend in 2009.

The sustainability of the NHS in Greece is a major challenge. A key issue that arises from this article is that of uncontrolled health spending, the International Monetary Fund and its imposed control mechanisms towards the reform torque sector, and a subsequent reduction in spending during the economic downturn, with a stable downward trend in 2012, both in Greece and in EU members. At the same time, the establishment of EOPPY and the merger of the pension funds show the mood for elimination of established relationships that existed in the NHS and led to a waste of public money.

The aim of the health policy clearly must be to reduce health expenditure in order to avoid further burden on Greek households and, at the same time, to improve patient outcomes and support the NHS in a bid to become more competitive. ■

KEY POINTS

- ✓ In the Eurozone, fiscal debts and deficits must be reduced leading to annual spending cuts
- ✓ Greece's healthcare system is a mix of models which leads to funding complications
- ✓ Owing to continued economic crisis and unemployment, a significant sector of the population receives no healthcare protection
- ✓ Alternative funding models include revised health insurance models and taxation on unhealthy consumer products

Statistics	
Total population (2015)	10,955,000
Gross national income per capita (PPP international $, 2013)	25
Life expectancy at birth m/f (years, 2015)	78/84
Probability of dying under five (per 1, 000 live births, 0)	not available
Probability of dying between 15 and 60 years m/f (per 1, 000 population, 2015)	99/45
Total expenditure on health per capita (Intl $, 2014)	2,098
Total expenditure on health as % of GDP (2014)	8.1

Source: Global Health Observatory. World Health Organisation who.int/gho/countries/grc/en/

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