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The Greece Healthcare System

Authors

Gregory Roumeliotis, *MPhil*
General Manager Cryo Save Balcanica
Vice President of GHSMA
groumeliotis@eemyy.gr

Stefanos Chronis, *MSc*
Administrative Director
Polyclinic Health Unit SA

snchronis@aemy.gr

The Country

Greece covers an area of 131,957 km 2, with hundreds of scattered islands around its coastline. The country is divided into 13 administrative regions.

Over the last 15 years, a great many economic immigrants - some legal, others not - have been entering the country. According to official statistics, the population (in 2005) stood at 11,120,000 people. Women make up 50.5% of the total population. In 2005, the workforce amounted to 4,850,000 and unemployment was at 9.6%.

Greece is a parliamentary democracy. The capital is Athens with 4 million inhabitants. The official language is Greek (98%). Other languages are spoken in border zones (2%).

In 2005, the GDP was 181 billion (16,277 per capita), with an annual growth rate of 3.7%. In 2004 health expenditure was 10% of GDP; estimates showed that it would increase to 10.3% by the end of 2006. Life expectancy at birth is 82 years for women and 77 years for men (in 2005).

The Structure

The current Greek healthcare system was established by Law 1397/1983, on which the Greek National Health System (GNHS) was founded. The principles of law include:

• Equity in delivery and financing of healthcare services

• Primary healthcare development

• A new public-private mix in the service provision

• Responsibility of the state for the provision of healthcare services

• Decentralisation in the planning process, improvements and community participation

• Establishment of new payments methods for healthcare providers

As a result of this law, all hospitals that had been subsidised by the State became public; the employees became civil servants; and the establishment of new private clinics was prohibited. (This prohibition was suppressed nine years later.) Initially, vast numbers of doctors and other health professionals were appointed in the public sector, and many new hospitals and more than 200 rural health centres were built.

Interestingly enough, numerous legal provisions have not yet been enforced such as decentralising the system, organising primary healthcare and modernising administrative and economic processes in the public health sector.

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Financing

The Greek healthcare system is mixed, having elements both of the Bismarck and Beveridge models Health expenditure is covered by:

- State Budget
- Social Insurance Funds
- Private Insurance Companies
- Official out-of-pocket payments by patients
- Underground (black) payments by patients

Total health expenditure is covered (2005) by:

- By state and social funds: 52%
- By private payments of patients: 48% (Private insurance covers about 2%).

GNHS hospitals receive funds to pay all personnel directly from the State budget. Additionally, they receive one daily fee for each patient from the social insurance fund, which is low – considering the real cost of hospitalisation. As a result, they often face substantial deficits, which are afterwards covered by the State budget. However, in many cases, patients pay doctors in public hospitals some money “under the table” to minimize waiting time or because they think this will ensure better medical care.

In private hospitals (clinics) hospital fees and doctors wages are higher, as these are paid by private insurance companies, or directly by patients. Patients who have social insurance prefer to pay in private clinics, as this guarantees fast service and more luxurious conditions.

Problems

The main problems in the Greek healthcare sector can be summarised as follows:

• The number of doctors per capita is high. Experts estimate that the country needs 27,000 to 30,000 doctors. Currently there are more than 68,000, equivalent to 1 doctor for every 163 inhabitants. Some doctors supplement their income in rather unorthodox ways, resulting in unjustifiable increases in healthcare. • In contrast, there are few registered nurses – one nurse for every 250 inhabitants - primarily because this profession lacks the same social prestige. As a result, hospitals employ nurses' assistants to deal with the workload. Unfortunately, these assistants are not sufficiently trained.

• Primary healthcare is not organised by a central body, especially in urban areas. General practitioners represent less than 2% of the total number of doctors. Hospitals offer their services, covering both primary and secondary healthcare. As a result, there are waiting lists, a tendency to direct patients to the private sector or patients engage in unethical out-of-pocket payments.

• The fact that GNHS staff have a job for life and the lack of active HR evaluation and incentives are negative factors that impact on the productivity and effectiveness of the system. In a lot of cases, problems arise in the supply chain of technological equipment, sanitary materials and medicines, resulting in financial loss for public hospitals.

• Modern management methods and cost control systems, such as global budgets and DRGs, have yet to be applied in GNHS hospitals.

Regarding the establishment of modern and integrated Health Information Systems and despite the generous EU funding, absorption rates are very low, application has been very slow and therefore the system cannot have powerful and accurate tools to achieve optimum operation and planning, or perform financial and clinical audits.

In November 2006, the Minister of Health and Social Solidarity announced that he would propose three new bills to Parliament regarding the (i) central procurement of hospital supplies; (ii) administrative reengineering of the GNHS; and (iii) organisation of the primary healthcare.

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