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Reforms in Greek Health Policy
Drawing lessons during austerity and beyond

Policy Brief

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Executive Summary

In August 2018, the Greek government announced the exit from the bailout agreement with its international lenders – known as Memorandum of Understanding (MoU) – and the return of Greece to normal politics. Exit conditions referred to Greece's ability to undertake structural reforms in its public policy making processes and public administration mechanisms to ensure long-term stability in its public finances. Despite the advocacy of exit, however, not all reforms were effectively undertaken or seen to completion to allow Greece to maintain a long-term stability. Health policy is one of those challenging areas of reform regarding efficiency, effectiveness and social impact.

The Problem in Brief

Despite consecutive MoUs (2010, 2012 and 2015), health policy has been slow-moving regarding reform with some successes and failures. This brief explores the reasons behind the variable (full, partial and unsuccessful) implementation of reforms in health policy to identify obstacles and constraints. Despite being mandated by the MoUs, why did some health reforms succeed while others failed to be implemented? Implementation outcomes are due to three factors:

- the strategies and power of the main non-state coalition partner (the medical profession),
- the size of resources needed for successful implementation,
- and the ability (or not) of government to mobilize public opinion.

Lessons Learned

- *By themselves, crises and their public narratives do not provide enough impetus for reform.* Public opinion makes a difference, but politicians still need to build strong, empowered coalitions who will advocate or persuade others to support the proposed reform.

- Because reforms produce winners and losers, *pro-reform coalitions must be of sufficient size to win and contain monetary and other incentives to attract the two main actors: doctor associations and hospital administrations.*
- *Implementation resouces are pivotal to reform success, so spend wisely.*
- *Success begets success.* In the face of strong opposition, reforms are more likely to be successful in small steps, showing cumulative results over time.

The Roadmap

This brief examines three cases: the liberalisation of the pharmacy profession (successful implementation), family doctor reforms (partial implementation), and the referral system (mainly unsuccessful implementation). The brief concludes with practical lessons for policymakers facing implementation obstacles.

Health policy and the financial crisis

After a long battle with financial discipline and a series of consecutive MOUs in 2010, 2012 and 2015 with international lenders to avoid bankruptcy, the Greek government formally announced the exit from the bailout agreements in August 2018. Because MoUs identified structural inefficiencies in the public sector as a major cause of the country's fiscal woes, they provided funding and a detailed map of public sector reforms. As such, all three bailout agreements came with a very tight schedule and stark conditions that had to be met before the loans could become available to the Greek government. One of the areas identified as problematic from a structural and spending point of view was health care.

At the start of the financial crisis, negative GDP growth rates, significant national debt levels, severe government budget deficits, combined with unreasonably high health spending were highlighted as areas of immediate attention for the Greek government.[1] All three MoUs signed by the Greek government, the European Commission, the European Central Bank and the International Monetary Fund (the latter three known as the Troika), included clauses on reforming health policy (Simou and Koutsogeorgou 2014, Keramidou and Triantafyllopoulos 2018, Ladi et al. 2021), but it has been slow-moving with some successes and some failures. Hence, considering the direct mandate by the MoUs, why did some health reforms succeed while others failed to be implemented?

Our evidence shows success in health policy reforms varies according to:

- the strategies and power of the main non-state coalition partner (the medical profession),
- the size of resources needed for successful implementation, and
- the ability (or not) of government to mobilise public opinion.

[1] At the onset of the crisis Greece GDP showed negative growth levels of 4,3% in 2019, 5,5% in 2010 and 9,1% in 2011. National debt levels were at 147,5% and 175,2% of GDP in 2010 and 2011 respectively. Central government debt rose to -15,1% of GDP in 2090 and continued at -11,3% in 2010 and -10,5% of GDP in 2011. Against this framework Greece spending on health as a % of GDP was increasing in current prices similar to EU average until 2019 (Yfantopoulos et al.,2023).

In this context, we examine three cases in order:

- the liberalisation of the pharmacy profession as a case of successful implementation,
- family doctor reforms as a case of partial implementation, and
- the referral system for specialised care as a case of mainly unsuccessful implementation.

Reform implemented: The liberalization of pharmacists as a profession

The first MoU highlighted the positive effect of liberalizing restricted professions on economic growth and improvements in service and encouraged reforms to this end. The second MoU went beyond identifying specific professions in the economy and included the promotion of further reform and easing of regulations. One of those identified within the MoU was community pharmacies, the liberalization of whom targeted improvement of service efficiency. This was coupled with the liberalization of more types of non-prescription medicine and other pharmaceutical products in supermarkets for instance. Law 4336, adopted in August 2015, incorporated the legal basis for lifting restrictions in response to the third MoU. Following the general legal framework, an additional set of three Ministerial Decisions (82829/2015; 6915/2016; 36277/2016), a Law (4558/2018) and a Presidential Decree (64/2018) were defining the prerequisites for opening new pharmacies, and regulation ownership, hours and terms of operation. This did not come easy, as the original Joint Ministerial decision (36277/20.5.2016) was revoked at the Council of the State following legal action by the Pharmaceutical Associations of Athens and Thessaloniki.

Despite initial mobilization and resistance by pharmacy unions, the reform was adopted and implemented. Despite some initial favorale public opinion, political support for pharmacists evaporated when it became known they were guaranteed 36 percent profit margins by the state through price controls. Given that the two main actors, doctors and public hospitals were not affected, pharmacists could not muster the support needed to successfully derail reforms.

Reform partly implemented: The universal primary care system

Another problematic area identified in consecutive MoUs was the provision of primary care. Of particular concern were the governance of national insurance agencies, the contracting of physicians to supply services as part of the national health system, and the corruption of the primary care system in managing the uninsured.

The MoU prescribed the unification of all national insurance funds under a single payer structure, aiming at improving governance and management of the resources allocated to primary care. The new agency, the National Organisation for Healthcare Provision (EOPYY in Greek), was established in 2012 (Law 4052/2012) and started operating in 2013 as a unified structure, combining both purchase and supply of healthcare services.

The new law made provisions for the new agency to incorporate the primary care clinics from the Social Insurance Organization (IKA in Greek) and to contract many private physicians to provide public primary care services on a part-time contract, allowing time for private practice. Reforming the primary care system was an essential element in improving the governance system of healthcare provision according to the joint proposals between the Troika and Greek Ministry of Health.[2] The SYRIZA government in 2015 also included additional provisions to provide care to those who were uninsured with Law 4368/2016. The biggest change within the provisions of the new agency was the institutionalization of primary care teams into autonomous system units in the form of neighbourhood primary care services with special reference to the provision of care within the urban communities. 240 Local Health Units (TOMY) were planned in all urban areas to be operational by the end of 2018 (Law 4486/2017) when the law was sent to public consultation.[3] Each TOMY would incorporate four General Practitioners (GP), one paediatrician, two nurses and two public health professionals, one social worker, and two administrators. Despite the intention to have those

[2] For details on the debate between the Troika and the Ministry of Health see https://www.moh.gov.gr/articles/ministry/grafeio-typoy/press-releases/1195-synenteyksh-ypoyrgoy-ygeias-kai-koinwnikhs-allhleggyhs-k-andrea-loberdoy-sto-r-s-real-fm-kai-ton-dhmosiografo-giannh-papadopoylo

[3] For the consultation stage see https://government.gov.gr/σε-δημόσια-διαβούλευση-το-νομοσχέδιο/

TOMY set up by the end of 2018, only approximately half of them have been established.[4] The main reason for the severe delays in the implementation of the policy were reactions from doctors who were reluctant to join the system claiming low salaries and a requirement for public-only service while providing services for EOPYY (i.e., could not combine private patients in the allocated visiting hours).

Reform mostly not implemented: Referral system from primary to other care tiers

One of the problems identified within the Greek public sector were the points of corruption, especially in health care services. This phenomenon resulted in additional payments required by citizens to benefit from specialist services. Hence the remedy was thought to be improvements to the referral system and closer links between the various tiers of health care. In a similar vein, an issue of over-prescription was identified because of the lack of a digital system of monitoring referrals and prescriptions (Kolokotsa 2021). The practice of bypassing the formal referral and prescription systems led to corruption between doctors and patients, and pharmacists and customers, as well as the burdening of the system with the provision of free or subsidised medicines to patients not requiring either the amount or the type of medicine to improve their health.

Reform proposals envisaged that the primary care physician (family doctor/GP) would act as a patient gatekeeper within the system. Having access to digital patient records and a unified database, which were absent in Greece, primary care physicians would be able to refer patients to specialist care (Law 4486/2017). Such implementation endeavour in terms of the modernization of the referral system and the closing of the points of corruption and inefficiency required the mapping of available services within the primary care areas across the country, in addition to the mapping of secondary care services and contracted specialist primary physicians. The exercise identified a considerable lack in family doctors and GPs. At the same time, in terms of recruiting such personnel, many private specialists were unwilling

[4] The target date has been extended to 2023 under the new rules for clawing back funds available by the European Union for missing the targets: https://www.in.gr/2022/05/23/health/health-news/240-tomy-promitheies-kai-clawback-ypo-epitirisi-stin-ygeia/

to abandon private practice to incorporate public services. Hence, it was mainly these two factors that did not allow the referral system to materialize.[5] A Ministerial Decision (29106/13-4-2018) describing the process of referrals from the family doctor or GP to specialist care or other healthcare tiers was issued in April 2018, but it made reference to the fact that the system would not be operational until all secondary and tertiary institutions were linked to the e-prescription system, incorporating an e-referral system. The document did not specify timelines, however, and the system was temporarily abandoned.[6]

Lessons learned from health policy reforms in Greece

Overall, the state of the art regarding the provision of health care in Greece shows that a number of *constraining* factors to the reforms can be highlighted:

- strong opposing special interests,
- the lack of monetary and human resources to implement the changes,
- the absence of incentives for the political coalitions to align with the reforms, and
- the lack of clear roadmap with step-by-step cumulative successes.

Nonetheless, a number of *facilitating* factors have been identified:

- the intensity of conditionality attached to the reform by the Troika,
- the absence of strong public opinion against it or the presence of favourable public opinion,
- the inclusion of major stakeholders,
- the inclusion of external funding in supporting the reform, and
- the political strength of the pro-reform coalition.

[5] At the time of the requirement by the MoUs the system had not materialized. As a result of Covid-19 related legislation however, the government recently managed to complete the e-referral and e-prescription systems using a top-down approach allowed by the emergency laws in 2020 (Law 4704/2020). The original law (3892/2010) was passed but never implemented until ten years later.

[6] The system of referrals was resuscitated in April 2022 when the modifications to Law 4486/2017 were put under public consultation (http://www.opengov.gr/yyka/?p=3230), which became law in June 2022 (4931/2022). The implementation of the law is still questionable but in general it is way out of the timeline proposed for the original reform and contains important deviations from the original framework.

The three cases have some key distinct features in terms of the politicization of the reform both at the design and implementation stages. They also differ in the number of resources made available by the state and by external agents, as well as the actual support among the targeted stakeholders, where a series of interesting dynamics developed. The pharmacists were not united but at the same time public opinion was on their side. The primary care general physicians had an overly disproportionate power stake over other specialists and managed to leverage delays on the implementation of the reform and the rollout of the primary care units. In the referral system, the administrative capacity of the system was not prepared to undertake the task of digitally linking the different care tiers and in addition to an unfavorable public opinion who place the issue of choice above the one of cost, creating an overall hostile environment against the reform, which was effectively abandoned.

Looking at the current state of play, despite the reform of the pharmacists' profession, Greece still operates a local pharmacy approach, as the pharmacy is largely linked to personalized primary care services for the immediate neighbourhood, although the hours of operation and the night shift availabilities have improved.

Nonetheless, the advent of the pandemic was instrumental in propelling reforms forward.

- It made the pharmacy a first point of combat against the Covid-19 virus with pharmacists engaging with the digital prescription system.
- Primary care reform has recently picked up political steam because of a clawback provision regarding external funding and the advent of the COVID-19 pandemic.
- The referral scheme showed new life following the success of the digital prescription system and the public's mentality change in seeking referrals through digital portals. Of course, partial success did not come without an incentive, which was the mandatory premium on top of patients' contributions to medicines and medical examinations.

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