

Viewpoints

Economic crisis, austerity and the Greek public health system

For 2 years the Greek financial crisis has captured global attention. In return for loans from the International Monetary Fund (IMF) and European institutions, Greece agreed on harsh across-the-board austerity measures, yet most commentators offer little hope for recovery, at least in the short run. The economy is expected to contract by a further 6.1% in 2011 and 3% in 2012, while unemployment is projected to reach 18.5% in 2012 up from 7.7% in 2008.

The Greek health-care system has been accumulating structural problems for a decade¹ that have been exacerbated by the economic crisis. In terms of expenditure, a failure to contain costs, in part due to an absence of explicit funding criteria, created budget deficits for sickness funds. Although the system is highly centralized, resource allocation suffers from a lack of planning and coordination, weak managerial and administrative capacity, and underdeveloped mechanisms for assessing needs and setting priorities. In addition, an oversupply of specialist physicians coexists with an undersupply of general practitioners and nurses. The combination of an absence of a functioning referral system and irrational pricing and reimbursement mechanisms leads to poor coordination of care, large out-of-pocket payments and a sizable black economy, impeding the system's ability to deliver equitable financing and access to services.

Since the onset of the crisis, the Ministry of Health has considered a range of proposals for reform, all aiming to achieve greater efficiency and reduced expenditure, responding to one of the IMF's key loan conditions, that public health expenditures must not exceed 6% of GDP.² The reforms include merging the four largest insurance schemes, collecting detailed monthly data on hospital activity and expenditures, reducing pharmaceutical expenses by means of policies including, but not limited to, adoption of e-prescribing, implementation of negative and positive lists of drugs and a reference price system, enhanced purchasing and procurement mechanisms, and centralized purchasing of medical supplies.³

While many of the proposed reforms target known weaknesses in the system, implementation has been complicated by the economic climate. The Greek public health system's post-crisis woes fall into three categories: fiscal, demand related and organizational.

First, fiscal austerity has taken its toll on public hospitals and other health services. The Minister of Health's directive for 2011 called for a 40% reduction in hospital budgets, but many hospitals failed to achieve this target. While there is scope for savings in the public health system and many measures go in the right direction, some necessary structural changes have been delayed while budgetary cuts place vulnerable groups at risk. Achievements so far include negotiating a price reduction of over 90% for certain generic drugs and reducing activity considered unnecessary with the assistance of hospital computerization. However, progress in adopting e-prescriptions has been slow, the publication of a recommended price list for medicines was postponed, pharmacy rebates are below target, prescribing guidelines are not yet adopted and generic prescribing is around 12.5%, well below the target of 50%.³

Reflecting the intense pressures to reduce expenditure, the Ministry of Finance imposed blanket cuts in budgets for public hospitals, agencies tackling illicit drug use and other public health organizations. Spending on mental health decreased by 45%, despite much greater need as a consequence of the crisis^{4,5} and, following a public outcry, the Ministry of Health announced that it would step in to cover the shortfall for these units.

Secondly, increased utilization of public health services has overstretched dwindling resources. Between 2009 and 2010 there was a 24% rise in hospital admissions and preliminary data for 2011 (covering January–October) indicate a continuation of these trends: a 8% rise in hospital admissions, 22% rise in patients visiting local health centres and 17% rise in laboratory tests. These increases reflect an inability to afford private health services, which previously played a large role in Greece, as well as a rise in self-reported ill health.⁶

Thirdly, administrative weaknesses constrain the ability of the Greek National Health Service (Ethniko Systema Ygeias, ESY) to maintain services. Growing uncertainty, combined with current austerity measures, have led to waves of applications for early retirements by civil servants, including health workers, while the government has limited hiring of new personnel. The ESY is characterized by an abundance of specialist physicians, although concentrated in urban centres, while there are comparatively few nurses and general practitioners, with numbers of the latter being the lowest in Europe per head of population, at only about 5% of all physicians. Since 2008, there has been a small decline in what has been a very high number of physicians (figure 1), most likely reflecting the public sector policy of recruiting only one individual for every five that leave. There is growing concern about long waiting times and more people are failing to seek treatment even though they feel they need to; out-of-pocket expenditures on primary care are high.

Although there is widespread recognition that the Greek health system requires wide-ranging changes, these will take time and some actions are needed now. Yet this is complicated by the imbalance between reduced resources and increased demand. A key priority is to curtail rising out-of-pocket expenditure but this will require action against tax evasion. In hospitals, a move to a DRG-type system will address value for money but more appropriate funding mechanisms are also needed in other areas. There is a need to safeguard programmes for vulnerable groups, such as those with mental illness and drug rehabilitation programmes. Action is also needed on the supply side; while the crisis has seen a substantial, and necessary, decline in the annual growth of physicians, more should be done to increase the number that are general practitioners and who work in rural areas. Measures are also needed to address the widespread out-of-pocket payments in primary care. More also needs to be done on pharmaceutical policy, such as measures to increase generic prescribing, to allow savings on drug expenditure to be reallocated to other important areas, such as recruitment of nursing staff. However, all these measures require political decisiveness and coordination across ministries, with a shared focus on equity and quality.

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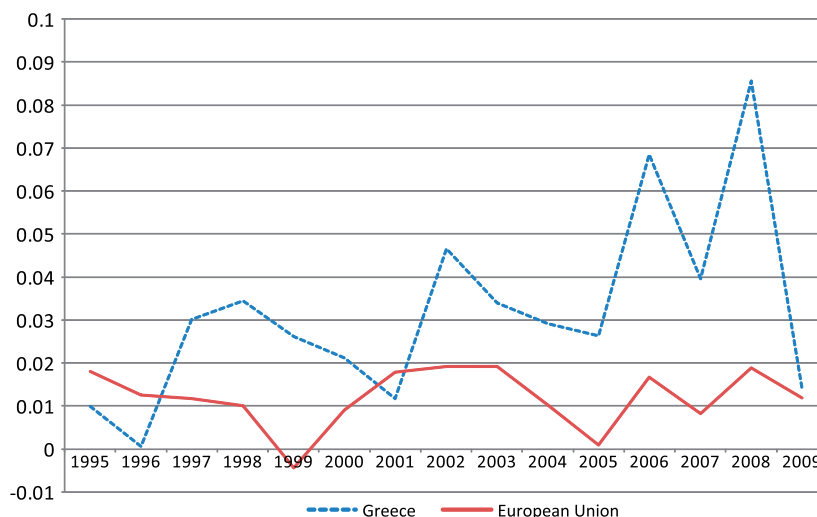


Figure 1 Growth of physicians per capita 1995–2009 compared to EU average. Data: WHO HFA

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Economic crisis and infectious disease control: a public health predicament

Will the economic downturn limit the capacity of infectious disease control in Europe? The recession peaked in 2009, with GDP growth rates tumbling by -2% for Greece and -18% for Latvia; conversely, most recently the European Union (EU) unemployment rate escalated to 9.5% , whereas youth unemployment soared to 21% . More than 80 million people live below the poverty line in the EU, disproportionately impacting children and the elderly. Public expenditures were cut in response to mounting government debt, disassembling the protective social welfare net. EU population standard of living is expected to deteriorate as a consequence and so is the risk of social exclusion. During times of economic upheaval, elimination of government services can have other unforeseen consequences: budget cuts in public health practice can fuel the epidemic potential of infectious diseases. Dismantling infectious disease control during times of social deterioration is the recipe for epidemics.

Regrettably, in Europe infectious disease control is not on the top of the policy agenda during prosperous times and much less so during economic duress. This is, in part, due to the fact that the infectious disease burden in Europe is estimated to hover at a low 9% , compared with 89% from non-infectious diseases, apparently not a source of concern. Besides, efficacious infectious disease control undermines its

own justification for existence, since the outbreaks, that are the best 'advocates' for infectious disease control, are prevented by that same control programme. Prevention programmes are inherently difficult to justify, particularly for low burden diseases during times of budget trimming.

Yet, the policy discourse during the economic crisis should not lose sight of a few important public health aspects. Disease burden in the population is only one criterion for priority setting; it should also take into account the epidemic potential of a disease, severity, antimicrobial resistance, dispersion in the general population or hospital (nosocomial infections), economic impact, risk perception, time trends, preventability, the burden on the health-care system, etc.¹ The global financial crisis, which began in 2007, has disproportionately impacted vulnerable groups in society.^{2,3} These groups carry a disproportional infectious disease burden compared with the general population in Europe; indeed, we have observed this trend in every member state of the union.¹ Particularly, during times of economic upheaval, the poor, infants, elderly, migrants, homeless persons and prison populations are at risk of becoming conduits of epidemics.⁴ We have described a number of disease transmission pathways to operate during economic downturns: the pool of susceptible populations (e.g. due to decreased vaccination