The Review

Economic crisis and primary care reform in Greece:

driving the wrong way?

The economic crisis in Greece[1] may offer an opportunity for the reorganisation of the health system,[2] and although primary healthcare reform is high on the political agenda, questions remain about the direction of restructuring.

THE POLITICS OF PRIMARY HEALTH CARE IN GREECE

Weaknesses in the Greek health system include poor continuity of care, excessive use of curative services, lack of preventive measures, low levels of satisfaction, high rates of out-of pocket payments, and significant inequalities in the range and quality of health services.[3,4]

In the past a plethora of occupational funds had offered different packages of primary healthcare coverage. In some cases they used their own infrastructure (GP-led health clinics) and/or contracted private physicians and laboratories, situated mainly in urban and semi-urban areas.[5] In 1953 the state established the first public medical posts in rural areas a few years later, obliging medical graduates to offer their services to local populations as fully employed civil servants.

In 1983 the Greek National Health System (Ethniko Systima Ygeias [ESY]) was founded following the Alma Ata Declaration's emphasis on primary care.[6] It foresaw the replacement of the existing primary healthcare infrastructure with ESY urban and rural health centres and the unification of social health insurance schemes. In the next decade 176 health centres and 19 small hospitals[4] were established in rural areas offering health services accessible to all, comprehensive and free at the point of use. Unfortunately, the 220 urban health centres envisaged by the ESY implementation plan,[4] were never established. The sickness funds' primary care infrastructure and variable benefits remained untouched, due to opposition from physicians engaged in private practice, and social groups who received enhanced healthcare benefits.[7] The 1983 reforms missed a unique opportunity to overhaul the fragmented system of social health insurance[8,9] and to create a universal, integrated primary healthcare system.

From 1994 to 2009 numerous primary healthcare reform plans sought to promote users' freedom of choice, to introduce the family/personal physician as the cornerstone of primary care system's structure, and to unify primary care services. A purchaser–provider split, selective contractual arrangements with existing providers, gatekeeping, and capitation payments for family doctors were endorsed by all of these plans,[6,9] but ultimately none were implemented. Their failure was partly due to the Greek state's administration[8,10] but mainly to obstruction by those with vested interests, such as private physicians, part-time social security doctors, and wealthy insurance funds.[7]

In March 2011 the government passed yet another bill for the unification of primary care, introducing the capitated 'personal doctor' as the referral point within the healthcare system. It also left intact all existing primary healthcare providers, created incentives for entrepreneurs to invest in primary care facilities, and tried to integrate these providers through selective contracting with a single social health insurance purchaser. One year later this crisis-led 'reform' is partly implemented, facing mainly the opposition of the Greek Medical Association based on the reasonable fear that single private surgeries will soon be absorbed by primary healthcare corporate.

PRO-CRISIS PROVISION OF PRIMARY CARE SERVICES IN GREECE

Primary health care in Greece is fragmented, tripartite, and based on a complex public/private mix of the ESY, social health security, and the private health sector.

ESY

The ESY consists of 201 rural health centres, 1478 rural medical posts/surgeries, three urban health centres, and the outpatient clinics of 140 public hospitals.[11] Health centres are considered as decentralised units of the ESY regional hospitals and rural medical posts are considered as satellite units geographically attached to health centres. All health centres are tax-financed, receiving budgets on a retrospective basis in accordance to last fiscal year's payroll and overhead costs but not weighted for local healthcare needs. ESY health centres and medical posts are staffed with 1787 full-time salaried medical doctors (mainly GPs, pediatricians, dentists, and specialists in internal medicine) and approximately 2414 other health professionals,[11] most of them enjoying permanent tenure. ESY centres and their satellite surgeries offer 24-hours a day, free at the point of use, preventive, curative, emergency, and rehabilitation services to their rural populations of 10–30 000 citizens. Outpatient clinics of ESY hospitals offer specialist and diagnostic services to urban and semi-urban populations, free of charge with minimal co-payments during working hours, and on a fixed fee-for-service basis during evening hours. No referral system exists, and users can bypass primary care to seek specialist services. Although ESY health centres represent a major breakthrough, their weaknesses include shortages in personnel and equipment,[12] lack of medical record documentation,[12] low technical and scale efficiencies compared with social security's primary care units,[13] and low users' satisfaction rates,[14] a fact that causes a constant flow of patients from rural to urban areas in search of better care.[14]

Social health security

Social health security consists of 36 occupational sickness funds that offer different packages of primary healthcare coverage to almost 95% of the population. Some funds have their own primary care infrastructure, while others purchase services from contracted private physicians and laboratories.[11] Their health units are staffed by full-time salaried medical doctors (mostly specialists) and part-time salaried doctors who are also free to do private practice.[15] Within this complex regime, users have free access, during working hours, to a

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range of mainly curative and diagnostic services at their insurance fund's primary healthcare units and/or access, on a co-payment basis to contracted private physicians and laboratories. No referral system exists and social security beneficiaries can directly seek hospitalisation at public or private hospitals. Although this primary care infrastructure substitutes to some extent for the absence of public primary healthcare services in urban areas, it still suffers from many weaknesses including surprisingly low users' satisfaction rates,[15,16] excessive use of curative and diagnostic services,[15] and unethical practices; social security doctors often use their posts to attract patients to their private offices.[3,15]

Private health sector

The private health sector infrastructure consists of approximately 25 000 private physicians, 12 000 dentists, 400–700 private laboratories, and the outpatient departments of the 167 operating private hospitals.[17] Private physicians in Greece, most of them specialists, run their own surgeries, and may also work as part-time salaried employees at private hospitals, receiving bonus payments for hospital admission. Corporate-owned diagnostic centres control more than 70–80% of the country's total biomedical equipment.[17] Private physicians and diagnostic centres receive users' payments, fee-for-service payments from contracted social health insurance funds, and fee-for-service or capitated payments from private health insurance schemes. The private primary care sector in Greece absorbs more than 65% of total private health expenditure and substantial profits are made by the private diagnostic centres.[17]

IMPLICATIONS ON THE FUTURE OF PRIMARY CARE IN GREECE

In our view there is an urgent need for the rationalisation and consolidation of Greece's fragmented primary care system. The most obvious obstacles seem to be the financial interests of diagnostic services and corporate and part-time social security doctors, as well as the justifiable fears in some population groups of losing part of their advanced healthcare benefits.

For more than 16 years primary healthcare reform plans have sought to overcome these obstacles by suggesting the virtual,[18,19] rather than the actual, integration of primary care services in the country. Existing providers and their micro-regimes of vested interests would have remained untouched. Now primary care users, once members of a geographically determined population, become members of an 'enrolment list' and under the guidance of their personal physician consume services in a mixed healthcare market. With these proposals the Alma Ata Declaration's principles of a free, universal, integrated, and community-oriented primary care system have been abandoned.

Despite their problems, the Greek ESY's primary healthcare centres represent the only organisational structure able to offer holistic services to clearly defined local populations.[20] In a country like Greece with 27 years of experience of community-based health centres, it seems irrational to imitate once again controversial policies based on quasi-market mechanisms. The plan in the original Greek ESY Foundation Act for complete replacement of the existing primary care infrastructure, with public, community-based, urban, and rural health centres free at the point of use, seems to us to be the only realistic way to move forward.

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