

International exchange

A future for primary care for the Greek population

Peter P Groenewegen PhD

NIVEL – Netherlands Institute for Health Services Research, Utrecht, The Netherlands

Arnoldas Jurgutis MD PhD

Department of Public Health, Klaipeda University, Klaipeda, Lithuania

ABSTRACT

Background Greece is hit hard by the state debt crisis. This calls for comprehensive reforms to restore sustainable and balanced growth. Healthcare is one of the public sectors needing reform. The European Union (EU) Task Force for Greece asked the authors to assess the situation of primary care and to make recommendations for reform. Primary healthcare is especially relevant in that it might increase the efficiency of the healthcare system, and improve access to good quality healthcare.

Approach Assessment of the state of primary care in Greece was made on the basis of existing literature, site visits in primary care and consultations with stakeholders.

Results The governance of primary care (and healthcare in general) is fragmented. There is no system of gatekeeping or patient lists. Private payments (formal and informal) are high. There are too many physicians, but too few general practitioners and nurses, and they are unevenly spread across the country. As a consequence, there are problems of access, continuity, co-ordination and comprehensiveness of primary care.

Conclusions The authors recommend the development of a clear vision and development strategy for strengthening primary care. Stepped access to secondary care should be realised through the introduction of mandatory referrals. Primary care should be accessible through the lowest possible out-of-pocket payments. The roles of purchaser and provider of care should be split. Quality of care should be improved through development of clinical guidelines and quality indicators. The education of health professionals should put more emphasis on primary care and medical specialists working in primary care should be (re-)trained to acquire the necessary competences to satisfy the job descriptions to be developed for primary care professionals. The advantages of strong primary care should be communicated to patients and the wider public.

Keywords: economic crisis, Greece, health reform, primary care

How this fits in with quality in primary care?

What do we know?

Strong primary care is especially important in that it may to some extent buffer the negative effects of the economic crisis on vulnerable people. It contributes to better population health, less inequity in health and access to care, better opportunities to cost containment and lower healthcare costs.

What does this paper add?

Assessment shows that the current Greek healthcare system lacks key characteristics of strong primary care. Reform of primary care is therefore one of the priority areas for the Greek government. To increase the chances of successful reform, the strategy should be to combine local or regional pilots with national level policy development and implementation.

Introduction

The economic crisis that besets Europe is felt strongest in Greece. Its clearest symptom is the high state debt to gross domestic product (GDP) ratio. The Greek crisis became urgently visible from the moment the European Union (EU) had to intervene with loans and debt regulation from 2010 onwards.¹ The economic crisis is doubly important for healthcare. First, the healthcare sector constitutes a large part of the economy. Health expenditure as a share of GDP amounts to just over 10% on average in the EU-15 (2010). For the largest part, these are public expenditures. Although they are often seen as a cost factor, increasing the tax burden and labour costs, they are also a source of employment. Continuing to invest in healthcare might therefore have a stabilising influence on the economy. Second, healthcare plays an important role in the long-term well-being of the population and contributes to a healthy future workforce. The economic crisis has had a negative influence on population health, especially mental health.^{2,3} This is partly through health effects of psychological insecurity, stress and access to material goods, and partly a consequence of lack of access to healthcare.⁴ Good primary care is especially important in that it may to some extent buffer the negative effects of the economic crisis on vulnerable people. Therefore, the healthcare sector is not only a cost factor, but also an important investment with potentially good returns.⁵

Increasing the efficiency of the healthcare system and providing access to good quality healthcare for those hit hard by the crisis should, therefore, be part of the policies to address the crisis.⁶ The healthcare sector may then act as a motor for revitalisation when the economy starts to recover.

Against this background, it comes to no surprise that the healthcare sector plays a substantial role in plans for reform to address the economic crisis. The combination of the European Commission (EC), the European Central Bank and the International Monetary Fund – the Troika – negotiates with countries in the Eurozone on financial support in exchange for commitments to restructure the economy. In the case of Greece, the EC has installed a Task Force for Greece (TFGR) that provides assistance to Greece in several domains, one of which is healthcare.⁷ Technical assistance to Greece in the field of healthcare is provided on the basis of agreed collaboration between the Greek government and the TFGR. The Greek Ministry of Health (MoH) established a Health Reform Steering Committee with several subcommittees, including one on primary care in September 2012, and launched the initiative ‘Health in Action’ with the aim of developing specific structures, processes and tools to manage the reforms in the Greek health system. One of

the key objectives of Health in Action is the development of an integrated primary healthcare network with the aim of meeting population needs and ensuring the efficient use of public resources.⁸

At the background of this objective, is the policy theory that stronger primary care contributes to better population health, less inequity in health and access to care, better opportunities to cost containment and lower healthcare costs.⁹ The current Greek healthcare system lacks key characteristics of strong primary care. Reform of primary care is therefore one of the priority areas for the Greek government.¹⁰ The draft Programme for Technical Assistance in the field of health (December 2012) defined primary care as: ‘an easily accessible and geographically available comprehensive outpatient service, capable of independently handling the majority of health problems, with a gatekeeping function towards specialised health care and with important tasks related to home care’, in line with international definitions.^{11–13}

The authors were asked by the TFGR to make an assessment of the current state of primary care in Greece through a quick scan of the available (international) literature, consultation with stakeholders in the Greek healthcare system and site visits in primary care.¹⁴ The assessment should lead to recommendations for reforms of primary care and form the basis for a concrete action plan. Our aim is to describe the assessment of primary care in Greece and the recommendations to strengthen primary care.

Approach

The assessment of primary care in Greece is based on a field mission that aimed to assess the current state of primary care, current and future challenges and a vision for the future of primary care in Greece. The mission to Greece was conducted on 9–11 January 2013 by the authors and was followed by meetings in April and June 2013 to discuss the results of the mission and the outline for an action plan. Background documents on healthcare in Greece, which included international research papers and international reports on healthcare and primary care in Greece were studied.

The mission in January consisted of one day of information gathering and consultation at the MoH with stakeholders, including experts from the MoH, from healthcare and from health services research, and two days of fact finding through site visits to health service delivery organisations in Athens and surrounding areas. Healthcare facilities for the visits have been selected to include at least one example of the different models of organisation of ambulatory/outpatient care:

- a rural health centre within the Greek national health system (NHS)
- a semi-urban health centre within the NHS
- an accident and emergency department within a public general hospital
- a prefectural health unit of the unified insurance organisation (EOPYY)
- a local health unit of EOPYY
- a private diagnostic centre and
- a private general practice.

Our assessment of primary care follows an analytic framework that distinguishes the key dimensions of primary care (Figure 1).¹⁵

This analytic framework was used to describe the current situation of Greek primary care for each dimension and to identify the main problems and challenges in each dimension.

Results

Key aspects of the structure of the Greek healthcare system

The Greek healthcare system is a mix of three main components.^{16,17}

First, there is a tax-based national health system (NHS), introduced in 1983, that is responsible for public hospitals and health centres outside the main

urban centres. The NHS includes a view of primary care, based on universal coverage and equal access. Primary care was to be developed based on urban and rural health centres, staffed by general practitioners (GPs) and with a referral system to specialist and hospital care. Since the establishment of the NHS, several policy initiatives to reform primary care have been taken, laws have been written and have passed parliament, but sustainable changes have not been implemented.^{17,18}

The second component is an insurance system, based on premiums paid by employees and employers, and organised in a few large and many small occupation-based social insurance funds that combine responsibility for healthcare and pensions. Recently, in 2012, the health insurance part of the main social insurance funds merged into one organisation, EOPYY, covering more than 90% of the population. EOPYY runs its own healthcare delivery units in urban areas, covering more than 70% of the population and providing directly accessible care to the insured.

The third component is a private insurance system (fairly small and mainly consisting of additional insurance) and a private delivery system, consisting of private hospitals, diagnostic centres and private physicians, most of whom have contracts with EOPYY.

All healthcare is directly accessible without referral. The population thus has direct access to a variety of healthcare institutions, funded from the NHS, the social insurance system, private insurance or private payments. Healthcare units operate on fixed budgets

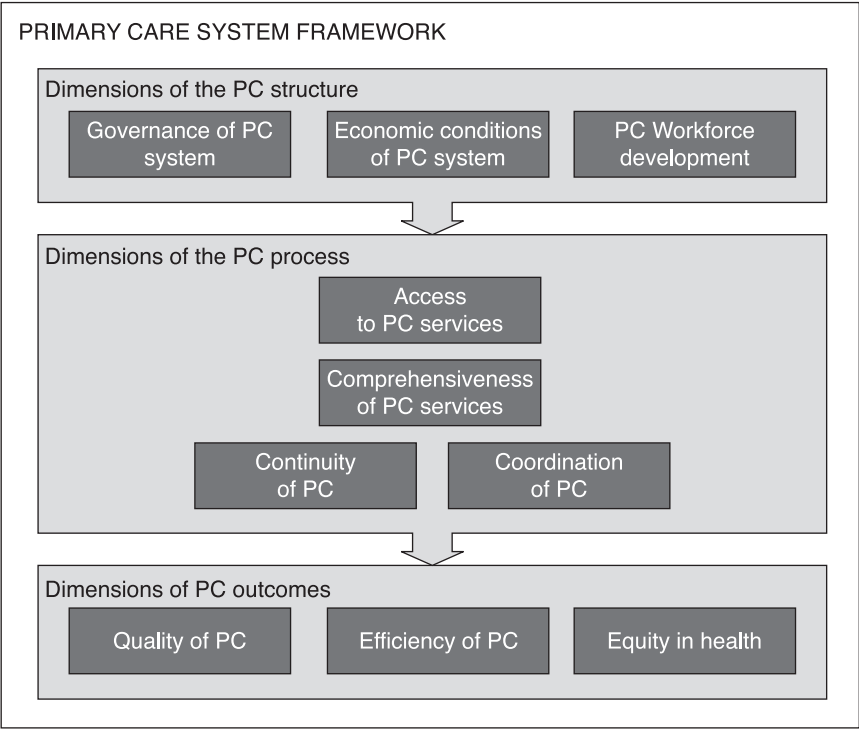


Figure 1 Primary care system framework (source: Kringos et al 2010)

based on historical patterns, covering operational costs and capital investments, and are reimbursed on a retrospective basis for services delivered.¹⁷ Total health spending reached 10.2% of GDP in 2009, slightly above the average of 9.9% of GDP in European Organisation for Economic Co-operation and Development (OECD) countries in the same year. The OECD figure for Greece in 2011 is 9.1%, lower than the European OECD average.¹⁹ Now within Troika targets, all public expenditures are decreasing and so are healthcare expenditures.^{20,21} As a separate target, expenditures for prescribed drugs are being reduced by price cuts.²² An important characteristic of Greek healthcare is that people pay a large share of healthcare expenditure out-of-pocket in the form of official co-payments and under-the-table payments. The share of private expenditure was estimated at 37% (of which an estimated 40% was under-the-table payments).¹⁷ This amounts to US\$1118 purchasing power parity (PPP) per capita, more than double the average among EU OECD countries in 2010.¹⁹

As a result of the structure of the healthcare system, it is fragmented at all levels. This makes it very difficult to identify what exactly is the primary care sector and it includes a wide range of directly accessible services (Table 1).

Recent data from the MoH indicate that up to 35% of outpatient visits are to private physicians and are paid for out-of-pocket. Visits to doctors at rural and

semi-rural health centres and non-specialised physicians comprise only 5% of visits.²³

The geography of Greece poses its own problems for healthcare delivery. A large share of the population lives in a few major conurbations. The rest of the country is sparsely inhabited, often mountainous, and consists of numerous larger and smaller islands.

Assessment of key dimensions of primary care

Governance of primary care

The governance of primary care is unclear as a result of division and mal-distribution of responsibilities between several ministries, between national government and district and local authorities, health insurance funds and NHS, and the public and private sector. There is no broadly supported vision of primary care, addressing priority setting, financing, supply planning and management, service provision and quality monitoring. Although since 2001 there are regional health authorities, governance of primary healthcare is strongly centralised and autonomy is severely restricted both in the NHS and in the EOPYY services. For example, the directors of health centres or units do not have the authority to change the mix of personnel.

There is no national quality management infrastructure or routinely used indicators to monitor PHC services and there are no incentives for care providers to improve the quality of care.^{17,24}

The NHS health centres are administratively part of general hospitals. They are usually large organisations, regulated according to national requirements, irrespective of local circumstances and needs. Private diagnostic centres are well equipped with modern diagnostic technology and often used as a first point of contact with the healthcare system, offering also office-based medical care, including preventive check-ups, for those insured privately.

There is no strong patient movement in Greece. There are a number of small, disease-specific organisations without an institutional role in the healthcare system. There is no information about the actual implementation of patients' rights.¹⁷

Workforce development

The workforce is unbalanced, with too many physicians and too few nurses and other health professionals; and too many specialists and too few GPs. Moreover there are large geographical inequalities, with shortages in rural and remote areas partly solved by the requirement of physicians after graduation to work for one year in an underserved area. General practice as an independent medical speciality was established in 1985 to staff the newly established NHS health centres.^{17,25}

Table 1 Directly accessible health services providing first contact care

Health service	Number
Outpatient departments of public hospitals	134
Rural health centres	201
Regional rural clinics	1460
Special regional rural clinics	38
EOPYY clinics	150
Diagnostic centres	4000
Private physicians	25 500
Private dentists	12 586
Private clinics	175
NGO health foundations	400
Municipal clinics	80

Source: presentation by N Bechrakis.²³

Nevertheless, there is a shortage of practising GPs (approximately 1 per 3000 inhabitants) and fewer than half of the GP posts in rural healthcare centres are filled by specialists in general practice.²⁶

There are seven public university medical schools.¹⁷ General practice specialisation takes four years, most of which (38 months) is spent in a hospital where residents are trained by specialists in other fields. Only 4.3% of undergraduate students stated that they would choose general practice.²⁷ The major obstacle discouraging them from choosing general practice as a specialty was the lack of specialisation of this discipline, followed by perceived difficulty in finding a career post, low grade of acceptance by the medical community and low social prestige.²⁶ There is no attention to evidence-based medicine during specialty training.^{28,29} The culture during undergraduate medical training is clearly oriented towards specialisation, and the Faculty of Medicine of the University of Crete remains the only medical school to include primary care in its undergraduate curriculum.³⁰

There are no human resource policies to stimulate general practice training or to regulate the distribution of primary care providers and facilities more evenly.

Economic conditions for primary care

There is no reliable estimate of primary care's share of total health expenditure, because of the fragmented system with many different services providing first contact care. The earnings of GPs are lower than those of other specialists and low compared with other countries. Primary care providers are in salaried service in either the NHS health centres or the EOPYY health units, or they are self-employed. EOPYY physicians have the right to work in private practice in the afternoon/evening with a contract to EOPYY on a fee for service basis for a restricted number of services per month and with private payments beyond this number. Apart from that, EOPYY also has contracts with independent physicians. Hence, EOPYY is both provider and purchaser of care. Doctors from NHS health centres are not allowed to work in private practices. Nevertheless, salaried physicians in public hospitals are allowed to ask fees from outpatients in the afternoon. In general the incentives are to provide more services.¹⁷

Access

Access to healthcare is strongly hampered by the fragmentation of the system, unequal distribution of oversized health centres, formal and informal cost-sharing and there are also large regional differences in access due to low numbers of GPs and vacancies. There is no system of mandatory referrals or gate-keeping. As a consequence, people can visit whichever healthcare provider they want. This leads to an 'in-

fraction' of the system. Pathways to more specialised care are obstructed, leading to long waiting lists to get an appointment with a physician, which in turn obstructs the pathways to emergency care. To avoid waiting a long time for an appointment, patients self-declare their problems as an emergency. With no professional triage, patients are waiting a long time for a physician who does not know their medical history and who is overburdened by the number of patients. There is no effective appointment system for office and phone consultations in primary healthcare. There are some projects to use telemedicine, but not on a regular basis.³¹

Access is also hampered by the size of health centres and units. Smaller general practices could bring care closer to the people and in the community context of patients. In the 1980s, there was a pilot in a few EOPYY healthcare units to establish smaller general practices within larger catchment areas. A key priority of the management of such healthcare units would be to strengthen these satellite practices.

Comprehensiveness

Directly accessible care is usually specialised, there is no comprehensive approach to patients and there is no family and community orientation. Care is restricted to those who visit the particular service rather than community- or population-based, making programmatic and outreach preventive care impossible. Hence, the service is internally fragmented and disease- and diagnosis-oriented. Sometimes health centres and units lack crucial equipment or the personnel to operate it. We observed a huge difference in equipment in the private diagnostic service we visited and the EOPYY and NHS centres. In these centres, physicians often have a very small role, limited to prescribing and referring. Home visits are uncommon in the Greek healthcare system,³² although there is an increasing need as a result of the ageing of the population.

Rural health centres play a limited role in prevention. Those we visited operated clinics that provide primary and secondary prevention services, e.g. an antismoking counselling clinic, hypertension clinic, diabetes clinic. However, the approach is passive and not community oriented, targeting only patients who visited the clinic.

Because of cultural beliefs and traditions, children's health problems are mainly presented to private paediatricians (with out-of-pocket payments). There is no integration of different primary care services or between primary care and social care.³³ Home care is mainly organised within the social sector (Ministry of Labour), led by social workers, and only informally related to healthcare. Organised home care programmes depend on temporary EU (structural) funding. Many people rely on informal care and the private sector.³²

There is a lack of modern public health policy approaches with little health needs assessment or priority setting at community or national level. To date, Greece has neither developed a health targets programme for setting priorities, nor a national plan for the implementation of a Health in All Policies approach.¹⁷

Continuity

Continuity of care is very weak in all three dimensions – interpersonal, longitudinal and informational. Personal continuity is a problem due to the fragmented healthcare system. Informational continuity relies on good information systems, both within primary care and between primary and secondary care, but there is no uniform use of medical records (either paper or electronic) and referral letters are not common. Only occasionally do primary care practices receive information within 24 hours about patient contacts with out-of-hours services. There seems to be no information exchange between specialists and GPs after the completion of an episode of treatment.

Extension of the system of ‘e-prescription’ to diagnostic procedures and referrals is one way of facilitating continuity of care. E-prescription is a recently introduced system that obliges physicians to prescribe drugs via an electronic system. Use of the system is mandatory and currently followed by 90% of physicians. Problems include a lack of computer equipment in health centres and units, causing an increased administrative burden. Physicians in hospital emergency and outpatient departments and private physicians often send patients off with a written prescription and advise them to go to a health centre or unit to have the prescription entered into the e-prescription system. Patients often feel obliged to pay some money for entering the e-prescription. The system of e-prescribing could be the starting point for electronic medical records that allow exchange of information between care providers.

Co-ordination

Co-ordination of care is very weak, leading to inefficient healthcare utilisation and waste (repeated diagnostic tests and prescriptions). Co-ordination of care is severely hampered by the absence of a referral system and lack of information exchange between healthcare providers. Many different pathways to care are used next to and after each other without co-ordination. In the NHS centres, referral to (out-patient) specialists is more common, while these centres are administratively part of public hospitals.³⁴ Even though EOPYY healthcare units employ a range of specialists, there is no internal referral system from the emergency services to the office-based specialists or between specialists.

As a consequence of the lack of co-ordination, repetition of diagnostic tests and prescriptions is common.³⁵ E-prescribing should lead to a clearer picture of drug use by individual patients and facilitate co-ordination of care.

Health centres provide opportunities for co-ordination within primary care, because they also employ nurses, health visitors and midwives, and because they have links to social services. However, there is no information about actual co-ordination. There are no explicit institutional links between home care and primary care, but local primary care and home care services seem to work together in practice.³⁶

Quality of care

There is a lack of information about the quality of primary care. Quality indicators for primary care should be developed between healthcare providers, purchasers and the MoH. They should be part of systematic quality cycles, but with the exception of the Cretan Guideline Evaluation Group this is not done.³⁷ There are no generally accepted and used clinical pathways for chronically ill people, nor are there guidelines. An attempt to measure the quality of care of patients with cardiovascular disease was presented in the semi-rural health centre visited, which serves an area with 48 000 inhabitants. The centre has reviewed information on systolic and diastolic blood pressure, level of glycosylated haemoglobin, low-density lipids and cholesterol recorded in electronic records set up for patients with cardiovascular disease. This review was limited to just 69 patients. Lack of personal continuity and an absence of patient lists were cited as the main obstacles for the introduction of a quality assessment and improvement system.

Within the framework of cost control in the pharmaceutical sector, prescription protocols are being developed and implemented. However, these protocols cover the prescription of medicines and do not encompass comprehensive management of diseases.³⁸ The e-prescription system will enable feedback to prescribers about prescription volume and the use of generic drugs. This might lead to quality improvement.

Euro-barometer surveys have shown large dissatisfaction with the healthcare system and many people feel that healthcare becomes unaffordable. Satisfaction with the ease to reach and gain access to GPs is relatively low.¹⁷ In general the public perception of quality of care is low.²¹

Efficiency

Although the necessary information to formally assess the efficiency of primary care is lacking, many signs point to inefficiency. As a result of direct accessibility of highly specialised physicians, these physicians also deal with health problems that do not require

specialised diagnosis or treatment. This leads to overburdened specialists and reduced access for those who need specialised care. To change this pattern, rules and regulations have to change, but information and education for patients has to be available also. Patients currently feel they save time and money by going directly to a specialist.³⁹ Financial incentives tend to lead to an increase in services, overuse of laboratory tests and uptake of expensive medical technologies. Greece leads Europe in the availability of MRI units.⁴⁰

Equity

There are clear and increasing inequities in healthcare in Greece. These inequities relate to health status, socioeconomic status and place of living. There are an increasing number of uninsured people. Greece has (as a consequence of its long and difficult to monitor borders) a large population of undocumented migrants. However, the number of uninsured has also increased because of the economic crisis. Unemployment is now somewhere between 26 and 30% of the workforce and an estimated one third of these are uninsured. Access to services for the uninsured is restricted. Out-of-pocket payments, and especially black market payments, also contribute to the inequity. A consequence of the lack of guidance and co-ordination of care is that people have to direct their own care pathways and some will be better able to do this than others. This leads to inequalities related to income and education and an unequal distribution of expenditures. Consequently there are large unmet needs among the uninsured and those on low incomes.²¹ Health services and human resources are also unequally distributed over the country.

Recommendations

Based on the assessment of primary care in Greece, a number of recommendations to improve primary care have been formulated into an action plan. The MoH and stakeholders should develop a clear vision for strengthening primary care with GPs as a core profession. Stakeholders should be actively involved in development of the vision for health. A national primary care development strategy should be adopted by the MoH and possibly by parliament.

Access to primary care should take place with the lowest possible cost-sharing from private or under-the-table payments. This is possible in a system of stepped care access through mandatory referrals to specialists, hospital and diagnostic services. Introduction of a referral system requires that the links between primary care and specialist and hospital care be re-defined. Patients should be on the list of specific physicians or practices (i.e. a personal list system). The community orientation of primary care should be

developed through relations with preventive services, community and home care and primary mental healthcare.

Funding of primary care should be geared to population needs through adequate resource allocation and this should take the form of a mix of capitation, fee-for-services and/or bonuses for specific targets. The level of payment for primary care professionals should be in line with their increased responsibilities. Those primary care professionals with a specialised primary care education, such as GPs, should receive specific incentives. Steps should be taken to split the purchaser and provider functions in healthcare and contracts between purchasers and primary care providers should be based on the same principles and conditions for all primary care providers. Primary care organisations should be able to make their own choices in using their budget.

Primary care physicians should develop clinical guidelines in co-operation with other stakeholders. The development of a system of quality indicators is strongly recommended. Quality indicators should form part of quality improvement cycles at different levels. Continuity of care should be facilitated by medical records. These could build on the e-prescribing system. Primary care professionals should have clear job descriptions that guide educational requirements and contracts and that inform patients on what they can expect from primary care. An assessment of training needs for primary care professionals working recently in practice is recommended and short training courses to obtain core competences stated in the job description should be developed and implemented. Policies for the education and training of health professionals should address the imbalance between generalists and specialists and serve to increase the flow into general practice training. Primary care should be included in the undergraduate part of medical and nursing curriculum. The curriculum for general practice residency should be reviewed and adapted so that obtained competences are relevant to primary care practice. A referral system and personal list system should, as far as possible, be reconciled with freedom of choice for patients of their preferred primary care provider.

Implementation of a comprehensive primary care system could begin in a small number of selected pilot areas. Pilot areas could be asked to participate on a voluntary basis, with clear requirements and conditions for participation, using a transparent selection procedure. The advantages of a strong primary care system for an equitable and sustainable healthcare system should be communicated to the wider public. Therefore, a mass media strategy should be elaborated. In the whole process of reorganising primary care, independent monitoring and evaluation are extremely important. This requires investment in collecting and analysing information.

Discussion

The assessment of Greek primary care and the recommendations as described in the mission report were accepted by the subcommittee on primary care of the Health in Action initiative and by the MoH.¹⁴ They form the basis for an action plan. The development of the action plan is the basic responsibility of the MoH with technical assistance from outside experts. It should fit in the broader reform agendas of healthcare and the public sector and it should be allocated the funds necessary for its implementation.

In our view, the crucial question is whether this will be just the next plan that is not implemented or whether there will be a real reform this time. We think that this will partly depend on the structure and contents of the action plan itself and partly on general conditions for institutional change in healthcare.

To start with the first, we think that the action plan should have a double focus: both national and regional/local (Figure 2).

This approach makes it possible to start directly with improvements for the Greek population through pilot projects and at the same time to work on longer term policy changes. The pilot projects will provide valuable information on the feasibility of reforms in different contexts (e.g. urban versus rural). Feedback on experiences of strengthening primary care will inform national policy development and national changes are necessary to create favourable conditions to implement local/regional reform plans. This approach is also expected to create support amongst the population and healthcare providers, depending of course on the success of regional/local pilots.

Institutional change in healthcare, in general, depends partly on the urgency of the situation. Past experience in Central and Eastern Europe has shown that a complete breakdown of the current political and economic system adds to the urgency of reforms.

Added to this were worsening public health indicators in that setting. This made way for a fundamental reform of the healthcare systems of most countries in Central and Eastern Europe. Primary care reforms in Western European countries lack urgency and are more gradual. Although the current crisis in Greece calls for fundamental reforms, the perceived urgency may be different, especially since the austerity measures, taken by the Greek government under pressure of the Troika, have met strong opposition. The urgency for health system reform might therefore easily be attributed to external forces and therefore be felt to be less urgent. This underlines the importance of involving stakeholders and communicating to the general public during the reform process.

The experience in Central and Eastern Europe has also shown the importance of supranational institutions such as the EU. The wish to join the EU has started reform processes that also influenced healthcare reforms.⁴¹ In the Greek case, pressure by the Troika will be of great importance for the direction and success of the reform process in Greece.

The political system also plays an important role in implementing health reforms. Past experience of trying to reform healthcare in Greece is one of making plans and drafting laws without actually implementing them.¹⁸ This adds to a feeling that primary care reforms will be the next ambitious plan that fails. This is why we have emphasised the double-focused action plan.

An important issue is also the role of strong pressure groups in politics and healthcare. Every reform has winners and losers and every euro spent on healthcare is somebody's income. Strengthening primary care will undoubtedly affect the interests of some groups. Therefore, the emphasis should be on the positive effects that could counter negative feelings. As an example, medical specialists might oppose a mandatory referral system, because they feel that this affects their future income. However, it should be emphasised

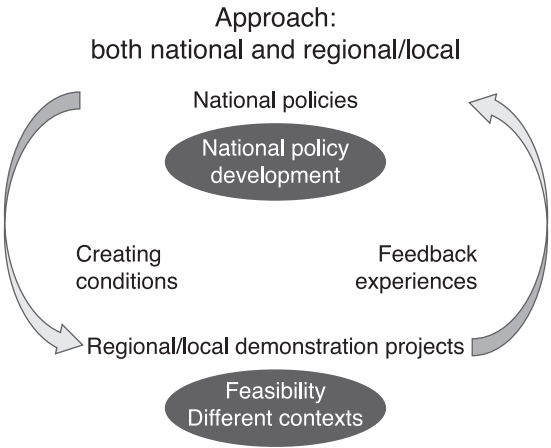


Figure 2 A double-focused approach to primary care reform in Greece

that the content of their professional work will improve by being able to do what they were educated for: diagnosing and treating more complex cases. Also, improved care at the community level will guarantee better continuity of care after complex interventions in hospitals and herewith better results of specialised services.

The structure of the healthcare system affects the chances of success of reforms. In general, the role of government is stronger in national health systems compared with social insurance systems, and reforms are easier when the government has a strong role. However, the Greek healthcare system is a mix of NHS and social insurance. The mix of responsibilities of the state and the social insurance system is an additional challenge to effective reforms. It will almost unavoidably be affected and this has to be resolved for healthcare in general.

Structural reforms in healthcare are long-term processes; witness the changes in Central and Eastern Europe, but also health reforms in Western Europe. Political and economic stability is an important condition for ongoing progress. Part of these long-term processes is the mutual influence of structural changes and predominant cultural values. These cultural values relate to out-of-pocket payments in the form of 'gratuity payments', to the role of technology and specialisation, and the role of the state in societal arrangements relative to that of family. These values only adapt gradually. To get support from different stakeholders for this long-term reform process, they should be provided with evidence of positive changes, both from pilot projects in Greece and from the reforms in different Central and Eastern European countries.

The experience of Greece will be relevant for other countries hit by the state debt crisis. However, the point of departure will be different. The healthcare systems of other Southern European countries are different from that of Greece in general structure and role of primary care.

As we mentioned previously, our assessment of the state of primary care in Greece is not based on a rigorous scientific evaluation, but on a quick scan. Much is based on site visits and stakeholder consultations. We have only seen a very small sample of how healthcare is delivered in Greece. In the review process of the Mission Report¹⁴ we have therefore explicitly asked Greek experts to assess how generalisable our observations are and we have retained only those observations perceived to be generalisable.

In conclusion, we think that in response to the economic crisis it is important to focus on strengthening primary care, because of its direct relevance to the most vulnerable groups in society, its potential for cost containment and for a more sustainable healthcare system. We acknowledge that it is long-term

process, but now is the right moment for the Greek government to start an ambitious reform and to make crucial steps towards improvement of primary care.

REFERENCES

- 1 Katsimi M and Moutos T. EMU and the Greek crisis: the political-economy perspective. *European Journal of Political Economy* 2010;26:568–76.
- 2 Economou M, Madianos M, Peppou LE, Patelakis A and Stefanis CN. Major depression in the era of economic crisis: a replication of a cross-sectional study across Greece. *Journal of Affective Disorders* 2013;145:308–14.
- 3 Karanikolos M, Mladovsky P, Cylus J *et al.* Financial crisis, austerity, and health in Europe. *The Lancet* 2013; 381:1323–31.
- 4 Zavras D, Tsiantou V, Pavi E, Mylona K and Kyriopoulos J. Impact of economic crisis and other demographic and socio-economic factors on self-rated health in Greece. *European Journal of Public Health* 2013;23:206–10.
- 5 Suhrke M, McKee M, Arce RS, Tsovala S and Mortensen J. *The Contribution of Health to the Economy in the European Union*. European Commission: Brussels, 2005.
- 6 Kousoulis AA, Angelopoulou KE and Lionis C. Exploring health care reform in a changing Europe: lessons from Greece. *European Journal of General Practice* 2013; 19(3):194–9.
- 7 TFGR. *Quarterly Report April 2013*. ec.europa.eu/commission_2010-2014/president/pdf/qtr4_en.pdf
- 8 Andrianaki F. *Health in Action initiative*. Presentation, 9 January 2013.
- 9 Kringos DS, Boerma WGW, Van der Zee J and Groenewegen PP. Europe's strong primary care systems are linked to better population health, but also to higher health spending. *Health Affairs* 2013;32:686–94.
- 10 Theodorakis P. *Overview of the PHC Policy and Governance in Greece: structure, legal basis, recent reforms*. Presentation, 9 January 2013.
- 11 Starfield B. Is primary care essential? *The Lancet* 1994; 344:1129–33.
- 12 Boerma W and Fleming D. *The Role of General Practice in Primary Care*. World Health Organization: Geneva, 1998.
- 13 Health Council of the Netherlands. *European Primary Care*. Health Council: The Hague, 2004.
- 14 Groenewegen PP and Jurgutis A. *A Future for Primary Care for the Greek Population. Technical assistance in the field of health*. Mission report. NIVEL/Klaipeda University: Utrecht/Klaipeda, 2013.
- 15 Kringos DS, Boerma WGW, Bourgueil Y *et al.* The European Primary Care Monitor: structure, process and outcome indicators. *BMC Family Practice* 2010;11:81.
- 16 Mossialos E, Allin S and Davaki K. Analysing the Greek health system: a tale of fragmentation and inertia. *Health Economics* 2005;14:S151–68.
- 17 Economou C. Greece. Health system review. *Health Systems in Transition* 2010;12(7):1–180.
- 18 Davaki K and Mossialos E. Plus ça change: health sector reforms in Greece. *Journal of Health Politics, Policy and Law* 2005;30:143–67.

- 19 Kanellopoulou S. Health care expenditure in Greece and in Europe. *GREECE MACRO MONITOR*. Eurobank: Athens, 2012. www.eurobank.gr
- 20 Kandiloros H. *Overview of Requirements Falling under the MoU Greece – Troika*. Presentation, 9 January 2013.
- 21 Economou C (2013) *Overview of the Greek Health Care System*. Presentation, 9 January.
- 22 Vadoros S and Stargardt T. Reforms in the Greek pharmaceutical market during the financial crisis. *Health Policy* 2013;109:1–6.
- 23 Bechrakis N. *Role of PHC in Decreasing Workload of Hospitals*. Presentation 9 January 2013.
- 24 Economou C and Giorno C. *Improving the Performance of the Public Health Care System in Greece*. OECD Economics Department Working Papers, Nu 722. OECD: Paris, 2009.
- 25 Lionis C, Symvoulakis EK and Vardavas CI. Implementing family practice research in countries with limited resources: a stepwise model experienced in Crete, Greece. *Family Practice* 2010;27:48–54.
- 26 Mariolis A, Mihas C, Alevizos A *et al.* General practice as a career choice among undergraduate medical students in Greece. *BMC Medical Education* 2007;7:15.
- 27 Avgerinos ED, Msaouel P, Koussidis GA, Keramaris NC, Bessas Z and Gourgoulanis K. Greek medical students' career choices indicate strong tendency towards specialization and training abroad. *Health Policy* 2006; 79:101–6.
- 28 Sbarouni V, Tsimtsiou Z, Symvoulakis E *et al.* Perceptions of primary care professionals on quality of services in rural Greece: a qualitative study. *The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy* 2012;12:2156.
- 29 Koupidis S. *Gate-keeping and Referrals*. Presentation, 9 January 2013.
- 30 Belos G, Lionis C, Fioretos M, Vlachonicolis J and Philalithis A. Clinical undergraduate training and assessment in primary health care: experiences gained from Crete, Greece. *BMC Medical Education* 2005;5:13.
- 31 Sarantavagas G. *Primary Health Care – technical aspects*. Presentation, 9 January 2013.
- 32 Vivilaki V. *Home Care*. Presentation, 9 January 2013.
- 33 Lionis C, Symvoulakis EK, Markaki A *et al.* Integrated primary health care in Greece, a missing issue in the current health policy agenda: a systematic review. *International Journal of Integrated Care* 2009;9:e88.
- 34 Perdikaki P. *Service Aspects: scope of clinical and public health services*. Presentation, 9 January 2013.
- 35 Oikonomou N and Tountas Y. The Greek economic crisis: a primary health care perspective. *The Lancet* 2011;377:28–9.
- 36 Genet N, Boerma W, Kroneman M *et al.* *Home Care Across Europe. Part II country descriptions*. World Health Organization: Geneva, 2013.
- 37 Lionis C, Tsiraki M, Bardis V and Philalitis A. Seeking quality improvement in primary care in Crete, Greece: the first actions. *Croatian Medical Journal* 2004;45: 599–603.
- 38 Apostopoulos N. *Clinical Guidelines in the Greek Primary Health Care System*. Presentation, 9 January 2013.
- 39 Kouerinis M. *Links to Specialized Care*. Presentation, 9 January 2013.
- 40 OECD. *Health at a Glance: Europe 2012*. OECD Publishing: Paris, 2012. dx.doi.org/10.1787/9789264183896-en
- 41 Groenewegen PP, Dourgnon P, Groß S, Jurgutis A and Willems S. Strengthening weak primary care systems: steps towards stronger primary care in selected western and eastern European countries. *Health Policy* 2013. doi:pii: S0168–8510(13)00164–4. 1016/j.healthpol.2013.05.024.

PEER REVIEW

Not commissioned; externally peer reviewed.

CONFLICTS OF INTEREST

None declared.

ADDRESS FOR CORRESPONDENCE

Professor Peter P. Groenewegen, NIVEL – Netherlands Institute for Health Services Research, PO Box 1568, 3500 BN Utrecht, The Netherlands. email: P.Groenewegen@nivel.nl

Received 2 September 2013

Accepted 1 October 2013