REFORMING THE NATIONAL HEALTH SYSTEMS IN GREECE AND FRANCE: A PARALLEL EXPERIENCE

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Each National Health System largely reflects the economic, social and cultural characteristics of a given country. This is particularly true of their core elements such as, for example, the role of the GPs in the UK; the freedom of access and the role played by Social Security and Public Health Insurance in France; the largely decentralized character of the German system; or the advance of very costly therapies in the USA. In the late 80s and early 90s however, all EU member states introduced, under the influence of the Maastricht process, far reaching reforms in their health systems. The presentation that follows, proposes to show how two countries, Greece and France, have followed quite close paths in this process. An how the results of their effort can be beneficila to others.

The creation and problems of the Greek National Health System

Greece provided itself with a National Health System, only as late as in 1983. The core principles of the Greek NHS were that healthcare was to be provided in state owned institutions, both hospitals and primary health care facilities; that doctors would be full time employees; and that the public health system should follow a regionalized structure in its decision making system. In terms of availability and access to care facilities, one can argue that the 1983 reforms were the most significant in the country's history. Moreover, since the institutional approach was accompanied by a far-reaching effort to expand the infrastructure, to introduce new healthcare technologies and increase the personnel of the public health sector.

For a number of years, real and uninhibited access to public and free of charge services marked a very important raise. However, som e of the most significant changes that were included in the 1983 legislation, although enacted, were never implemented. These include: the establishment of primary health care facilities in urban areas, the reform of the healthcare finance system and the development of a regionalized decision making mechanism. The organization of the social health insurance system and the provision of

primary healthcare services were not affected, even though a big effort was made to create a state owned, primary health care network in rural areas.

The reform's failure in these fields is the main reason behind the intense criticism towards the Greek NHS in the late 90s. In effect, after a first wave of expansion and new services to which the patients were granted access, after 16 years the system is confronted to a series of imbalances and failures:

Imbalance between hospital and primary health care services, leading to overcrowding of public hospitals and a high level of expenditure,

Financial imbalance for public hospitals, which are plagued by the incapacity in which social security funds find themselves to pay for the services that they use,

Failure to achieve a global balance between offer and demand, through the existence of more than 30 public social health insurance funds, each with different entitlement and access conditions.

The centralization of the NHS's decision making process at the Ministry's of Health Central Headquarters, not to say at the Minister's own cabinet, only exacerbated the aforementioned problems, added to which were bureaucratization and waste of scarce financial resources, increase in under-the-table payments and corruption whilst, at the same time, the private sector expanded significantly.

In the 1990s, the levels of public dissatisfaction with the system peaked and the stege was set for reform. Although significant measures were put forward by successive Ministers and were consequently voted upon by Parliament, they were not implemented. Such measures included: establishment of a primary healthcare system and introduction of gate keeping by GPs; unification of healthcare financing under one purchasing authority; introduction of a managerial and accountability culture within the system, by the appointment of trained management teams in public hospitals.

Power conflicts and opposition within the system, inability of the NHS' a bureaucracy to introduce reforms and political fence-sitting both by individual ministers, as well as by the political system as a whole, led to the approval of three successive and similar bills, none of which were implemented.

The 2000 reform plan

The crisis in which the Greek NHS found itself at the end of the 90s was the most important one in its history. For the first time, the expansion and development of the private sector, financed only through out-of-the-pocket payments or private health insurance schemes, challenged the most important success of the NHS to that moment: equity and access to care.

In June 2000, a very significant reform plan was presented to the Council of Ministers, was also approved by it and presented to the public. The most important aspects to the proposals were: decentralization and development of regional structures; establishment of new managerial structures within the hospitals; modifications of the terms of employment for NHS doctors; unification and coordination of healthcare financing agencies; development of public health services; and accreditation and quality assurance of healthcare services.

Implementation of the reform plan

A special team was put in place at the Ministry and was awarded responsibility for the enactment of the reform plan. This «mechanism» succeeded in implementing speedily a first act, 2889/2001, voted in Parliament in March 2001.

Regional structure of the Greek NHS

According to this law, Greece is now divided into Regional Health Authorities or «Regional Health Systems», PeSY. Each PeSY is a public entity, managed by a nine-member board, chaired by a President-Executive Director, appointed by the Minister of Health and subject to parliamentary approval. PeSY board responsibilities include: service planning and coordination; financial control and quality supervision of all healthcare services in a region. Before, public hospitals were individual public entities, supervised directly by the Ministry. Now they are decentralized subsidiary units of each Regional health System, with managerial and financial autonomy.

The new system's architecture wants to achieve more local based needs assessment, better responsiveness to local problems and quick solutions to patient's problems at the local level. Previously, these functions rested with the Ministry's heavy, bureaucratic mechanisms, lacking in adequate responses, both at the strategic level, as well as to the level of everyday problem solving.

New hospital management system

The now subsidiaries of the PeSY hospitals are governed by a new management structure, enjoying a larger array of competencies and responsibility than previously. Hospitals are run by a five-member management team, consisting of the managing director and the divisional directors, for medical services, nursing and administration, as well as the president of the hospital's scientific committee. Contrary to the previous board members, consisting mainly of political appointees determined through a traditional «spoils» system and representatives of workers, the new management team is made up of hospital staff members who can directly act on management decisions.

Hospital Directors General are appointed for a five year team, after a selection process where they are short-listed by an independent assessment committee. Performance contracts are now agreed with the PeSY Executive Director, evaluation being based on both quantitative and qualitative indicators.

New employment conditions for hospital doctors

Under the 2889/2001 law, newly appointed doctors do not enjoy permanent tenure, as was the case previously. They are awarded five-year contracts permanent tenure after three successful assessments and ten years of full service in the NHS.

Contrary to the old status, where University based doctors could private practice, now all Greek NHS doctors are prohibited from working in private institutions or practices. They can, however, see patients privately, but within the public hospital and for two days a week. Fees have been set up by a Ministerial decree; they vary according to the rank and specialty of the doctor, while they are awarded 35% of the fee, the rest going to the auxiliary personnel and to the hospital budget. Patients pay for those medical visit costs, whereas diagnostic routines and treatments are covered by social health insurance.

The Greek reform's unfinished business...

The provisions of law 2889/2001 and the speed and rate of their implementation mark favorably the current healthcare reform process. However, entitlement and access to care arrangements differ between Social Security funds, as well as the terms provision of primary healthcare. Fifferences in financing primary healthcare services and remunerating physicians create a system of blurred financial incentives between healthcare professionals and particular population groups.

Unification of healthcare financing agencies and coordination of the provision of primary healthcare services, two of the most important elements of the undergoing reform, have not yet found their way to Parliament, although drafts of relevant bill have long been finished.

Healthcare financing

Draft legislation aims in unifying the health insurance plans of Greece's five largest Social Security Funds, under a new Health Insurance Fund, «Organization for the Management of Healthcare Financial Resourses», ODIPY. These five organizations cover about 90% of the total Greek population and include blue-collar (IKA) and rural workers (OGA), the self-employed (OAEE), civil servants (OPAD) and marine workers (NAT).

The new Health Insurance Fund will manage the sum of healthcare resources of the above-mentioned Funds and act as a purchaser for primary health-care and hospital services.

These services can be provided, both from the public sector, through each «Regional Health Systems», PeSY, as well as from the private sector, on the basis of needs assessment, cost and quality. It will also reimburse expenditure for pharmaceutical care.

Differences in entitlement and coverage between existing Social Security Funds will gradually dininish and ODIPY will be able to grant to the insured equal access to a comprehensive package of healthcare services.

Primary healthcare

Draft legislation indicates that the Greek NHS will gradually absorb primary health services, both publicly owned and those contracted by the individual health insurance organizations of the Social Security Funds. The law provides mainly for the publicly owned polyclinics of the largest social insurance agency, IKA. These will be transformed, using additional infrastructure capital where necessary, into «urban primary healthcare centers», accessible to all the insured of the existing Funds that will merge into ODIPY. Furthermore, all ODIPY members will have access to general practitioners, who will be independent contractors, remunerated on a per capita basis. ODIPY will also retain the right to contract out, if necessary, for additional healthcare services, to be provided by the private sector.

Failure to push through the aforementioned second bill of the reform, on financing and primary healthcare, will seriously impound the efforts already undertaken. However, healthcare is not the only sector of policy where public service reform moves in major, yet incomplete, steps. The French NHS reform is a case in point too.

The Jupée reform in France - commonalities and differences with the Greek experience

It was France's Prime Minister himself, Alain Jupée, which launched a significant reform of the French health system. There again, three were the core components of this undertaking: terms of financing, gerionalization of the offer of healthcare services and primary healthcare.

Constitutional Reform of the terms of financing of healthcare

The first and most important element that the French government addressed was the terms of financing of healthcare. The rising budget deficit of FRench social security and the important part in this deficit of the healthcare insurance accounts was the reason behind

the government's initiative. An important obstacle lay before: the independence of the social security funds in managing the receipts of the social security contributions as, in fact, France's social budget is more important thatn the budget of the state. However, when the government introduced a new tax to compensate for the running social security deficit, it turned the tables on the traditional Bismarck-Beveridge definition of systems.

Through the reform, the social security budget (Projet de Loi Financement dé Sécutité Sociale, PLFSS) is now discussed and voted upon by Parliament, with an annual expenditure target. The part of this financial envelope that is earmarked for health insurance includes four partial targets: hospital expenditure divided into (1) public and (2) private, primary health care expenditure divided into (3) consultations and (4) pharmaceutical prescriptions.

Although these four categories of health insurance expenditure make up for the annual target, they are handled separately: hospital expenditure passes to the govenrment's control, through the creation of a new organization, put in place and under the authority of the Ministry of Health and Social Security, the Regional Hospital Agencies; whereas primary health care expenditure control, is still handled by the social security funds themselves.

The role of the «Agences Régionales d' Hospitalisation» - ARH / Regional Hospital Agencies

Following the amendment to the constitution, in France's 22 administrative regions an equal number of Agences Régionales d' Hospitalisation - ARH / Regional Hospital Agencies was set up. In fact it did not take a long time to put them in place, since the government opted for a very flexible organizational setup: putting together the already existing at the regional level decentralized services of the Ministry of Health and Social Security and those of the National Health Insurance Funds.

The Directors of the Regional Hospital Agencies are appointed by the Council of Ministers, upon proposition of the Minister of Health and Social Security. Their responsibilities, like those of the PeSY in Greece include: service planning and coordination; financial control and quality supervision of all healthcare services in a region. Here too, the new system's architecture wants to achieve more local based needs assessment and sharper responsiveness to local problems.

The degree of financial control in France is much more effective. In fact, the part of the national health insurance budget that is earmarked for hospital expenditure, public and private, is itemized in 22 regional financial envelopes. Setting regional envelopes does not only aim at keeping expenditure within the nationally set targets; it also serves another purpose: to promote per equation between different Regions, gradually bringing the less endowed ones to the same level of those already enjoying sufficient expenditure and thus, infrastructure and facilities, promoting equal access to healthcare for the whole country. It is through the sole responsibility of the Regional Hospital Agencies, that these funds are allocated at the regional level, between the different hospital units, public and private.

The Directors of the Regional Hospital Agencies, using their control on financial resourses as a «stick», were able to take this process a step forward, overhauling the way thw provision of healthcare services was organized in their Region.

First of all, they needed to have a very clear idea of the strengths and weaknesses of their region, before taking action to solve problems. Thus, a complete audit of each region was

undertaken, including: review of health status indicators; citizen's expectations and needs assessment studies; review of data concerning all health care provision units in the given region. The data collected gave place to a five year «business plan» and a specific technical instrument was put a their disposal to that end, called «Schéma Régional d' Organisation des Soins», SROS/ or Regional Plan for the Organization of Healthcare Services.

Negotiated between thw Directors of the ARH and hospitals for a five-year period, this regional plan contains mutual obligations, through a written contract: specific financing conditions from the part of the ARH; specific goals to be achieved by hospital management. In many cases these agreements provided for important changes, both in the operational goals of different units, as well as in their core mission. For some, it meant purely and simply closing down a unit and transfering personnel and funds within the system. In order to help these important restructuring operations, a special fund was created at the regional level and a variety of legal instruments were elaborated and used to promote cooperation between different hospitals, both public and private.

One needs to mention that these operations did not only aim to streamline hospital services and healthcare provision, with a view to keep cost at a low level. Taking into account the volume of activity of a given hospital unit, with a view to minimize risk, was also a main factor leading, in some cases, to closing down a unit. These operations were not always easy to put through. Contrary to Greece's case, public hospitals are still individual public entities with, at the helm of their Board, the mayor of the city where the hospital is situated. Only a well-studied and well-proposal could convince local authorities and local opinion that closure or transfer of activities was the only valid decision.

The French reform's unfinished business

From the Regional Hospital Agencies to the regional Health Agencies

Today, the Directors of the ARH are finishing negotiations for the second Regional Plan for the Organization of Healthcare Services / or SROS, for the period 2002-2007. At the same time, Social Security accounts show that the reform has succeeded in one of its main goals: in effect, the budget deficit for healthcare insurance has been turned into a surplus and an important part of this success can be put to the credit of the Regional Hospital Agencies.

Wowever, rising expenditure for pharmaceutical care, at a rate of 7% annually remains a sensitive point. The lack of control by the stete on primary health care services and expenditure, still handled by the social security funds themselves, is the main reason behind it.

The new legislative and Government in place of the same political board as the ones that first launched the reform in 1996, have given rise to discussions for a new legislative initiative, in order to complete the 1996 acts. The main point of such an initiative will consist of transferring authority and responsibility for primary health care services and expenditure to the Regional Hospital Agencies, transforming them in what can be termed as Regional Health Authorities.

Some useful conclusions

What can be learned by the experience of others? This is the most interesting question. In this part I will try to sum up the main conclusion of this short presentation, or, the ones I deem most useful.

Decision-making system: the regional level chosen to set up the decision-making system, the main common factor between the Greek and French reform processes is a solution that has proved right in many countries.

Financing health care: in a situation of scarce financial resources, the source of the funds, whether they come from the state budget or social security contributions, is not as significant as traditional analysis (Bismarck versus Beveridge) thinks. The most important is the way these funds are used and the core result in the level of health care services offered to the citizens.

Efficiency of a unit versus efficiency of a system: the new axiome in health system reform is that it is not the efficiency of the individual health provision units that is the most important; it is the efficiency of the healthcare system as a whole, in the way it apprehends and follows its citizens-patients. And the most efficient system is the one that guides the individual citizen-patient to the best suited to his needs health professional or healthcare provision unit.

Hospitalization and primary health care: the previous point demonstrates that a balance can be achieved between these two alternative and concurrent levels care services, only if they are managed by one structure.

Freedom of choice and equal access to care: guaranteeing freedom and equal access to care is the very difficult equation on which all healthcare systems will be tested.

Κεκοιμημένων ανάμνησις...

Επί τη συμπληρώσει είκοσι ενός ετών από του θανάτου του αειμνήστου Καθηγητού Ιερωνύμου Δ. ΠΙΝΤΟΥ (1911-1981) ετελέσθη, υπό τη Συζύγου του κ. Αναστ. ΠΙΝΤΟΥ και Φίλων του, τρισάγιο επί του τάφου του. Ο Καθηγητής Ιερ. Δ. ΠΙΝΤΟΣ, Διδάκτωρ του Πανεπιστημίου του Μονάχου, Υφηγητής και μετέπειτα Επίκουρος Καθηγητής του Πανεπιστημίου Αθηνών, εξελέγη Καθηγητής (1947) της Έδρας Εφηρμοσμένης Οικονομίας και κατόπιν (1961) της Έδρας της Οικονομικής Γεωγραφίας, της Παντείου Ανωτάτης Σχολής Πολιτικών Επιστημών, της οποίας διετέλεσε και Πρύτανις (1975, 1976).

Διετέλεσε, επίσης, Καθηγητής του Πανεπιστημίου της Νέας Υόρκης (1956-1961), ενώ το 1975, Πρύτανις ών, ίδρυσε με Ομάδα Συνεργατών του το Ινστιτούτο Περιφερειακής Ανάπτυξης, του οποίου και παρέμεινε Πρόεδρος του Διοικητικού Συμβουλίου μέχρι του θανάτου του (1981).

Πέραν των Πανεπιστημιακών δραστηριοτήτων του ο αείμνηστος Καθηγητής διετέλεσε Υφυπουργός Εφοδιασμού, Εμπορίου και Βιομηχανίας, 1945 (Κυβέρνηση Βούλγαρη - Βαρβαρρέσου), Οικονομικός Σύμβουλος στις Πρεσβείες της Ελλάδος στο Λονδίνο και στην Ουάσιγκτων, Οικονομικός Σύμβουλος της Γενικής Γραμματείας του Ο.Η.Ε. επί θεμάτων εκβιομηχάνισης και τεχνικής βοήθειας προς τις υπανάπτυκτες χώρες (1946-1961), Υποδιοικητής της Ε.Τ.Β.Α. (1964), Μέλος της Εκτελεστικής Επιτροπής του Συμβουλίου Κοινωνικής και Οικονομικής Πολιτικής (1978) κ.ά..

Συνέγραψε σειρά σημαντικών έργων, ιδίως κατά την περίοδο 1934-1964, σε ελληνική, αγγλική και γερμανική γλώσσα, πλήθος άρθρων και ειδικών εκθέσεων επί οικονομικών θεμάτων, ίδρυσε (το 1961) την Εταιρεία Ερευνών Επαρχιακής Οικονομίας κ.ά..

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