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Chapter 10. The Downsizing and Commodification of Healthcare: The Appalling Greek Experience Since 2010

Noëlle Burgi

Introduction: Healthcare Challenges

Healthcare is one of the world's largest industries. In 2011, the world spent a total of 6.9 trillion US dollars[1] on health. Healthcare accounted for 10 percent of global gross domestic product (GDP) in 2013,[2] of which 59.6 percent was public expenditure. The economic, political, social and ethical stakes are high. Depending on the purpose ascribed to healthcare, two opposite conceptions emerge: healthcare as a fundamental human right, or as a marketable and tradable commodity. The first defines health not merely as the absence of disease but as a state of general physical, mental and social wellbeing. It views healthcare systems as a public good, as core social institutions that should be universally accessible to all on the basis of clinical need, not ability to pay. Enshrined in the Declaration of Alma Alta (1978) that identified primary health care (PHC) as the key to achieving health for all, this view was also the essence of the post-war Western European social security and national health systems, and served as a landmark for the belated construction in the 1980s of the post-dictatorship Greek, Spanish and Portuguese Welfare States.

The second approach, healthcare as an economic transaction, became increasingly prominent in the 1990s and 2000s, along with the deepening hegemony of neoliberal social and economic doctrines. It was transmitted by institutions of international economic governance such as the World Bank, which successfully networked at global level to impose a conceptualization of healthcare based on investor-friendly principles of health economics and cost-effectiveness analysis, and the international Monetary Fund (IMF), which prescribed relatively standard policy prescriptions focusing on maximizing private provision, imposing user fees and prioritizing markets and competition as part of its Structural Adjustment Programs. The ostensible design was to "increase value for money" in health systems and create the conditions for sustainable economic development. A growing body of critical research, however, disputes the validity of these arguments. Indeed, market-style devices have failed to save money or to generate proven efficiencies, let alone produce more equitable patterns of service delivery; quite to the contrary, they increased bureaucratic and overhead costs while deepening health inequalities and undermining existing public health services and research (Lister 2008; Sachs 2005; CSDH 2008). Even market-friendly OECD researchers have recognized the complications, contradictions and increased costs incurred by the implementation of standard healthcare restructuring packages (Lister 2008: 25, 77).

Western Europe has not been immune from the trend toward commodification of healthcare. Since the 1980s governments have to varying degrees espoused a market fundamentalist ("neoliberal") political rationality that "casts the political and social spheres both as appropriately dominated by market concerns and as themselves organized by market rationality," and promotes "policies that figure and produce citizens as individual entrepreneurs and consumers whose moral autonomy is measured by their capacity for "self-care"—their ability to provide for their own needs and service their own ambitions, whether as welfare recipients, medical patients, consumers of pharmaceuticals, university students, or workers in ephemeral occupations" (Brown 2006: 694; Foucault 2004). Accordingly, most Western European governments introduced measures borrowed from the "one size fits all" package advocated by the elite community of policy-shapers and rule-makers to restructure their health and social protection systems. However, the pace of transformation was variable and was spread over several decades. European governments for the most part deliberately chose an incremental implementation method in order to contain social contention and control the transformation process. Being rich enough and

relatively (albeit unequally) autonomous, the core countries among the twelve first EU members (EU12) were and are in a position to direct the process and control the pace of change. In fact, until recently, none had experienced situations comparable to highly dependent "Third World" countries or the countries "in transition" from Eastern and Central Europe that experienced the severe, indeed coercive, conditions of structural adjustment programs. Today, however, that situation has changed: Greece has been submitted to a particularly harsh austerity regime since 2010, akin to the structural adjustment programs applied in vulnerable countries of the Global South. Greece thus constitutes a particularly good analytical terrain to assess the validity of the two above-mentioned approaches.

This chapter analyzes the principal measures implemented in the Greek public health sector since 2010 and their social and ethical consequences. It brings to light the difficulties and contradictions that emerged in the "reform" process in which World Bank/IMF "one size fits all" recipes—e.g. cost sharing, the purchaser/provider split, activity based systems of payment, privatization of support and private insurance schemes—have been arbitrarily and coercively imposed on the Greek healthcare system with the primary aims of cutting costs, extracting resources from the public health sector in order to repay a crushing debt load,[3] and reorienting behaviors toward the "consumption" of private insurance and health services. As in other key sectors for the future of the country such as higher education (Athanasiades, Vareas and Souvlis, Chapter 7 in this volume), prescriptions dictated by the Troika have been introduced precipitously, in total disregard and even in denial of their sanitary and social effects. In the end, the problems of the Greek National Health System (ESY) have been amplified rather than solved. The first section presents a synthetic description of the ESY on the eve of the first 2010 Memorandum of Understanding (MoU). It is followed by a reminder of the comprehensiveness of health, which depends not only on primary and secondary care institutions, but also on key social determinants of health such as social security, housing, education, food security, or decent work. The chapter also discusses the main restructuring devices that were introduced in the primary, secondary, and pharmaceutical healthcare sectors. The argument, based on a growing body of evidence, is that the quasi-liquidation of the weak Greek Welfare State has amplified the life-threatening effects of the adjustment programs' market-style approach: the hope of living a decent and good life (Sen 1999) has receded and people have been made vulnerable, exposed to illness and premature slow or rapid death.

The Greek National Health System (ESY)

The Greek national health system has never been particularly coherent or efficient. Created in 1983, the ESY unquestionably constituted the most important effort in Greek history to institute a genuine national health service. The original project had sought to unify a plethora of occupational funds and replace the existing incoherent primary care infrastructure with entirely new ESY public community-based urban and rural health centers, endowing all citizens with an equal access free at the point of use. However, powerful entrenched interest groups (physicians engaged in private practice, autonomous insurance funds, civil servants, trade unions, bureaucrats and even politicians from both the opposition and ruling parties) did not allow the project to be completed as initially envisioned (Mossiaios and Allin 2005). Prior to 2010, Greek healthcare thus formed a threefold system involving a complex mix of (a) Beveridgian type structures, which are tax financed (the ESY); (b) Bismarckian inspired bodies (a network of public health insurance funds financed by social security contributions); and (c) private services.[4]

Before 2010, the ESY included 201 rural and 3 urban health centers, which were decentralized units of the ESY regional hospitals; 1478 rural medical posts/surgeries that were attached to health centers; and the outpatient clinics of 140 public hospitals. The centers and surgeries provided preventive, curative, emergency, and rehabilitation services free at the point of use for the rural population. Outpatient clinics of ESY public hospitals provided the urban and semi-urban population specialist and

diagnostic services free of charge or with minimal co-payments during daytime, and on a fixed fee-for-service basis during evening hours.

The network of public health insurance funds included thirty-six occupational sickness funds offering different packages of primary healthcare to some 95 percent of the population. These funds were compulsory and structured by branch or socio-professional category. In order of importance, the first of the four main funds was IKA, the Foundation of Social Security created in 1934 and the most important private sector workers' fund. It had its own primary care infrastructure with its own full-time salaried medical doctors (mostly specialists) and part-time salaried doctors who were also allowed to engage in private practice. The other three large funds belonged respectively to the agricultural workers (OGA), the self-employed and professionals (OAEE), and the public sector employees (OPAD). All health centers purchased services (partially or exclusively) from contracted private physicians and laboratories. Users of all funds had free access to a wide range of mainly curative and diagnostic services that were either delivered at the insurance funds' primary care units, or provided on a copayment basis by contracted private physicians and laboratories.

Finally, the private sector consisted of approximately 25,000 private physicians, 12,000 dentists, 400-700 private laboratories, and 167 operating private hospitals with their outpatient departments. Corporate-owned highly profitable diagnostic centers controlled almost all the country's biomedical equipment. Private physicians and diagnostic centers would contract with public and private health insurance funds and be paid by users as well as by the funds (on a fee-for-service basis). The private primary care sector absorbed more than 65 percent of total private health expenditure (Kondilis et al. 2012).

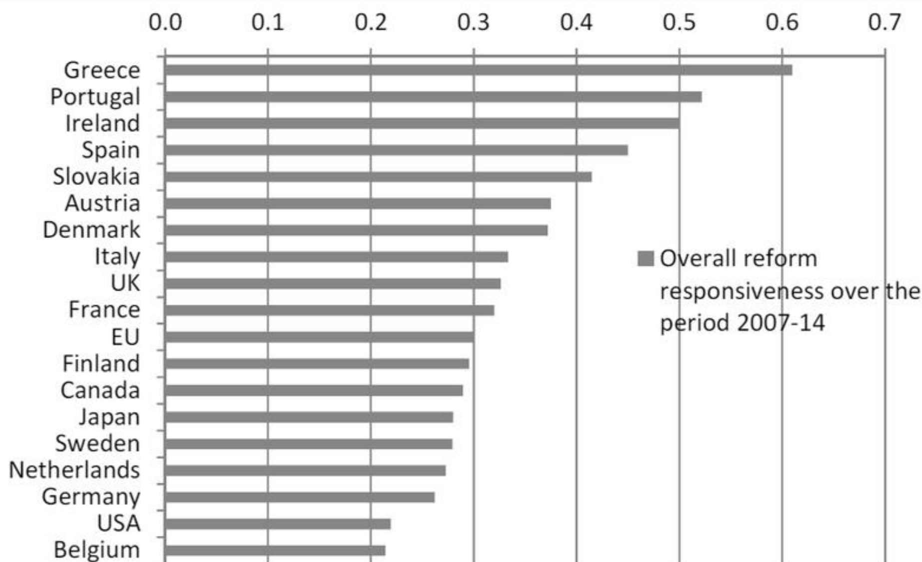
For a number of reasons, this complex, highly fragmented, uncoordinated system was in a state of constant difficulty before 2010. The important share of the private health sector, the lack of general practitioners, the big differences in services and coverage provided by the various insurance schemes, and real deficiencies in rural care and access rendered it very inefficient and unequal. Moreover, the very poor pay status of both ESY and social insurance primary healthcare workers did not make the public sector attractive and caused a series of structural problems: permanent hiring difficulties in hospitals, important understaffing (especially nurses and physicians), important shortages of intensive care units (that sometimes had to close due to understaffing), long waiting lists and a widespread habit to slip *fakelakia* (envelopes) to doctors (supposing she or he has not asked for it in the first place), most often a surgeon, in order to jump up the waiting list and if possible get better treatment. Many more corrupt practices were (and remain) commonplace in the healthcare sector that was one of the most indicative areas of mismanagement prior to the crisis. So, unquestionably, change was badly needed. (Economou 2010; Mossialos, Allin, and Davaki 2005; Siskou et al. 2008; Ioakeimoglou 2010).

It must be remembered, however, that despite its shortcomings the public health system contributed to a significant improvement in public health. According to World Health Organization (WHO) data, between 1980 and 2008 noteworthy gains in life expectancy were achieved in Greece through a decrease in avoidable mortality (i.e. caused by diseases treatable by medical care), especially a remarkable decline in child mortality (down from 17.94 to 2.65 deaths per 1,000 live births during that period), and neonatal (down from 13.58 to 1.79), postnatal and maternal mortality. Another interesting indicator may be found in the "World Health Report" published by the WHO in 2000, in which the Geneva-based organization ranked its 191 members. As far as the overall quality of medical care is concerned, Greece ranked 14th, ahead of Sweden (23rd), Germany (25th) or the United States (37th). France ranked first, followed by Italy; Spain ranked 7th and Portugal, preceded by Norway, ranked 12th. Even though the WHO ranking has been criticized, the report highlighted undeniable and remarkable gains in health care in Southern European states in a comparatively very short period of time. That progress has been largely eluded in contemporary discourse.

“Reform Responsiveness” and the Social Determinants of Health (SDH)

During the past few years, Greece has done much “better” than any other OECD country in implementing the “internal devaluation” austerity regimes prescribed by the Troika, as indicated by the chart below (OECD 2015: 126). According to the OECD, Greece has “performed” as the “leader” of the Organization’s “Going for Growth reform responsiveness.” However, Greece has “led” in quite another and far more tragic way by being plunged since 2010 in a deep, prolonged, and still worsening depression, unmatched in European peacetime history. The impact of the depression on key social sectors is directly correlated to the degree of the country’s “reform responsiveness.” As far as health is concerned, the radical downsizing of the public healthcare sector (a key measure of the various MoUs imposed on Greece) has dramatically harmed public health.

Figure 1. Eurozone: reforms pay off



Public health is not only determined by the quality of healthcare institutions. It is influenced by much broader social conditions—access to schools and education, conditions of work and leisure, housing, future prospects, the state of peoples’ communities, towns or cities. These structural conditions of daily life constitute together “the social determinants of health and are responsible for a major part of health inequities between and within countries” (CSDH 2008: 1; Daniels, Kennedy, and Kawachi 1999; Daniels 1985). For most “peripheral” European countries, austerity has meant that their life conditions have been abruptly transformed, leading to a deep regression with lasting health effects. The major indicators evidencing Greece’s descent into the abyss are well known and need only cursory restatement here: as already indicated elsewhere in this volume, economic output has fallen more than 27 percent since 2009, resulting in the closure of thousands of small and very small businesses which are the backbone of the economy; mass unemployment affects a quarter of the population and half the youth; living standards have fallen sharply (minus 31.4 percent on average); labor rights have been severely

restricted if not liquidated; public services have been largely curtailed; direct and indirect taxes have increased, representing a 337.7 percent tax burden increase for the underprivileged (Giannitsis and Zografikis 2015); economic and social inequalities have soared.

The downsizing of Greek public health institutions has significantly amplified the adverse effects of austerity policies. In 2010, the first MoU imposed drastic public health spending cuts, from 6.6 percent of GDP in 2010 to 6 percent in 2012. At the time, internationally recognized researchers and authoritative journals such as *The Lancet* estimated that the 6 percent target set by the Troika was arbitrary and abnormally low (e.g. Stuckler and Basu 2013; Karanikolos et al. 2013, Kondilis et al. 2012, 2013; Kentikelenis et al. 2014). Greece, however, went much further than demanded by her creditors. As shown in table 1, public health expenditure had shrunk to 5.7 percent of GDP in 2012; since then, it contracted further, reaching 4.6 percent in 2014 and 4.8 percent in 2016 (compared to a EU average of 6.5 percent and much higher ratios in the more developed countries). It must be underscored that the cut back is even more significant than it seems at first glance because the percentages refer to the GDP for each year which itself collapsed more than 27 percent during the 2009-16 period. Moreover, further cuts are expected. Funding of public hospitals decreased more than 50 percent. Primary health care (PHC) spending was reduced 55 percent between 2009 and 2014 (Kyriopoulos 2015).

Table 1. Total public health expenditure (% GDP)

Years	**% GDP**
2004	4,8
2005	5,5
2006	5,7
2007	5,6
2008	5,4
2009	6,4
2010	6,6
2011	6
2012	5,7
2013	5,1
2014	4,6
2015	4,9
2016	4,8

Source: OECD (https://data.oecd.org/healthres/health-spending.htm#indicator-chart)

As a result there has been a reconfiguration of health care spending. According to Giannis Kyriopoulos (2015), former Dean of the Athens National School of Health, while the funding of public hospitals fell by more than half between 2009 and 2014 and total health expenditure (public and private) is in sharp decline, the share of public hospital expenses in total expenditure increased 41 percent between 2008-13 becoming (without means) the last resort for patients. This reflects poorer access not only to private hospital care (the share of which declined by 28 percent during the same period), but also to primary care (basic medical services, dental care, diagnoses, physiotherapy and others) for which expenditures have fallen by 55.59 percent during these years. The share of pharmaceutical expenses in total expenditure nearly tripled (from 10.5 percent to 27.4 percent between 2009-14) due to expanded co-payments introduced by successive governments. At the same time, the disorganization of healthcare facilities encouraged the quest for favoritism and some corruption with formal and informal payments to private sector doctors, up 52% (Kyriopoulos 2015; see also Georgakopoulos 2016).

Perverse Drug Policies

Changing doctors' and patients' behaviors regarding drug consumption was an issue that needed to be addressed. In 2009, Greece had the highest expenditure on pharmaceuticals among OECD countries (2.4 percent of GDP compared to an OECD average of 1.6 percent). Deep policy changes since the first bailout program led to a sharp decline. Prescribed by the Troika with the stated aim to reduce spending from € 4.37 billion in 2010 to € 2.88 billion in 2012 (achieved), and to € 2 billion by 2014 (Kentikelenis et al. 2014), a wide range of policies was directed at pricing, prescriptions, monitoring assessment, and markups for wholesales and pharmacies (Carone, Schwierz, and Xavier 2012: 50-2). Increasing the use of generics was among the top priorities. Measures included the reintroduction of a positive list for pharmaceutical coverage with routine reviews investigating the price paid for medicines. Fixed rebates as well as volume rebates on all medicines sold to social security funds have been introduced. Furthermore, if spending in the public pharmaceutical budget exceeds a routinely revised ceiling, a clawback system has come into play. On the surface, this would seem a positive development but the reform has generated perverse effects.

Drug prices are now usually based on an average of the three lowest EU prices. Substantial cost-savings were thus achieved[5] without necessarily ensuring better public access to drugs because of permanent shortages, increased co-payments and the sharp fall in living standards. The factors accounting for permanent shortages are complex. Run-down hospitals very often cannot buy the medicine needed by patients and let them try to solve the problem by themselves. Pharmacies are in trouble. On the one hand, they have accumulated large debts because of public insurers' delays in paying them (four to five months on the average, but delays reach ten or eleven months). They were owed € 0.5 billion in 2015 according to official statistics (Karamanoli 2015; Mantas, interview 2016). On the other hand, suppliers give pharmacies between one and three months payment deadlines, but they often require an immediate payment. Pharmacies are then left with the option to pay their orders up front pending a reimbursement by public insurers; alternatively, if they cannot afford to do so, they might organize informally with other pharmacies (some of them the very well organized nonprofit social solidarity pharmacies mentioned below) to find, exchange or borrow drugs from them, or else request the patients to pay their medicine in advance or send them off to try their luck elsewhere. These solutions are fragile. Very many pharmacies have closed and many others have been bought by Greek and multinational wholesalers. Wholesalers turn to other markets in search for higher profits because of Greece's relatively low prices and long delays in clearing her debts toward them. Drugmakers have sometimes imposed quotas on the quantity of medicines the Greek market is supposed to need, meaning that orders are not necessarily delivered in full. They officially claim that they do not have enough stock. Some of them have stopped selling higher-priced medicines in Greece (Kresge 2012). At the same time however, pharmaceutical companies have sought to take advantage of Greece's position as one of the international reference countries for the establishment and negotiation of new drug prices.[6] Novartis, for example, allied with Greek public officials and doctors to sell some of its new products at exorbitant prices in Greece with the intention of making high profits in more populous countries (such as Turkey or on a much broader scale Brazil). The Novartis scandal is currently being investigated in Greece and the United States to establish facts and determine responsibilities. Meanwhile, international initiatives are being taken to try to moderate manufacturers' appetites due to the general crisis of public finances. In Greece, the pressure on pharmaceutical companies is greater because the state requires a 25 percent discount for each new drug priced in Greece in addition to clawback and rebate reimbursements. Lastly, it should be added that the Greek pharmaceutical industry is structurally vulnerable both to multinational strategies and to government policies. The industry produces high quality generics and is an actual and potential important provider of jobs, but it can hardly ward off threats (such as price dumping) from multinational pharmaceutical industries. It is also weakened by reduced profits due to paybacks, the overall amount of

which for 2014 is estimated at 30 percent of the National pharmaceutical spending budget (Anastasaki, Bradshaw, and Shah 2015).[7] While endogenous opportunities of growth are lost, the society is also deprived of a useful supplier.

To make things worse for people, a number of policies shifted part of the healthcare costs to patients, causing more out-of-pocket contributions and reductions in access. Regarding medication, the benefits basket has been changed to exclude certain products and services from public coverage and introduce co-payments, affecting mainly clinical tests and pharmaceuticals (private insurers have also restricted their drug coverage). Average co-payments for medicines increased from 9 percent in 2011 to 25 percent in 2013, and 35 to 40 percent today (Interview[8] 2014; MCCH[9] Archive 2015). The share contributed by patients may in extreme cases reach 75 percent. However, because of the combined effect of drug shortages, wholesalers' and drugmakers' strategies, and the strict rule according to which reimbursements of medication is brought in line with the average three EU lowest prices, it happens regularly that prescribed drugs either are unavailable on the market or no longer exist. Hundreds of essential drugs like insulin, anticoagulants, antidiabetic agents or immunosuppressants either do not circulate or are difficult to find. Currently children's vaccines are unavailable. Cancer treatment medications are sometimes extremely difficult to find. This means that even when people with illnesses such as cancer are fully covered by public health insurance, they might be forced to finance most of their medication. Dysfunctions are particularly deadly for patients with chronic diseases such as diabetes or cancer. According to Dr Charis Matsouka who at the time of the interview (2014) directed the Department of Hematology at the university General Hospital Alexandra in Athens, forty percent of patients on chronic therapies have stopped their treatments.

Hospitals' Three Month Horizons

Drastic measures have been introduced to restructure public hospitals and the rest of the ESY. In the past few years, the country endured large hospital closures (in Athens, Thessaloniki and elsewhere), closures and/or mergers of a great number of clinics and specialized units, the regrouping of hundreds of labs, and the removal of some 2,000 public hospital beds if not more. In addition, public hospitals were submitted to new public management control mechanisms: hospital budgets are now managed by a private firm (ESAN) and various techniques aiming at controlling hospital activity and limiting doctors' autonomy have been implemented, namely a monthly data collection system for the monitoring of public hospital activity and expenditure through compulsory electronic procedures.

The Corporatization of Public Hospitals

One of the most far-reaching changes concerns the funding of public hospitals. "Diagnosis related groups" (DRGs), an activity-based payments (or prospective-price-control) system based on costs associated with patient diagnosis, have replaced the previous global per-day payment. This method was imported to Europe from the United States despite the fact that scientific research and independent evaluations have brought to light since a long time its harmfulness both for public finances and for patients (e.g. Dolenc and Dougherty 1985; Fetter and Freeman 1986; Halloran and Kiley 1987; Chelimsky 1987; Dougherty 1988, 1989; Angell 2006; Davidson 2010). Indeed, activity-based payments are expensive. Commercialized care supporters see it as a tool to boost internal productivity because hospital revenue is directly related to their business volume (the number of acts and consultations reported). As the senior French medical professor André Grimaldi writes, the criterion is purely book value and does not allow distinguishing between a technical activity, which is easily quantifiable and measured, and other more complex interventions that require time and multidisciplinary skills. In France, for instance, *any* medical consultation is now supposed to not exceed twelve minutes. The overall aim of medical practice and the shared obsession of managers and productivity-oriented doctors thus ends up

being to achieve a growing number of acts rather than the delivery of general care. In other words, activity-based systems of funding are powerful managerial tools that transform the purpose of care facilities: they create “business hospitals” (Grimaldi 2009; on Greece, see Ioakeimoglou 2010). These tools have already substantially increased social insurance funds’ reimbursement prices for private hospital services in Greece (Kondilis et al. 2013). According to neurologist Dr Makis Mantas, former coordinator (until July 2015) of SYRIZA’s primary healthcare program:[10]

> “Activity-based payment systems increase public deficits. They have already multiplied sevenfold hospital costs. They favor private hospitals. Take the case of strabismus. That’s a very simple act. The operation used to cost € 70-90 in Greece. No private hospital wanted to bother. Today, the same operation costs something between € 700-900. Suddenly public hospitals that used to be responsible for all of them no longer are, while private hospitals take over more and more” (Interview 2014).

The advantage for private hospitals is that they can easily specialize in the simplest and low-risk treatments for which profits are high and caseloads predictable. By contrast, activity based schemes lead to especially hard times for public and teaching hospitals because they remain responsible for the more complex, costly and risky treatments even while their resources are diminished and public medical research is negatively impacted.

“Modern” Working Conditions

Downsizing the workforce, cutting wages and liquidating workers’ rights in the entire public sector may retrospectively be considered as one of the top priorities of Greece’s creditors right from the start. In 2011, there was evidence that the cutback of public hospitals’ expenditures resulted from 75 percent payroll cuts (rather than enhanced efficiency as successive governments claimed until 2015) (Kondilis et al. 2013; Stuckler and Basu, 2013). Although public health professionals were among the lowest paid in the EU before the financial crisis, their wages have been reduced by at least 40 percent since 2010. Interviewed in 2014, Dr Charis Matsouka says that while she had reached the top of the hierarchy in the health system, she earned altogether € 2,000 a month including her expenses. Today, a newly appointed consultant’s or university lecturer’s average salary is about € 1,100 (Ifanti et al. 2015; interviews, 2017).

The contraction of the workforce in the public healthcare sector has been dramatic. Overall, it lost 30 percent of its workforce due to the freeze on hiring, the *de facto* non-replacement of retired personnel and non-renewed contracts for temporary staff. In 2011 alone, officials at the Athens Medical Association estimated that 26,000 public health workers (up to 9,100 doctors) were about to lose their jobs (Triantafyllou and Angeletopoulou 2011). The decline of the number of doctors has been much larger than predicted by the Troika (Corriea, Dussault, and Pontes 2015) due to rapidly deteriorating working environments and conditions. Many doctors and nurses took early retirement. There has also been since 2010 a constant mass exodus of young and well qualified Greek graduates, specialized physicians and other staff seeking better working conditions outside Greece, mainly in the EU and especially in Germany. It is estimated that more than 7,500 Greek doctors had emigrated in 2014, mainly to Germany where they are employed in positions below their qualifications and wages (€ 3,000) compared to their European colleagues (Burgi 2014; Smith 2015).

Understaffing, patient overload, and shortages have brought public hospitals to the point of breakdown. The staff is faced with extreme work intensification, exhaustion and burnout, leading to precarious and dangerous working conditions. Working hours have been considerably lengthened. Doctors’ working time including standby periods and ordinary consultations can reach thirty-two uninterrupted hours; when they are on call duty they might work up to ninety-three hours during the

week. The matter was referred to the European Commission, which in turn put the case before the European Court of Justice. The latter judged that such long uninterrupted periods of work were illegal.[11] The 2003/88/CE directive states that a twenty-four hour period of work must be interspersed by at least eleven consecutive hours of rest, and must not exceed maximum forty-eight hours per week. Greece has been condemned but recruitments did not follow (except for self-employed non-statutory staff on short-term contracts) while there are thousands of scheduled hires that never take place and high unemployment among doctors and nurses[12]. By mid-2017, a law to conform to European working time standards in hospitals was in preparation. However, as it is still impossible to recruit statutory staff, the bill provides for an option whereby physicians who wish to do so will be able to work 60 hours a week, provided they take responsibility for their "choice" by signing a document (previously, excess hours were binding). As residents end up leaving the ESY all over the country, intensive care units if not whole hospital departments are threatened. Hospitals have run out of the most elementary supplies. They lack everything—sheets, scissors, painkillers, blood pressure meters, sterilized equipment, vital medication, cancer screening, and appropriate equipment for surgical interventions. Some of the public cancer clinics cannot even feed their patients (MCCH Archive 2015). Since 2009, cancer clinics have been abruptly closing at various times of the day because of lack of resources, and cancelling consultations without providing alternatives. In January 2016, Laiko General University Hospital in Athens turned away dozens of cancer patients because it could not provide vital chemotherapy that had been scheduled (MCCH Archive 2015). Services constantly struggle for additional funding in order to survive. Dr Charis Matsouka testifies, "In the middle of the year [2014], we were on the verge of closing the lab. We asked for additional funds and they [the government] finally gave us some. But it happens every three months. So we constantly have a three months horizon. It's exhausting. And it's depressing for us…"

In some extreme circumstances, newborns have been kept from their mothers until she could pay the hospital bill; cases where cancer patients have been ejected from surgery because they could not pay € 1,800 for their treatment have been reported by cardiologist Giorgos Vichas who heads the Metropolitan Community Clinic of Hellinikon. Such occurrences are linked to the high proportion of uninsured and have remained exceptional thanks to the ingenuity of Greek doctors who find creative ways of getting around the regulations.

Dismantling Primary Healthcare (PHC)

Outside the "three months horizon" of public hospitals, there are many more patients. As mentioned above, the fragmented and unequal PHC network already faced important difficulties before 2010. In 2011-12, the four main social insurance funds (IKA, OGA, OAEE, and OPAD) were transferred with their staff and infrastructure to a new unique National Organization for Provision of Health Care Services (EOPYY). Considered as the way forward to ensure universality and equity of healthcare, the integration of social insurance funds had been hoped for since at least the foundation of the ESY in 1983. However, the changed context in the 2012 reorganization overshadowed equity. The social insurance funds absorbed by the EOPYY lost 53.5 percent of their assets in the March 2012 "hair cut" that restructured the Greek debt. This happened because they had been legally obliged to have 77 percent of their disposable assets on deposit at the Bank of Greece and because they were not, contrary to banks, compensated for their losses (that amounted to about € 10 billion in three months). And, of course, PHC would not be spared from cuts in social insurance health benefits, increased co-payments for diagnostic tests, staff, and wage cuts (Kaitelidou and Kouli 2012; Kondilis et al. 2013).

In 2014, the Minister of Health, Adonis Georgiadis, split the purchaser/provider functions. The purchasing function remained within the jurisdiction of EOPYY while healthcare provision would be assigned to a newly formed National Primary healthcare Network (PEDY). The Minister maneuvered skillfully to provoke the "voluntary" departure of half the doctors working in the health centers that had

been integrated to EOPYY two years earlier. In February 2014, he closed overnight all the PHC network units and promised that they would reopen (as PEDY) within a month. PEDY structures took much longer to start (mal)functioning (an embryonic network appeared in Attica at the end of March). In the meantime, approximately 6,500 to 8,000 doctors were laid-off. Georgiadis announced that they would be allowed to integrate the primary healthcare structures with the status of ESY employees on condition that they sign full-time contracts and close their private afternoon offices. Although the idea of creating a new exclusively public employment status was welcomed, it did not come with the promise to upgrade the salaries offered to the workforce: doctors would have to settle for low wages (€ 1,100), renounce additional sources of revenue and prospects for future career progression. Many of them decided to "self-fire," the contract staff lost their jobs, others retired and a minority went to courts. The latter won their case. They were allowed to return to their jobs and keep their private practices open for a renewable period of time. Today, a mere 2,700 doctors work in the PEDY network with different employment statuses: those who returned immediately got a wage increase according to their seniority (up to € 1,800); some young doctors recruited on short, fixed-term contracts are paid a full time € 1,100; and finally those who decided to return after winning their case in courts kept their previous rights and wage levels. The two first categories of doctors are not allowed to have other sources of revenue.

Apart from pleasing the Troika by sharply reducing the number of public sector employees, Mr. Georgiadis' initiative proved problematic. First, due to the importance of understaffing, primary care facilities (mainly those of the former IKA) have virtually ceased to function. I saw a general practitioner take care of twenty-four people in an hour and a quarter, which amounts to an average of three minutes per consultation. This is not exceptional. The work of the physician is as painful as is the situation for the patient. Patients for the most part know what they have and only come to renew their prescriptions. But there is always at least a minority who do not know what is happening to them and who will not find the attention they need. Doctors do not have time to do much more than control health books or old prescriptions, and establish new ones. In addition, they are closely monitored by the electronic platform: they cannot prescribe drugs or medical checks beyond what their individual budget allows. If they venture, the system starts by issuing an Orwellian warning that appears in red letters on the computer before it locks up, and the physician, who is then fined, cannot prescribe anything else. In primary health services (as well as in hospitals), precarious physician assistants recruited on short term contracts do not want to risk their jobs or be fined. The others are also trapped by the system, so most doctors do not treat people. If necessary, they send them to the hospital where it is still possible to prescribe medications or exams freely. But it is a vicious circle, because hospital doctors are overwhelmed and do not want to spend their time issuing prescriptions.

Patients turned massively to hospital emergencies. This is the second major pitfall of Mr. Georgiadis' reorganization. To ease emergencies and address the consequences of under-staffing in primary care, the Minister of Health believed he could find a solution by encouraging private sector physicians to enter into agreements with the EOPYY: contracted doctors would commit to treat two hundred patients a month and be paid € 2000 monthly. This extremely costly measure for the public health system has proven very inefficient because most doctors "get rid" of their two hundred patients in the first week, if not faster, and for the rest of the month, patients are left with virtually no free primary healthcare: they then have to pay for a private consultation, or go the hospital emergencies.

Such was the situation in the spring of 2017 when the current Health Minister, Andreas Xanthos, launched a new four-year "Primary health care" bill (Terzis, 2017). Its primary objective still is to ease hospital emergencies, although the government also intends to put the whole system back on its feet. From now on, there should be only two levels of access to primary care. At the first, basic level, "local health units" (ToMYs) established throughout the country and located in existing centers (IKA) or in new structures, will be staffed by at least two, if possible three doctors — a general practitioner, a pathologist

and a pediatrician. A total of 239 local units should be created within three years, 50-60 of which are expected to operate by the end of 2017. Where such units do not exist, private contracted doctors hired by the EOPYY should meet the needs. The Minister believes that the local health units will cover 30 percent of basic needs and private doctors the remaining 70 percent, his aim being to reverse these proportions in four years. According to him, these units could reduce the number of consultations in hospital services by about five and a half million. At a second level, better equipped and staffed "health centers" will replace existing services in provinces and rural areas, as well as all the structures incorporated in the National primary health care network (i.e. the PEDY, a designation that disappears). They will be open 24 hours a day. The government hopes to establish 240 health centers throughout the country, including Athens, by the end of 2017.

The total cost of the operation is estimated at € 300 billion. It should benefit from credits guaranteed by the EU and from a gradually increasing contribution of the state budget. This encompasses the recruitment of 3,000 people, including 1,300 doctors. Advertised positions target general practitioners, physicians and pediatricians. They will be paid on the basis of the ESY "A" pay grid (corresponding to hospital assistant), i.e. € 1,500 to € 1,600 net per month.

The initiative is welcome: it simplifies the organization of primary care, aims to create a single integrated national health system and could correct some malfunctions. But the strict budget constraints indicate that the public system is moving toward healthcare rationing. There is no way one could meet the needs of the whole country with only 1,300 newly recruited doctors, although the privileged profiles (general practitioners and pediatricians) correspond to a proven deficiency, since primary care services are overstaffed with specialists and understaffed with general practitioners. With only three doctors, the role of the new local health units is likely to be limited mainly to providing prescriptions and acting as gate-keepers that prevent the public from going to hospital emergencies. The government intends to restructure hospital emergencies to transform them into autonomous units with their own staff, separate from the hospital care teams: it is not yet known what this implies. On the whole, the precariousness of health care workers will increase and the critical mass required for quality public services will be missed. Dependence on the private sector can only increase.

Encouraging Private Insurance

Primary healthcare is slowly getting reorganized to fit the "maximum involvement of private sector" principle dear to cost-effectiveness analysts. The incremental introduction of market mechanisms in primary care merits discussion. Out-of-pocket payments are multiplying, the amounts of which may appear unimportant but seriously affect a great many people whose living conditions have deteriorated sharply. User fees for outpatient visits were raised from € 3 to 5 in 2011 (the SYRIZA government removed this fee but the 2015 Memorandum specifies that it must be reintroduced). Medical prescriptions are limited to three drugs. If more than three are needed, doctors must add a new prescription, each of them costing the patient € 1. There are also some hidden costs such as payments to schedule an appointment by phone with a doctor (Kentikelenis 2014). In the near future it should be possible to schedule an appointment on the net, which is of course a difficult option for the most disadvantaged and the elderly people. Private insurance is slowly growing in the primary healthcare market and is still relatively cheap. For instance, newspapers such as *Proto Thema* or *Anexartisia* offer their Sunday readers the possibility to collect coupons and get a "free" health card that basically will give them low-charge access to private diagnostic centers and doctors up to a very limited yearly amount.[13] Banks also offer their clients various types of low-cost health insurance packages (e.g. a price range that may start at € 85 and reach € 800 yearly).[14]

These amounts are not negligible for the very poor (entire households live on a small pension that may not be higher than € 300-400 a month and that is programmed to be further reduced). Alternatively,

if the additional cost is affordable, it is supposed to serve an educational purpose. As Aimee Placas writes in her conclusion (Chapter 14 in this volume), austerity has a pedagogical effect. As one doctor put it quite abruptly in an interview: “The project is to get people used to pay until the system is finally removed.” In the words of John Lister from the Globalization and Health Knowledge Network:

> There is no doubt that “one of the reasons the World Bank and other agencies have promoted user fees has been to nurture the emergence of insurance schemes even in the poorest countries... Among the key conclusions from a major USAID funded workshop in Zimbabwe analyzing the “lessons learned” in health care funding was that “user fees are vital to the introduction of any type of insurance system” (McEuen and McGaugh, quoted by Lister 2008, 34.)

There have also been more decisive steps. Deregulation of private health services started early on at the beginning of the first bailout. For instance, Kondilis et al. (2013) mention the removal of all limitations relative to the establishment by entrepreneurs of laboratories, medical centers, and dialysis units as well as restrictions concerning the expansion of private hospitals. Similarly, contracting with private insurance companies for services delivered by public hospitals has been introduced as well as the allocation to private insurance companies of 556 luxury hospital beds in public hospitals in 2011. Just before the introduction of the new law on primary care, two big multi-specialist private clinics (replacing PEDY structures) operating with leading private insurance providers and providing primary care were created in Thessaloniki and Athens.

Means-Tested Survival

Austerity does not affect everybody in the same way at the same moment everywhere. Our fieldwork and other research reveals that large groups of Greeks are unable to afford care and/or the cost of transportation to reach services. Before the advent of the global financial crisis, they would go and see a doctor despite the low level of primary care. Now they tend to neglect preventive checkups; they reduce, discontinue, and even stop their treatments, and replace their prescribed medication by cheaper alternatives. As a generalist recently (2017) told me, people have become their own doctors. Psychiatrist Spyros Sourlas reports that his patients avoid therapies and ask him instead to prescribe antidepressants[15]. Eva Karamanoli (2015) also observes that patients “ask for the cheapest treatment instead of the best.” One indication of patient cutbacks is the sharp surge in dental diseases that affect an important part of the Greek population, mostly the poor and vulnerable.[16] According to a recent survey by the Hellenic Dental Federation, worsening widespread dental decay it is not primarily caused by changes in daily hygiene but rather by the acute fall in living standards, poverty induced behaviors such as increased consumption of cheap high-sugar foods and the fact that the vast majority of dental problems are left untreated for at least a year because of the inability of families to cover the out-of-pocket expenses.[17]

The 2015 MoU has a couple of pages devoted to a “genuine social safety net” including a Guaranteed Minimum Income (GMI) and access to health for all. Such concepts suggest a real improvement compared to the present Greek situation. However, progress in this area does not go further than the World Bank’s notion of an “essential package” of care for the poor, which abdicates equity and universalism (Missoni 2013). The general principle adopted to varying extents by most European countries in reconfiguring their Welfare States has been to undermine if not abolish unconditional rights and replace previous social systems with minimum means-tested allowances for the poor, thus equalizing conditions downwards (Burgi 2009; 2011). In the Mediterranean South, the new “European social model” currently nearing completion offers a safety network that barely provides means-tested survival. “Indeed what began as a “minimum” provision became increasingly perceived as a target, effectively a “maximum” for organizations such as the WHO” (Lister 2008, 30).

This is well illustrated by the reforms concerning unemployment benefits and health insurance. The general trend (Moreira et al. 2013) is to reduce the amounts and duration of unemployment benefits but to extend the coverage (which provides health insurance) to previously excluded unemployed groups. In Greece, before July 2011, the government used to provide unemployment benefits and healthcare to the unemployed for a maximum of one year, but patients short of financial resources could still be treated in hospitals following the termination of their benefits. After July 2011, however, new regulations stemming from the MoUs required that Greeks pay all costs out of pocket once their benefits had expired; moreover, in March 2012, the amounts and duration of unemployment benefits were drastically reduced (from € 561 to € 360). In the meantime, unemployment rates (around 25 percent, 73.5 percent of which were long-term unemployed according to 2014 OECD and EUROSTAT figures) as well as the numbers of uninsured skyrocketed and remained huge. In 2016, Doctors of the World estimated that there were roughly 3 million uninsured, including the self-employed that are not recorded in official unemployment numbers; Makis Mantas estimated the share of all categories of uninsured as high as 35 percent of the population, 60 percent of the total being self-employed; the figure of 2.5 million uninsured was usually put forward in official European and OECD reports.

Although these estimates cannot be checked, the unquestionable massive proportion of uninsured and pauperized people having no access to healthcare prompted the creation of solidarity clinics and pharmacies that are staffed by hundreds of volunteers and that spread all over the country since the beginning of the crisis. They provide as much as possible (their resources being very limited) care and medicines for free to people in need (the uninsured as well as more and more people, albeit insured, who are unable to access health services or pay for their treatment). Together with the wider social movement, solidarity clinics and pharmacies put great pressure on the government of the day to devise measures to protect the uninsured. Thus, in 2013, Minister of Health Georgiadis introduced a primary healthcare voucher system for only 100,000 uninsured. His ministerial decree did not mention pharmaceutical treatment nor allow for secondary (hospitalization) care. Angry doctors from the social solidarity clinics denounced "a drop in the ocean," and said that "the Ministry of Health is hoping to impress us with an aspirin, when a much more radical cure is needed" (MCCH Archive 2015). By the summer of 2014, the Minister issued another decree granting secondary healthcare to all uninsured under conditions to be scrutinized by special three-member committees. However, these bodies never really functioned. Instead, the uninsured admitted to hospitals were asked to sign a document in which they would recognize that they owed the hospital the cost of their treatment. Likewise, although they were allowed to go to a hospital to be examined by a doctor, if ever the latter prescribed medicines or further diagnostic tests, the patients had to pay out of pocket for them.

In 2016, law 4368/2016[18] and a corresponding joint ministerial decision (KYA, March 2, 2016) intended to correct the aforementioned deficiencies in order to guarantee "equal and universal healthcare". All citizens legally settled in Greece may now access public healthcare by simply presenting their social security number. Refugees recently entered and registered in Greece (but not undocumented immigrants) are also covered. However, except for the very poor, free care does not include medicines, half the cost of which on average is borne by the patients. The exemption from user fees is subject to conditions such that only a small number, estimated at some 170 000 people, is involved (out of at least 2.5 million potential beneficiaries). Free medicines are subject to the following criteria: (a) annual income must not exceed € 2400 for a single person (the double for a couple with two children and an additional € 600 per dependent person); (b) if a person has no income but owns property worth up to € 150,000 or more or if a person has a bank account with assets equivalent to three times the annual criterion of € 200 monthly (ie a credit balance of € 7,200), s(h)e must pay user fees; (c) disabled people with a disability rate of less than 67% are not covered 100 percent (with a slight difference in their favor if there are children); (d) access to specialist consultation is restricted: the provision of free public health services is

strictly limited to whatever public resources are available and does not extend to services that local hospitals or health centers contract to private providers. In other words, if a patient living in an area where the local health center has, say, no cardiologist and sends insured patients to a contracted private physician, the uninsured patient cannot access that cardiologist; she must travel most probably to a big city or forego specialist care. As a result, universal access to health services and drugs is far from being achieved.

The General Minimum Income referred to in the third MoU is another component of the new European minimalist "social model." The GMI has been pilot tested (November 2014 to April 2015) in thirteen local governments (one per region). EU official discourse refers to the pilot program in terms of "social investment" and indicates that minimum income supports (only) "extreme poverty" (in the technocratic vocabulary, "social investment" means the opposite of hard-won unconditional rights to transfer incomes; the latter are given the derogatory qualification "social consumption"):

> "The policy to support minimum income (extreme poverty), under the harsh conditions of economic crisis, is considered to be a typical example of social investment…" (brackets in original) (Ziomas et al. 2015).

The GMI is now called "Social Solidarity Grant" (KEA being the Greek acronym). It came into force in 2017 (Ministerial Decree of 24 January 2017 based on Law No. 4320/15). The scheme includes a regressive allowance slightly lower than the extreme poverty threshold[19] not exceeding € 200 monthly for a single person, somewhat more depending on the size of the household, for example € 400 for a family of four or € 500 for a couple and four minor children. It also includes in-kind social benefits and job seeking assistance. Access conditions are similar to those applied to the Universal Health Access Program mentioned above. The household's income during the six months preceding the application must not exceed six times the amount of the allowance,[20] or a ceiling of € 5,400 regardless of the number of persons in the household. There are also criteria for ownership, which also vary according to the size of the household. They include the taxable value of real estate in Greece or abroad (€ 90 000 for a single person, with a ceiling fixed at € 150 000), the objective cost of all types of private vehicles (including bicycles: the total amount must not exceed € 6,000) and the total amount of bank deposits or any other credit institution (€ 4,800 for a single person, € 9,600 for two adults and two minor children, € 14,400 for two adults and six minor children, with intermediate ceilings referring to the composition of households). Implementation of the scheme is entrusted to the municipalities. However, their budget constraints, the diversity of practices from one municipality to another as well as inconsistencies in the program do not allow the social services to accept all those who would be entitled to benefit the scheme (Interview at the municipality of Keratsini-Drapetsona, 2017).

Severe depression and violence

15 percent of the Greek population was living in "extreme poverty" in 2015 (10.8 percent in 2013 and 2.2 percent in 2009) (Hellenic Parliament 2014, Matsaganis and Leventi 2013, Matsaganis et al. 2016). Even taking into account the fact that the financial component of KEA is complemented by social benefits— which are basically limited to (always means-tested) food distribution—, the new "genuine" safety net is not likely to enhance living standards and consolidate the social determinants of health. The revised "European social model" is heading toward limited means-tested provisions that allow survival of the poorest, but not a decent life.

The most immediate adverse repercussions of pro-cyclical austerity policies (involving the downsizing of healthcare and other social protection institutions in response to economic downturns) are on mental wellbeing, risks of suicidal behavior and interpersonal violence (homicides and domestic

violence). This has been observed historically across countries and continents (Stuckler and Basu 2013). Epidemiological nationwide surveys conducted in Greece by Marina Economou and colleagues point to major depressions linked to economic hardship. The rate of severe depressions rose from 3.5 percent of the population in 2009 to 12.5 percent in 2014, a figure that persists today. Their inquiries corroborate other studies demonstrating significant increases in the rate of suicides during the three first years of austerity (plus 35 percent between 2010 and 2013) (Economou et al. 2013a; 2013b; 2016; Madianos et al. 2014). Suicides, however, represent only the tip of the iceberg. A much broader, worrying and tenacious mental health crisis linked to surging rates of stress, anxiety, and depression is the number of children confronted to increased (plus 30 percent) domestic violence and other forms of psychological stress associated with poverty. Spyros Sourlas[21] has observed a 30 percent increase of psychosomatic disorders (headaches, stomach aches) among children, one third of which end up in hospital. Gerasimos Kolaitis and George Giannakopoulos (2015) from the Department of Child Psychiatry of Athens University Medical School and Aghia Sophia Children's Hospital in Athens report that they encounter "an ever-increasing number of families with complicated psychosocial adversities" and that the recorded number of abused or neglected children admitted for child protection to the largest Greek pediatric hospital has risen from 81 cases in 2011 to 170 cases in 2014." The closure of local public and nonprofit mental health service units and termination of local psychosocial programs following the 2010 Greek decentralization laws, and the simultaneous introduction of structural adjustment policies leave these children, their parents, and the rest of the vulnerable defenseless. Locally more and more cases of abandoned children are occurring and dealt with through judicial and/or repressive actions instead of preventive treatment programs.

Human rights violations are greatest in the most vulnerable countries and social milieus. In Greece, one of the weakest members of the EMU, studies have reported a vertiginous list of Greek, European, and international norms, rules and laws that have been trampled by the memoranda and successive Hellenic governments, including the current Syriza government (Cadtm, 2015; Salomon 2015; Ghailani 2016). Children, women and migrants are, as one would expect, the first victims of human rights violations. In 2012 and 2013 the Greek government orchestrated "clean-up" campaigns against drug users and migrants. They hunted down and insulted migrant women, warning the country against the spread of AIDS—that "can be transmitted from an illegal female migrant to the Greek customer, to the Greek family"[22]—and against "health time-bombs" threatening Greek men and households. The latter slur was publicly articulated by Ministers of Citizen Protection Michalis Chrysochoidis and of Health Andreas Loverdos on April 1, 2012 during a press conference[23] in which the two men presented a new health plan (the decree GY/39A) that targeted migrants, homeless people, drug users and sex workers as potential sources of epidemics. Decree 39A allowed the police to detain anyone for the purpose of compulsory infectious diseases testing and to publish personal data of HIV-positive subjects; it led to multiple round up operations and the arrest, criminal prosecution, imprisonment, scapegoating and humiliation of thousands of people. Following intense international and domestic protests the decree was overturned in May 2013 by Deputy Health Minister Fotini Skopouli, but then restored a month later (June 2013) by incoming new Health Minister Adonis Georgiadis and finally repealed in April 2015 by SYRIZA Health Minister Panagiotis Kouroumblis (Mavroudi 2013, *The Lancet* Editorial 2013, Papastergiou and Takou 2014, Gamba 2013, Gkresta and Mireanu 2013, Matsa 2014, Kandylis, Daliou, and Sagia 2015).

"It is important to emphasise that no systematic association exists between migration and importation of communicable diseases" (Langlois et al. 2016, Rechel et al. 2011, Grove and Zwi 2006). As Human Rights Watch researcher Judith Sunderland said at the time, "addressing infectious diseases such as HIV, hepatitis, and tuberculosis requires investing in health services, not calling the police".[24] Much the same can be said of the European Union's approach to the current flow of refugees. Constantly exposed to institutionalized mechanisms of marginalization and discrimination that generate cumulative

vulnerabilities (Smith and Daynes 2016), refugees need special care and attention. Chiara Montaldo, medical coordinator of the refugee task force, Médecins Sans Frontières (MSF), who was in Greece in November 2015, testifies:

> We see trauma. We see growing incidences of respiratory tract infections and hypothermia… We also treat skin infections, mainly scabies, prevalent in those who have been detained in unhygienic conditions, but so far we haven't observed an epidemic… Signs of trauma are difficult to diagnose and manage, particularly as people are on the move. Psychologists are only treating those showing acute need, and can only scratch the surface of trauma-related symptoms. Language barriers and cultural sensitivities also need to be considered…(Refugees) often have acute mental health problems and trauma symptoms, notably depression and post-traumatic stress disorder (PTSD), related to organised violence, torture, human rights violation, resettlement, and traumatic migration experience. (Morgan 2015).

The refugees, however, face the greatest problems in accessing, if at all, adequate healthcare and the current policy of automatic detention in closed camps implemented in Greece in order to hold and "process" all refugees crossing the Aegean Sea further aggravates their health problems[25] (Filges 2015, quoted by Langlois et al. 2016; World Without Torture 2012). Overall, rather than estimate and respond to the refugees' health needs, increasingly complex and violent measures are taken by EU member states to build firewalls, police their borders, detain and exclude refugees once they have crossed those borders, and finally shift the blame and the burden on Greece[26] (Cabot 2014[27]). By portraying refugees "as a threat to a robust and healthy society, a threat of disease itself," by having them "screened and quarantined to avoid the spread of disease," health concerns are inverted in such a way "that the receiving population is seen to be under threat rather than attending to the health needs of the displaced" (Growe and Zwi 2006). If Europe's skewed priorities, that place an "emphasis on protection from the refugee above protection of the refugee" result in not letting refugees and asylum seekers "receive appropriate and timely health care, then this may indeed place the wider community at risk over time" and lead to the catastrophic results that this policy was purported to avoid (Smith and Daynes 2016, Grove and Zwi 2005).

The Calculus of Power

Briefly addressing the question of the differential distribution of the livability of life, of access to a decent life, Judith Butler recently noted the need to look at those "whose lives are becoming more and more unlivable under conditions of austerity and precarity…we need to understand that calculus of power in order to understand that particular form of inequality" (Butler 2015). As far as the process of healthcare restructuring is concerned, some conclusions may be drawn that help to shed light on that calculus. In 2010, when the then Prime Minister of Greece, George Papandreou, asked German Chancellor Angela Merkel for gentler structural adjustment conditions, she replied that the aid program had to hurt: "We want to make sure nobody else will want this," Ms. Merkel is said to have told him (Walker 2012). The program hurt terribly and its long-term consequences will further hurt for decades. Blind and deaf to the needs of their people in this and other areas such as education (Athanasiades et al., Chapter 7 in this volume), successive Greek governments implemented the most destructive austerity regime—"with butcher's knives" as Minister of Health Andreas Loverdos acknowledged—and pretended until January 2015 that their "responsible" action had increased efficiency and effectiveness in the healthcare sector without impacting essential medical services (Stuckler and Basu 2013; Kentikelenis et al. 2014; Burgi 2014). Since 2010, the European Commission seized the opportunity of the "crisis" (as well as reinforced supranational powers) to target health systems for reform in a growing number of countries (Azzopardi-Muscat et al. 2015). The Commission is not supposed to interfere in social policies, which fall within the

national competence of Member states, but it has a Treaty obligation to assess the health effect of all policies, including the Troika's. In August 2015, it finally published a social impact assessment for the third Greek adjustment program that was, in the words of UN Independent Expert on Foreign Debt and Human Rights, Juan Pablo Bohoslavsky, "disappointing in many respects." The study, writes Bohoslavsky in his End of Mission Statement, "fails to draw any lessons from what went wrong." Surprisingly, "the social impact assessment … does not mention the term "human rights" even once" (Bohoslavsky 2015). In the meantime, at global level, between 2013 and 2014, "the collective wealth of billionaires with interests in [the pharmaceutical and healthcare sectors] increased from $170bn to $250bn, a 47% increase and the largest percentage increase in wealth of the different sectors on the Forbes list … Companies from these sectors spend millions of dollars every year on lobbying to create a policy environment that protects and enhances their interests further" (Oxfam 2015, 6). As the Commission on Social Determinants of Health (CSDH 2008) stated in its 2008 final report, "social injustice is killing people on a grand scale."

Until recently, there was some light in this dreary and indeed lethal picture. Men and women, all of them voluntary workers, have been fighting since 2009 to defeat illness and death, to restitute life and re-empower the humanness of their fellow citizens. At least forty solidarity clinics and pharmacies have been created since the first one opened in Rethymnon, Crete, in 2009. Their activity and organizational skills have developed remarkably. The Metropolitan Community Clinic at Helliniko in Attica for example was established in 2010. At the onset twenty-five people worked there. They are 300 today. The first year they secured 1,200 medical consultations and 47,000 in 2015. Regardless of nationality, social status, or origin, any person in need is welcomed and given the free care and attention needed, and treated when possible, if the resources are available and if it is not too late. Many Greeks do not even know that there might be a haven where their words will be heard, their diagnoses studied, their medicine provided for. Solidarity clinics do not advertise their existence nor the name of their donors and people often end up finding them when their health situation is poor. Despite their very limited resources (that come exclusively from donations), these autonomous, independent, and self-managed groupings, that see themselves not as an alternative to public healthcare but as resistance bodies and strive to enable access to health for all, have saved thousands of lives and reinstalled hope (MCCE Archive). Solidarity clinics and pharmacies, and beyond the health sector many other solidarity initiatives[28], embody the social and democratic ethics that are being discarded by dominant elites, and which need to be restored to give people the means and the right to have lives worth living. For the time being, however, hope is waning because austerity became endless after Alexis Tsipras's surrender to Germany and the Eurogroup in July 2015, and because thereafter, the Greek Prime Minister chose to cling to power and apply a memorandum even more violent and punitive than the previous two. Apathy and despair are gaining ground. Activists and volunteers, exhausted, are quitting their organizations. Today, no one knows how the Greek society will seek to defend itself from the attacks on its very substance.

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[1] International dollars taking into account the purchasing power of different national currencies. WHO data.

[2] Latest available data available from the WHO Global Health Expenditure Database.

[3] The EU and IMF have been aware since 2010 that the debt was unsustainable.

[4] I am mainly basing myself here on the very clear and synthetic paper by Kondils et al. (2012). For detailed accounts, see Toundas et al. 2012; Siskou et al. 2008; Ioakeimoglou 2010.

[5] According to Petrou and Talias (2016), one billion euros savings in 2012 (from € 5.4 billion in 2010 to an estimated 3.5 billion in 2012).

[6] On reference pricing and price negotiations for new drugs, see for instance Gandjour (2013). On the Novartis scandal, see for instance http://www.cardiobrief.org/2016/03/29/us-doj-expands-investigation-into-phony-novartis-speaking-events/.

[7] And at 644 million euros in 2015 (see the following *Iatronet* press release: http://www.iatronet.gr/eidiseis-nea/perithalpsi-asfalisi/news/32734/sta-644-ekatommyria-evrw-ypologizei-o-eopyy-claw-back-kai-rebate-gia-to-2015.html). The third August 2015 Memorandum extends the clawback ceilings for diagnostics, private clinics and pharmaceuticals to the next three years, and prescribes further reductions in generic prices "including by making greater use of price-volume agreements where necessary." See "Greece's third MoU annotated by Yanis Varoufakis" in Varoufakis's online blog available at http://yanisvaroufakis.eu/. Multinationals are suspected by the Panhellenic Association of Pharmaceutical Industries, which represents most Greek producers, and by other actors of price dumping practices, namely in tenders for hospital drugs (Melck 2015; MCCH, 2015) and reimbursement fraud has been reported (Kresge 2012).

[8] Interview with Charis Matsouka, Athens, 2014.

[9] MCCH Stands for Metropolitan Community Clinic of Hellinikon (referred to at the end of this chapter).

[10] Interview in Athens 2014 and 2016.

[11] Judgment of the Court (Ninth Chamber) of 23 December 2015. European Commission v Hellenic Republic. Case C-180/14.

[12] On the recruitment of unauthorized undocumented nurses in Greek hospitals, see Fouka et al. (2013).

[13] See for *Proto Thema*: http://www.protothema.gr/ugeia/article/545984/apo-auti-tin-kuriaki-to-thema-sas-vgazei-karta-ugeias-dorean/ and for Anexartisia: http://www.eyclub.gr/μεγαλη-προσφορα-τησ-καρτασ-υγειασ-ey-club-ey-check-up/.

[14] See the ad of Piraeus Bank: http://www.piraeusbank.gr/el/idiwtes/asfaleia/asfaleia-ygeias.

[15] It costs the patient € 50 to € 60 (reimbursed € 15) to consult a psychiatrist.

[16] Dental diseases may have long-lasting effects. Scientific studies find a strong correlation between bad oral health and chronic diseases such as cardiovascular diseases, diabetes and coronary artery diseases.

[17] In 2003-15, volunteer dentists of Doctors of the World examined 9,382 children in sixty-six schools in Athens and found that 81 percent needed follow-up care and 34 percent swift dental care (Tagaris 2015; MCCH 2015).

[18] See art. 33 of that law (in Greek): https://www.e-nomothesia.gr/kat-ygeia/nomos-4368-2016.html.

[19] "Extreme poverty" in Greece refers to a poverty threshold the amount of which is estimated from the cost of a consumer basket with a minimum of basic products at constant prices. That amount varies according to the localities considered. In their most recent research, Matsaganis et al. (2016) studied "Athens", "Other urban areas", "Rural and peri-urban areas". For a single person, it amounted in 2015 respectively to € 222, € 216 and € 182; For a couple with 2 children: € 640, € 614 and € 524 (Hellenic Parliament 2014, Matsaganis and Leventi 2013, Matsaganis et al. 2016).

[20] € 1,200 for a single person, a little more depending on the composition of the household, for example € 3,000 for a couple and four children.

[21] Interview in Athens, 2015.

[22] Comment by the then Health Minister Andreas Loverdos, 16/1/2011, quoted by Kandylis et al. (2015).

[23] See the press release of the interview: goo.gl/yZ4WfV. See also the article published later in May by the daily newspaper *Ethnos* (in Greek):
http://www.ethnos.gr/koinonia/arthro/loberdos_apasfalismeni_ygeionomiki_bomba_oi_molysmenes_me_hiv_ierodoules-63651291/.

[24] https://www.hrw.org/news/2013/07/03/greece-repeal-abusive-health-regulation.

[25] A recent systematic review showed an "independent adverse effect on the mental health of asylum seekers, including PTSD, depression, and anxiety" (Filges et al. 2015, quoted by Langlois et al. 2016).

[26] Some self-serving and cynical EU officials and states seem to think, as one official quoted by the *Washington Post* said, that "Greece wouldn't be the worst place to have a humanitarian crisis for a few months" since the population there was much more refugee-friendly than those in the Balkans or Eastern Europe (Pop 2016).

[27] See Heath Cabot, chapter 12 in this volume.

[28] *Ibid.,* and e.g. Hart (2015).