



# **Quality in and Equality of Access to Healthcare Services**

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## **Country Report for Greece** *March 2008*

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### **Chapter 4**

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**Susan Gregory**

## Acronyms

CEO	Chief executive officer
EPAPSY	from the Greek ΕΠΑΨΥ Association for Regional Development and Mental Health
EEC	European Economic Community
EU	European Union
GHM	Greek Helsinki Monitor
IKA	Social Security Organization
JIR	Joint Inclusion Report
KAPI	Open Care Community Centers for Older People
MSU	Monitoring and Support Unit Psychoargos Phase B
NAPIncl	National Action Plan for Social Inclusion
NHS	National Health System
NGO	Non Governmental Organization
OGA	Agricultural Social Insurance Organization
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees

# 1 Introduction

## 1.1 Country profile

The health sector in Greece is based on a public/private mix. It is comprised of three distinctive sub-systems, namely: (a) the National Health System (NHS) providing hospital care throughout the country and primary care coverage in rural areas (Beveridge model), (b) the Social Insurance Organizations covering different professional groups (Bismarck model), and (c) the private sector, reflecting a totally competitive market (market model). Funding of services, as well as the criteria for remuneration of providers, vary among these three sub-systems. The NHS is funded by general taxation and insurance premiums. The insurance organizations are funded through contributions from employers and employees, while the private sector is funded either by social insurance contributions or by private payments and private insurance.

Greece spends about 10% of the gross domestic product (GDP) and is among the OECD countries with the highest health care expenditure, as a GDP percentage (OECD 2006). Public health expenditures represent 51.7% of total health expenditures, while social insurance accounts for 35.9% of public health expenditures. Private insurance represents only 4.8% of private health expenditures. The households spend 7.2% of their income for health services. According to the results of a survey conducted by the National School of Public Health (NSPH) in 2002, 2.44% of the Greek households pay more than 40% of their disposable income for health services. The high private expenditures, with private health insurance contributing only a small amount, are partly a result of an informal economy that represents a significant problem in Greece, especially in the case of inpatient care. In addition, private expenditures include the users' contribution to certain health services such as the contribution of 25% in the cost of pharmaceutical care, as well as out-of-pocket payments for services without or limited insurance coverage such as dental care. It must be also mentioned that primary health care absorbs about 69% of households' private expenditures for health, with dental care representing the largest part.

Primary health care in Greece is provided through the following four structures: (a) NHS: health centers in rural areas, semi-urban clinics and public hospital out-patient departments which are financed mainly through the state budget and to a lesser degree by insurance funds, (b) social insurance funds: polyclinics owned, operated and financed by the funds, (c) local authority services: few welfare services and clinics financed by the state budget, and (d) private sector: physicians in private practice, private hospital out-patient departments and diagnostic centers, financed by out-of-pocket patient payments, voluntary health insurance or in the case of contracts with sickness funds, by the funds. Two patterns for the provision of primary health care by sickness funds exist. The first includes funds, which have their own medical facilities and cover all the primary health care needs of their insured population. In this pattern medical professionals are paid a salary. The second pattern of provision relates to funds, which do not provide direct medical services but make contracts with independent medical practitioners who are remunerated via a defined fee for service on a retrospective basis. The level of remuneration is subject to approval by the Ministry of Health (MoH). A variation of this pattern is the free choice of professionals who are paid by insured persons in accordance with current prices on the medical market and then receive a set amount from the sickness fund.

The training and the recognition of general practice as a specialty began in approximately 1999 and still few doctors are trained and working in this area while the gate keeping function seen in other countries e.g. U.K. does not exist in Greece. This fragmented structure and lack of comprehensive coverage of primary health care results in inequities in access to care and in the quality of services provided. (Kyriopoulos et al. 2000, 2000a; Yfantopoulos 1999).

As it concerns inpatient care, there are three main categories of hospitals:

132 general and specialized NHS public hospitals operated by the MoH, 23 public hospitals operated by other ministries (military hospitals), sickness funds hospitals, teaching hospitals and hospitals for prisoners and 218 private hospitals, the majority of which are for profit. The reimbursement of public hospitals is retrospective and it is based on a predefined per diem basis. The

informal payments mentioned above, mainly concern the provision of hospital services and payments of fees primarily to surgeons, in order to by pass waiting lists or to ensure a better quality of service.

There are marked disparities between rural and urban areas (specifically Athens and Thessaloniki) in the distribution of doctors, with a heavy over-concentration in the two main urban centers and deficiencies in the overall numbers of nursing personnel in particular means that many public health units and services are under-functioning due to a lack of staff appointments. Furthermore, the emergency departments of all state hospitals are available for use by anyone in need, regardless of age, nationality or health insurance coverage and in the major urban centres hospitals operate an emergency rota system for different categories of disease.

## ***1.2 Promoting social inclusion through policy action at the system level***

The four Greek National Action Plans on Social Inclusion (NAPsIncl) - 2001-3, 2003-5, 2005-6 and 2006-8) do not provide sufficient evidence that the health sector constitutes an important component of the strategy for combating social exclusion in Greece (Economou 2006). They do not formulate concrete objectives for the reduction of socio-economic inequalities in health, while the policy measures for health care lack sufficient planning, budgeting and implementation requirements. In addition, they do not give sufficient attention to the question of financing of health services and to the disproportionate economic burden of the lower socioeconomic groups due to the various forms of co-payments and cost-sharing. A systematic approach to address access problems to health services in disadvantaged regions or social groups due to insufficient transport infrastructure, long waiting lists or the existing mix between public and private suppliers of services, is absent. Finally, the Greek NAPsIncl lack well planned policies that would correspond to the needs of socially excluded groups including migrants, illegal immigrants, asylum seekers, older people and people with mental health disorders.

More specifically, the 2001-2003 NAPsIncl recognized the existence of important geographic inequalities including the health infrastructure and the quality of services provided. The health status varied between the socio-economic groups. Furthermore, it was recognized that there were restrictions in the access of health services for the disadvantaged groups including persons with disabilities and the chronically ill. However, the extent of these problems was not documented with qualitative and quantitative data. Reference was made to health services access for those not insured and the poor, and it was stipulated that these groups are entitled to free outpatient, inpatient care and pharmaceuticals by acquiring a special identification card. In regards to the immigrants it was reported that in general, emergency care is fully covered, though not chronic care. According to analysts (Economou, Feronas, eds, 2006) the proposed policy measures were vague concerning the vulnerable populations and access to care as they referred to wider reforms that aimed in the correction of chronic structural weaknesses of the health system, such as the regional organization of the NHS, the managerial restructuring of hospitals, the creation of an integrated primary health care system, the introduction of general practice and the development of public health. Emphasis on prevention was limited in the existing health education policies, while specific reference was made of the mental health programme "Psychargos" and the programme on sanitation "Hippocrates" for the Aegean islands, without any estimations of the effectiveness of these programmes. A positive development was the regional reorganization of the NHS with the establishment in 2001 of the Regional Health Directives while primary health care was still not integrated.

The 2003-2005 NAPsIncl again stated equal access to care in the different geographic regions and among socioeconomic groups undertaking an ambitious reform program concerning the organization of the NHS, improving the infrastructure and fighting the informal economy. The areas of public health and primary health were again mentioned in this plan though no evaluation data of the implementation process was provided through the previous plan 2001-3 NAPsIncl. Documentation also did not exist for the completion of the first phase of implementation of the health map nor the continuation of the creation of hospital infrastructures though both the health map and the hospital

infrastructure were included as policy measures in the new plan. Furthermore, the 2003-5 NAPIncl demonstrated a lack of an integrated and coherent policy in combating social inclusion with the establishment of afternoon surgeries in the public hospitals providing services to those with the capacity to make out-of-pocket payments while at the same time not creating a system of access to services for the disadvantaged groups who could not make such payments. This initiative with the aims of ensuring citizens' choice of doctor, decreasing waiting lists, optimizing utilization of medical equipment and increasing the hospitals' revenues created conditions of unequal access based on ability to make out-of-pocket payments.

The 2005-6 NAPIncl recognized the inefficiencies of the past plans including the low user satisfaction, the modest efficiency and low effectiveness in the allocation resources and the maintenance of high regional inequalities in access. In this context, the policies of the new plan aimed at ensuring access to quality of health services for all, and developments in primary health care, public health and a sufficient increase in nursing personnel. As with the past plans again there was no assessment of the extent to which these measures were implemented, and to what extent they increased access to services or decreased inequalities. Characterized by a medical approach to solve past inefficiencies this plan included measures in increasing medical personnel, improving material and technical infrastructure, the abolishing of pharmaceuticals list and the administrative reorganization of the regional health directives. For example, despite the improvements in hospital infrastructure and the creation of new hospitals financed from the second and the third Community Support Framework, all this effort was accompanied by delays in the completion of the works and insufficient functioning of many hospital units. In addition, many departments and especially intensive care units are still not in operation due to staffing shortages. Finally, the implications of the new system of pharmaceuticals provision have not yet been evaluated. The new law for public health and the establishment of the Ombudsman for Health and Social Solidarity are steps in the right direction. Specific measures concerning the vulnerable populations were again limited such as in the mental health program

“Psychargos” in improving access to services for the unemployed and the uninsured poor.

In the National Strategy Report on Social Protection and Social Inclusion 2006-8, the health care sector’s contribution to the Greek social inclusion policies and programs is concentrated on four priorities: disability, mental health, immigrants and refugees and gypsies. As far as health services’ access of the disabled is concerned, the Report defines the existing structures which offer short-term stay. Though the report highlights the underlining inefficiencies it does not propose measures for improvement. In the field of mental health, once again, the report promotes the ‘Psychargos’ plan as a large-scale reform aiming at de-institutionalization and at creating community-based mental health services. Nevertheless, no assessment of the degree to which the plan has accomplished de-institutionalization and of the difficulties in its implementation is presented in the report. With respect to immigrants and refugees’ access to health services, the report underscores that lawful residents and working immigrants and refugees having the refugee status enjoy the same rights as Greek citizens. Moreover, nationals from countries being contracting parties in the European Social Charter, lawfully residing in Greece and not having sufficient resources nor insurance coverage, are granted a Social Protection Certificate with which they are entitled to hospital and pharmaceutical care free of charge at the NHS hospitals as outpatients. As it concerns the Greek Roma, the report focuses on the establishment of medical-social centers, providing preventive services and basic health and social inclusion services. In addition, the reports refers to the mobile units used to make visits to the gypsy settlements in order to conduct clinical examinations and vaccinations, provide consultation and psychosocial support, tackle social problems and record living conditions at the local level. According to the comments of the Social Protection Committee in the JIR 2007, the above mentioned policies and plans lack quantitative targets they do not provide any pre-assessment data and they fail to refer to the adequacy of financial and human resources considered necessary for their successful implementation.

It could be argued that the Social Protection Committee’s comments on the social inclusion part of the Greek Report are also valuable with respect to health

policy and measures taken in order to improve access to health services. The Greek Report refers vaguely, without giving more details, to two initiatives. The first is the intention of the Government to reform primary health care and the second is the extension and construction of hospitals. No mention is made for example about how to combat the informal economy or how to reform the financing mechanisms of the health system in order to reduce unnecessary private expenses, which indicate access and service use inequities.

### ***1.3 Quality in and equality of access to healthcare: summary of main findings***

The various reform initiatives during the '90s and in the beginning of the 21<sup>st</sup> century were never or partially implemented and lacked an integrated approach to reduce barriers and improve access to care for the general population. In Greece primary health services continue to be fragmented and not comprehensive in the services they provide. In addition there is no referral system leaving patients and their families to coordinate the continuity of care. The variations in the health basket provided by the numerous insurance funds results in inequities in access. Other significant barriers to access include the high percentages of private spending and informal economy waiting lists for certain services, regional inequalities in health resources allocation and access to health services and the absence of a rational priority setting, planning and efficient use of resources.

A number of policy initiatives along with inter-ministerial committees, and information centres have been developed to remove barriers and improve access to care for migrants, asylum seekers and ethnic minorities with limited success due to gaps in the implementation process. The NAPs even though they lack well planned policies and implementation procedures they have stimulated the development of a number of initiatives addressing the needs for health care for these populations. Nevertheless, they still face barriers to access to health and social care produced by legal and administrative difficulties in establishing eligibility, the gaps in health insurance coverage, inadequate information concerning their rights to health and social protection as well as the

bureaucratic processes of getting access to services and claiming benefits, language difficulties in communicating with health professionals, and biases and stereotypes of professionals towards them. Most of the health problems of these groups are connected with housing, working and living conditions as well as inadequate access to preventive and vaccination services. Good practices in improving access to care for these population groups involve NGO's and local authority initiatives but they are short lived and lack continuity due to the uncertainty in long term funding. Streamlining legal and administrative procedures in establishing entitlement of benefits is a pressing issue with many hurdles to overcome at every level of processing eligibility requirements for care and social services, (section 3.1 provides more information on these groups).

Disability<sup>2</sup> of all kinds is the main reason why people use health care services. Measures to reduce functional disabilities and improve health status amongst older people could have a potential major impact on the costs of health care as well as improving the quality of life of dependent older people and their family carers and at the international level there are numerous documents and policy statements providing guidelines on the achievement of these objectives (see Annex 1). Studies have shown that health expenditure for older age groups is negatively associated with health status rather than with age per se and that the highest expenditure is during the final year of life whatever the age (Garber et al 1998). Thus age per se may be less useful in predicting service use than other factors such as self-rated health, number of diseases and functional ability (Triantafillou et al 1999).

Health and social inclusion policies to support older people with functional limitations in Greece are focused towards those of all ages with functional disabilities but, from the perspective of the authors, also need to include strategies for health promotion, disease and disability prevention as well as for

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<sup>2</sup> Murray and Lopez (1996) made estimates in 1990 of the main causes of disability in the developed world; they calculated that mental disorders (including dementia and hereditary disorders of the central nervous system) accounted for 35.5% of life years lived with disability. In the Netherlands the same disorders including congenital disorders accounted for 28.4% of all healthcare costs (Meerding et al.1998).

rehabilitation throughout life. The fragmented social health insurance and primary health care system in Greece makes the access to services a cumbersome process by all sections of the population but even more so for older people relying on the goodwill of staff and the assistance of family members. Developments in home care services are very limited with the existing services being over-stretched despite recurrent discussions and political agreements that these services are of vital importance. In addition the absence of specialist geriatric services, few rehabilitation facilities, the inadequate staffing of health and social services especially with reference to nursing personnel, co-payments for essential prescription drugs and informal payments to doctors result in barriers to access of health and social protection services for older people with functional disabilities, especially for those receiving low pensions. In addition, distance from services and difficulties in transportation constitute a major problem for people with disabilities. Good practices of integrated health and social care services designed specifically for older people are the Open Care Community Centers for Older People and Home Care Services, although they encounter significant limitations in their financing, (section 3.2 provides more information on this group).

The most recent comprehensive policy initiative on mental health is the Programme “Psychoargos” with a detailed implementation and monitoring process. In the NAPs though they make reference to equity of access to health services of socially excluded groups mental health is not included. There is a national anti-stigma programme focused on research and provides a variety of services. People with mental disorders do not face particular problems in gaps in coverage or discrimination in the scope of the health basket. In terms of cost sharing and geographical barriers they have to cope with the same problems of access to care as those of the whole population. In contrast they face serious organizational barriers to general health care since hospitals insist on psychiatric hospitalization even when the mental health problem is well controlled. In addition, research indicates that discriminatory attitudes towards people with mental disorders are prevalent in general hospital personnel. (Sections 3.3 and 4) provides more information on this group).

## **2 Major barriers of access**

### ***2.1 Introduction***

The Ministry of Health and Social Solidarity is responsible for the formulation and implementation of national health policy. Health priorities are set at a national level defining the planning and financing of health resources allocation. The governance of the public health sector includes numerous bodies, such as the Central Health Council having a predominant advisory role, the various social insurance funds and a number of advisory committees on specific health issues. Moreover, the Regional Health Directives are responsible for the coordination of regional activities and the effective organization and management of all health care units. In practice, all decisions are still centralized at the Ministry of Health and Social Solidarity and civil society participation is limited.

The NHS enactment in 1983 introduced the universal coverage to all segments of the population. Access to health care is entitled through the employment status and citizenship. More specifically, health insurance is compulsory and directly related to occupation (the insured have no choice of fund). The uninsured and the poor are entitled to free access to public health care providers.

### ***2.2 Population coverage for health care under public programmes***

The public health sector is based on a combination of two systems; a compulsory social health insurance and the tax based National Health Service (NHS) system. The NHS in the mid 80s targeted at the diminishing of the existing inequalities by funding public health programmes and expanding health and social care programmes.

Although insurance coverage is compulsory for all the employed population evidence shows that 85% is covered for primary health care and 94% for hospital care while only 8% of the population is insured in a voluntary health

insurance scheme. The lack of comprehensiveness in the provision of primary health care, due to the variations in the services provided or subsidized by each fund, has resulted in the creation of inequalities in access to health care (Kyriopoulos et al.2000, 2000a ; Yfantopoulos 1999).

More detailed information on specific population groups, please refer to parts 3 and 4 of the report.

### ***2.3 Scope of the health basket***

Significant variations are observed in the health basket among the various social funds. The universal coverage through the NHS gives the possibility of access to the uninsured population or to the insured in the cases where the social fund may not cover specific items. Access to care through the NHS is provided to those on low income, older people and illegal immigrants. In addition, NHS initiatives in the late 90s included the enactment of the patient's right declaration, informing patients of their rights, the obligations of health professionals and of the relevant administrative processes of access to care. A range of services are provided by both public providers (NHS and social funds) including preventive, family planning, maternal and dental services. Though access to care is theoretically provided to all either through the insurance funds or the NHS there are significant inequalities in the volume and the funding of the services provided by the various social funds. (Kyriopoulos and Levett 1999; Petsetaki and Geitona 1999; Yfantopoulos 1999; Geitona 2001). Despite the fact that populations in need are eligible for medication, significant variations exist in the provision and utilization of drugs among the various social funds. In 2004, when the average per capita pharmaceutical expenditure was about 210 Euros, it was 190 Euros for the IKA fund, 100 Euros for the self employed fund, and 265 Euros public servant fund. The reform of the pharmaceutical policy in 2006 mainly focused on the drugs reimbursement rather than on pricing through the abolishment of the positive list, it is expected to diminish variations in the volume and the quality of drugs utilization, since all drugs (brand name and generics) can be prescribed. Even though there is not yet evidence of the effect

of this measure, it is believed that inequalities in cost – sharing and financing will increase especially among the disadvantaged groups.

## ***2.4 Cost-sharing requirements as barriers to access***

Population groups who are disproportionately affected by the financial burden of health related costs include older people, legal and illegal immigrants, asylum seekers and the disabled. For this reason, for the old and the disabled specific monetary benefits are provided by the state and the social insurance funds. There are additional allowances for those on low pensions and specific benefits for low-income groups (Geitona and Boukoura 2004).

The combination of low pensions with high private health expenditures and informal economy imposes barriers to the access and utilization of health services. The rise in private spending is accompanied by an increase in the informal payments from 7% in 1974, to 16% in 1995 and above 17.5% in 2006. Proportionally to the domestic economic growth, these percentages correspond to 0.3 of GDP in 1974, 1.1% in 1982, 1.4 in 1988, 1.2% in 1995 and 1.4% in 2006. Consequently, high private health expenditures affect disproportionately low income and socially disadvantaged groups (Kyriopoulos and Tsalikis 1993; Kyriopoulos et al.1998; Liaropoulos and Tragakes 1998, Mossialos et al.2005). The main reasons of the high private expenditure include the fragmentation in the provision of primary health care, the lack of comprehensiveness in the social insurance coverage, the existing barriers to access to healthcare provision, the regional inequalities in health resource allocation as well as the undersupply of health technologies in the public sector.

In the public health sector (NHS and social insurance) visits to primary health care, to GPs and specialists, are free of charge. Nevertheless, in order to reduce the demand in the NHS hospitals' outpatient units co-payment of 3 euros was introduced in the late '90s. Co-payment for medication accounts for 25% of drugs consumption in general, while for chronic and severe diseases it diminishes to 10% and to 0% respectively. Given that out- patient care absorbs

over 68% of private spending, research evidence has shown that more than one third involves the cost of dental care (Geitona et al.2004).

There are also significant variations in the provision and financing of health care among the various social funds. More specifically there are some funds that do not reimburse dental care, physiotherapy, counseling, family planning etc. Even though there are funds that reimburse some of the above services or they may provide some medical supplies, empirical evidence shows that patients' co-payments reached about 50% of the health service cost. This is due to the differentiation between the public sector nominal prices and the real cost of the provided health care. For example, a ministerial regulation on prices of visits to the contracting doctors 20 euros or 10 euros (second visit in the same month) whereas in some cases the co-payments are at a minimum of 40 or 50 euros per visit. Consequently, the existence of this situation has a negative impact on the vulnerable groups of the Greek population. This is because tax deduction or rebates have insignificant importance due to the fact that they are based on unofficial co-payments. Thus, they do not reassure income losses. In addition, the state subsidizes primary and hospital care for the low-income population through the regional authorities at the local level (municipalities, communities) and exempts them from any co-payment, with identification of their financial status (Geitona and Yfantopoulos 1995). The introduction of these measures for vulnerable groups has improved equity in financing health care. There is evidence showing that for the low income groups access to health services is provided free of charge through the numerous municipalities with the creation of local medical centers. Additional coverage concerning the provision of voluntary health insurance is an issue proposed for inclusion in the next social security reform and is expected to increase the inequities given that the low-income groups are not on the agenda.

## ***2.5 Geographical barriers of access to health services***

Accessibility in the context of patients' transport to health care is very important but only partial initiatives exist since there has never been a nationwide policy on the issue. Even though public transportation has expanded and improved

throughout the regions individuals with functional impairments and older people do face barriers in access. In the late 90s and early 2000, the regionalization of the health and social sector through the expansion of their services provision, was focused on the rational and equal distribution of services. Thus, local authorities have taken the responsibility of providing a variety of services including free health and social care, transportation to community health centers, home care, social support, and consultations. Recently, there is a trend by municipalities to expand their social and health care provision in the country through the creation of a local authorities network for the population in need in order to facilitate access and to prevent social exclusion. It is believed that such a network of services developed at the local level will improve access to care for people living in less densely populated areas such as on the Greek islands or villages on the mainland.

## **2.6 Organizational barriers**

Given that there is no referral system in Greece patients are free to choose hospital care in the public sector. As a result there are long waiting lists for specific hospitals and interventions especially in the urban areas while in others there are no people waiting. However, long waiting lists can be bypassed by informal payments placing at a disadvantage the vulnerable populations who do not have the ability to pay. There is an attempt to expand the provision of these surgeries through the public-private mix contracts and subsidized by the social funds. Severe waiting lists exist for oncology services in the metropolitan areas since such services are only provided in the urban areas. There are only three specialized oncology hospitals providing oncology services for the whole country. In these cancer centers, there are waiting lists for about 6-8 months for the first appointment for outpatient care including the choice of doctor. A priority is given to hospitalization of young cancer patients with waiting lists for at least one month while for non malignant surgical cases waiting lists are for more than three months, depending on the choice of hospital or medical department. In 2006, through the creation of one-day-clinics in these hospitals, waiting lists for

surgical and medical cases are significantly minimized up to 2-3 weeks with no choice of doctor

The creation of an integrated network of health and social care providers, as already mentioned, will facilitate access and will help to avoid delays in the provision of primary health or social care. The active role of the local authorities in the provision of health and social care will certainly minimize time constraints. The existing inequities in terms of how people pay for services and the variations in the provision of health care (NHS and social funds) have resulted in the existence of high time costs and informal co-payments in order to facilitate access. The economic burden to low income patients is significant since their disposable income is reduced (Kyriopoulos et al.2003). In addition, some recent proposals regarding the creation of 24-hour walk-in centres in local municipalities are supported by the government. The opening of hospitals' outpatients units in the afternoon with co-payments for patients and choice of doctor, facilitated access to prestigious providers and minimized time constraints for those able to pay.

## ***2.7 Supply-side responsiveness***

Research evidence shows that the gender of the practitioner doesn't affect health services utilization while the patient's gender is related significantly to the health care utilization (Zavras et al.2005). In addition, there is no evidence on how inequities in access may stem from the way in which health care professionals treat some groups systematically less favorably than others. Even though barriers to access between both sexes do not exist, it seems that some problems exist in the immigrant population and minorities, (see part 3.1). The communication with health professional may be difficult, requiring friends or family members who speak Greek to accompany immigrant patients. The lack of translation facilities in the health units is a barrier that cannot be easily overcome.

In general, research evidence has confirmed that immigrants do not respond to invitations for screening, immunization, preventive dental care and other

prevention activities. They seek health care when they have a specific need. Immigrants give a high rating in terms of responsiveness and satisfaction of the health care system while the Greeks give a lower rating, and are more confident about the provision of health care. On the contrary, low-income, older people respond better to preventive invitations, they also give a high rating in terms of responsiveness and satisfaction and are willing to pay more in order to improve their access to health care. Those with higher education and income and in the upper social class give a low rating in terms of responsiveness and satisfaction, due to the higher expectations they have of health care services. (Zavras et al.2005 and 2006; Economou et al.2004; Kyriopoulos et al.2004).

## ***2.8 Health Literacy Voice and Health Beliefs***

In Greece there is very little research on health literacy and health beliefs. What is characteristic of Greek society is that the seeking of care and the provision of care is strongly felt as a family matter and responsibility. The family of patients plays a crucial role in communicating with providers about the course of care in addition to providing care to family members while being hospitalized. The care of older family members or those with a mental illness is felt is the responsibility of the family. The stigmatization of mental illness is a barrier to seeking mental health services and more specifically inpatient care. According to the results of relevant research 77.5% of psychotic patients live with their family while 19.5% alone and 3% are in mental health facilities (Alevizos B. et al 1994).

## ***2.9 Interlinkages and overarching policy initiatives***

Equity in the access to health care is the primary principle of the NHS law. The government is responsible for setting priorities, planning and financing health care at the national level and to implement policies primarily through the Ministry of Health and Solidarity, and in accordance with the ministries of Economics, Social Protection and Employment and Development. In addition, numerous bodies and agencies also participate in the decision-making process

according to the field in which they are involved. For the health coverage under public programmes the responsibility belongs to the Ministries of Health and Solidarity and the Social Protection and Employment. For the health basket and the cost-sharing requirements the Ministries of Social Protection and Employment, Development (indirectly to the Ministry of Economics) and the Ministry of Health and Solidarity are involved. Moreover, the regional responsibility of health services depends on the Ministries of Health and Solidarity as well as the Interior and Public Administration. Consequently, the existing geographical and organizational barriers of access to the groups at risk are mostly related to the involvement of multiple actors and the lack of coordination among them in decision making and in the implementation of policies.

Decision making bodies belonging to the various ministries address overarching issues and propose initiatives regarding the barriers of access to care for vulnerable populations. Ministerial committees can exert influence and bring about changes in policy. For example, several expert bodies such as the specific drug committee exercised pressure on the co-payments or drugs cost-sharing and coverage in order to minimize access barriers for drugs and household co-payments, especially for specific groups at risk. Thus, the legislation regarding medication policy changed and the positive list for drugs reimbursement is postponed and all medications are reimbursed according to pharmaco-economic and other criteria.

Although all political parties acknowledge the needs of older people for specific support e.g. through services and pensions, this has not extended to changes in the health care system enabling better access. General opinion and that of some academics (Mossialos et al 2005) points to the vested interests of certain groups e.g. senior doctors, pharmaceutical companies, which lead to a non-rational use of resources. Interestingly there is little public or political debate on the issue of the likely increase in demand for NHS and long term care due to the ageing of the population. Data from the EUROFAMCARE study (Triantafillou et al, 2006) provides findings on the high costs to family carers of using health services for their older dependent person, within the context of a median income of 1000 euros per month for a 3 person household including an

older dependent person. This could provide a basis for a restudy to see the impact of changes in public policy to support family carers and/or older dependent people.

Overarching initiatives can not be critically and objectively assessed since integrated information systems are totally missing in the country and are essential to the monitoring of policies such as social insurance coverage and the utilization and access to health and social services. Thus, it is difficult to evaluate the effects of the implementation of any policies given that most times positive or negative criticism comes only from public opinion or political debates and there is no assessment based on scientific evidence. Nevertheless, some initiatives have started to be implemented regarding the systematic documentation and collection of socioeconomic, demographic, epidemiological and clinical data based on EU funding.

## ***2.10 Conclusions***

Decision-making is centralized at the Ministry of Health and Social Solidarity and is highly influenced by various governmental bodies and greatly by political forces, while civil society participation is limited. The Open Method of Coordination served as an impetus for Greek health policy makers to adopt participative processes in decision making although of limited outcome especially in including social partners. Thus, policies aimed at improving access and reducing barriers encompassed in the NAPs face many difficulties in the implementation process.

Even though the NHS enactment introduced the universal coverage to all segments of the population, the reforms followed in the 90s contributed to growing inequities due to the introduction of additional co-payments for health care services, such as outpatient visits and hospital admissions. Additionally, the lack of unification of the primary health care sector continues to lead to major inequities in access. As a result the vulnerable populations face more barriers to access to health services due to lack of integration of services and the existing inequities to access to care.

A positive initiative focused on the decentralisation of the NHS in 2001 with the establishment of the Regional Health Directives seemed to be a promising initiative though it has not been fully implemented. It is expected that through the regional expansion in the provision of primary health care as well as social care access to health services will be improved and barriers minimized for the vulnerable population. One promising initiative is the expansion of the Open Care Community Centres and the creation of the Community networks of Home Care that provide health, social and other support services for the disadvantaged population, mostly designed for older people and those with mental health disorders. Another initiative is the establishment in 2007 of an observatory committee responsible for the creation of an integrated migratory policy.

Finally, the most significant and promising way forward for reducing the existing barriers to access to healthcare would be the successful control of private spending and informal payments. The control of private spending depends greatly on the creation of integrated primary health care, the comprehensiveness in the social insurance coverage and finally on reforming the financing mechanisms of the health system. The necessity of reforming the financing of the healthcare sector has been suggested for many years and is characterised as an essential overarching policy. The introduction of a capitation payment in outpatient care and a case mix prospective system for financing hospital care could reduce unnecessary private expenses. Informal payments have become so ingrained as to constitute in our opinion a significant barrier to equal access to health care. A concerted, systematic and continuous commitment has to be made by the government to put a stop to this practice.

There is very little research done on access to care especially on the vulnerable populations. Thus there is minimal evidence on what works and what does not. In addition there is a lack of systematic monitoring of policies making it difficult to build on successes or make changes. Political and public debates and personal opinions influence policy rather than evidence.

### **3 Improving quality of and access to health care for people at risk of poverty or social exclusion**

#### ***3.1 Migrants, asylum seekers and illegal immigrants***

Health and social care benefits vary in these population groups according to the legislative processes defining their status in Greece. A distinction of the terms migrants, refugees, asylum seekers, refugees and minorities is provided below:

##### **Migrants**

In Greece, until 2005 the term alien (foreigner) was used extensively instead of the term migrant in the official terminology of legislative texts on migrants. It is in the recent Law 3386/2005 that the term migrant is defined as a “citizen of third country, person who does not have the Greek citizenship neither the citizenship of other state of European Union”.

##### **Asylum seekers and refugees**

The status and the process of status recognition of these population groups is stipulated by Presidential Decrees 61/1999 and 150/2006

##### **Minorities**

The only officially recognized minority in Greece is the Muslim minority of Thrace as it is recently reported in the first Greek report to the Committee of United Nations for the Human Rights (UN 2004:165). The Muslim minority of Thrace constitutes the unique group of Greek citizens with specific rights as members of a minority, granted in the framework of the Treaty of Lausanne 1923. The term minority has also been connected with the distinct cultural population group of Greek Gypsies or Roma a term used widely throughout Europe.

## **Migrants**

### **A brief overview**

Since the early 90s, Greece became a receiving country of big flows of migrants and refugees due to its geopolitical position to the Balkan countries, Eastern Europe and Asia and to the socio-economic conditions that prevail in the neighboring countries. According to the population census of 2001 by National Statistical Service of Greece (NSSG 2001), the total population of foreigners was 762,191 with 45.0% being women. In total, migrants in Greece come from roughly 120 different countries. According to the study of Panteios University of Social and Political Sciences the population of foreigners (from non- EU Countries) amounts to about 900,000 persons and the percentage of foreigners to the total population of Greece has increased 8.5% (Panteios University of Social and Political Sciences 2004:5).

### **Barriers based on legal, linguistic, cultural and religious issues**

The complexity of the legislative framework for the acquisition of work and residence permit is a predominant barrier to migrants. The extensive legislative process of the Greek state intensifies the debate of immigration and highlights legislative weaknesses. Acquiring a residence permit is characterized by inflexible, complex and costly administrative procedures. The migrants are not facilitated by the competent authorities through the provision of assistance with interpreters or the provision of special explanatory leaflets and legal support. Observations of the deficiencies of the legal framework along with proposals for improvement have been formulated by many organizations including scientific and social agencies, NGO's and the Citizen's Ombudsman.

The barriers of access to health and social care are summarized in the following points and constitute the main barriers for all groups (migrants, asylum seekers refugees and ethnic minorities)

- Legal and administrative difficulties in acquiring residence permit for illegibility identification card (not applicable to ethnic minorities)

- Financial difficulties in making out of pocket payments for health and social care services
- Inadequate information on access to services: health, social insurance and welfare system (allowances, benefits etc.)
- Language difficulties in communicating with health and social care professionals
- Biases and stereotypes of professionals towards these groups
- Fear and bias of these groups towards the operation of public services.

Migrants without a residence permit face problems in accessing health services on the basis of the immigration legislation (Ministry of Health and Social Solidarity 2005). Also, migrants without entry and residence permit and who are not insured do not have access to care in hospitals, infirmaries and clinics (Law 2910/2001).

In addition, administrative and legal gaps exist during the application period of a residence permit or the renewal process and having access to health and social services since the migrant's health book is connected to the residence permit eligibility process (Economic and Social Committee of Greece 2006). In fact, the adult migrants that have residence permit do not have substantial access to the social welfare system, even if article 39, paragraph 2 of Law 2910/2001 specifies "the provisions of Legislative Decree 57/1973 (of measures on social protection of the economically vulnerable), are also applied to the foreigners who reside legally in Greece". In practice, however, all categories of foreigners are not covered equally and the criteria for the provision of various benefits are specified in circulars which define the beneficiaries for each case (Ministry of Health and Welfare 2000).

### **Health problems**

A study conducted of hospitalized patients of the General Hospital of Attica (capacity of 270 beds) for the year 2003 showed the following in terms of health problems of the migrant population:

- The percentage of hospitalized migrants was 6.2%, a percentage that approaches the percentage of foreigners of the total population (7%,

according to data provided by the population census of the National Statistical Organization 2001).

- From the total number of hospitalized migrants 76% are women and 24% men, (though in the total population 54.5% are men and 45.5%, are women of whom 62.5% are found in the reproductive age). Data derived from the Census Population 2001 of the Greek National Statistical Organization.
- A high percentage of men are hospitalized for oto-laryngological problems with smaller percentages for urological, orthopedic and cardiovascular problems.
- Women, whose percentage is triple than that of men, are hospitalized mainly in the gynecological clinic (percentage 68%) while the rest 32% in the other clinics for orthopedic, urological, internal medicine and cardiovascular problems. Of the 68% of women hospitalized in the gynecological clinic, 62% concern childbirths.
- 14% of migrants cover the expense of hospital services privately; while only a small percentage (2%) are hospitalized with health care book for uninsured.
- Finally, 5% of cases are covered without verification of the insurance fund of the patient.

Data from the registry office of the General Public Hospital “Alexandras” in Athens recorded that in 2002, there was a total of 4,319 births, 1,867 were Greek (43.23%), 1,211 Albanian (28.04%) and the 1,241 (28.73%) concerned other categories (included unmarried women of all nationalities, and cases where one of the parents is a Greek national (Papsalis 2003).

Specific policy measures and policies on public health and health care services

- Application of non-discriminatory measures (Law 3304/2005).
- Creation of Information Centres (Greek initials: ΚΕΠ) on Health and Social Solidarity in every district (Law 3329/2005).
- The constitution of an Inter-ministerial Committee for the Observation of Migrant Policy, on the co-ordination of migrant policy in Greece (Law 3386/2005).
- The enactment of the state’s obligation to develop Integrated Action Plans for the integration of persons legally in Greece respecting their diversity (Law 3386/2005).
- The constitution of the National Committee for the Social Integration of Migrants (Law 3386/2005 and 3536/2007).

- The financial support of the state to NGO's on migrants,
- Provision of social insurance for migrants with residence permits (Law 2910/2001).
- Provision of social insurance of family members of migrants who have a residence permit (Law 2910/2001).
- Provision for the purchasing of stamps of social insurance for the renewal of residence permits (Law 3169/2003).
- Provision of social insurance for migrants working in the rural areas (Law 2639/1998).
- The provision of free health care and medicines for all migrants, refugees and members of minorities (Ministry of Health and Welfare 2000).
- Free medical and hospital treatment is given for all migrants, who have been infected by HIV or other infectious diseases (Law 2955/2001).
- Free health care is provided for the migrants who have been granted residence permit as trafficking victims (Law 3386/2005).
- Free health care is provided for the migrants who have been granted a residence permit for humanitarian reasons (Presidential Decree 266/1999).

### **Asylum seekers and refugees**

#### **A brief overview**

Greece from 2001 until 2004 had a medium rate of recognition of refugee and humanitarian status of 22.4%, 1.07%, 0.62% and 0.88% respectively. Comparative researches show that Greece has one of the lowest percentages of applications for asylum in Europe (Skordas and Sitaropoulos 2004).

#### **Barriers based on legal, linguistic, cultural and religious issues**

Refugees encounter excessive obstacles when they claim the refugee status due to the lack of adequate information by the competent authorities, interpreters and leaflets written in their language, complicated procedures, and costs in the submission of their application. The asylum applicants are not provided with any legal assistance during any stage of this process, apart from the assistance provided by NGO's such as the Greek Council for the Refugees (Amnesty International 2005). Also, the European Court of Human Rights

pronounced against Greece in two cases because of the absence of legal assistance for foreigners. Even after the enactment of law 3226/2004 for provisions of legal assistance to foreigners, the legal claim of asylum continues to be excluded because it is considered an administrative process.

### **Access to health and social care**

For asylum seekers and refugees (after achieving the recognition or the submission of official asylum request) key obstacles to access of health and social services include: the lack of information on the bureaucratic processes on issue of health care books for the uninsured, the lack of interpreters and professional biases in providing care for this population group. Those entitled to free medical, pharmaceutical and hospital treatment must present the refugee red (or pink) card or alien asylum-seeker's card in order to receive care (Presidential Decree 266/1999). Asylum-seekers remain for long periods with a police in-service note, without receiving the asylum-seeker's card, due to the work-load of staff. This category of asylum-seekers is not eligible for medical treatment, in violation of international human rights law and of Articles 2, paragraph 1 and 5, of the Greek Constitution (1975/1986/2001). Moreover, according to circular Y4a/oik.8992/13 July of 2000 of the Ministry of Health and Welfare one prescription per month for drugs is provided and only in emergency cases can a second prescription be made.

Specific policy measures and policies on public health and health care services of Asylum seekers and refugees

- Application of non-discriminatory measures (Law 3304/2005).
- Creation of Information Centres (Greek initials: ΚΕΠ) on Health and Social Solidarity in every district (Law 3329/2005).
- The constitution of an Inter-ministerial Committee for the Observation of Migrant Policy, on the co-ordination of migrant policy in Greece (Law 3386/2005).
- The enactment of the state's obligation to develop Integrated Action Plans for the integration of persons legally in Greece respecting their diversity and their cultural peculiarity (Law 3386/2005).
- The constitution of the National Committee for the Social Integration of Migrants (Law 3386/2005 and 3536/2007).

- The financial support of the state to NGO's on migrants, refugees and minorities.
- Asylum seekers and refugees are entitled to free health services according to article 15 of the Presidential Decree 266/1999.

## **Minorities: Greek Gypsies-Roma and Greek Muslims**

### **A brief overview**

#### *Greek Gypsies-Roma*

It is difficult to estimate with accuracy the number of Gypsies-Roma living in Greece today and even official sources provide varying estimations. The Comprehensive Action Plan 2001 for the Social Integration of the Greek Gypsies gave the number 250,000 - 300,000. The NGO, Greek Helsinki Monitor estimates the Gypsies-Roma population to be approximately 3% of the total Greek population, around 300,000 to 350,000 (Greek Helsinki Monitor 2003).

#### *Greek Muslims of Thrace*

It is estimated that the Muslim minority of Thrace is 98,000 inhabitants (Greek Ministry of Foreign Affairs 2001). A more recent estimate (2005) reports 100,000-120,000 (Amnesty International 2005). Though the Greek Muslims of Thrace have the same rights as all Greek citizens they face many problems due to their linguistic, religious and cultural differences.

### **Barriers based on legal, linguistic, cultural and religious issues**

These population groups encounter many barriers associated with their cultural, linguistic and religious beliefs. Policies have not been successful in providing opportunities to improve the social integration of these groups reducing marginalization and social exclusion. Thus, even if legally they have the same rights as all other Greeks they do not have equal access to services.

### **Access to health and social care**

Greek Gypsies-Roma encounter significant difficulties in their access of health and social services. In a report produced by the European Gypsies-Roma Rights Centre and the Greek Helsinki Monitor about the barriers to access to

health care and other social support services it is reported that many Gypsies-Roma lack basic identity documents (police identity, health book, birth certificates, tax reports, etc), making it impossible for them to claim basic health and social benefits. While there is recognition of this problem with identification access to services is still not facilitated. Many gypsy children are not vaccinated since many fail to attend school and the mothers are not adequately informed about vaccination procedures (European Gypsies-Roma Rights Centre and the Greek Helsinki Monitor 2003). The Doctors of the World (1999) found that Gypsies-Roma totally lack basic health information including on first aid and vaccinations and with only 15% receiving health and social benefits. Out of the 40% of Gypsies-Roma who have social security, only 30% are fully covered. These percentages are less than half of the equivalent average for Gypsies-Roma in other European cities. In addition, in a study conducted by the Centre of Information and Support of NGO, Efxini Poli, reasons of Gypsies/Roma not visiting out-patient clinics of hospitals include lack of awareness of their legal benefits to services, they also lack trust towards the health services and they feel the staff is not accommodating and friendly (Greek Helsinki Monitor 2002). At the same time the constant moving in search of seasonal work or work imposing constant movements (trading, collection, and selling of disposed objects etc.) makes it almost impossible to have periodical follow-up care.

The population of Greek Muslims of Thrace prefers to choose doctors of their own faith and generally have low trust in the health services. Women do not accept being examined by male physicians. The older population still faces language barriers and has difficulty in accessing services. Today in Thrace, there is a group of persons, the majority being middle-aged and older who lost their Greek citizenship, on the basis of the already abolished article 19 of the Code of Greek Citizenship. Many have not reacquired the Greek citizenship due to various legislative “gaps” resulting in their status of ‘anithagenias’ (lacking any citizenship). Nevertheless, the state continues to provide their health and social care benefits (National Commission for the Human Rights 2004).

### **Health problems**

Many health problems of Greek Gypsies -Roma are connected to their housing conditions: living in settlements such as tents, camps, dwellings made by plastic and other scrap materials, lack of basic utilities (electricity, water, heating, toilets) and the unacceptable environmental and sanitarily conditions of living. An international survey (ROMEUROPE 1999) by the NGO Doctors of the World, associates directly the poor living conditions in the settlements with the poor health of Gypsies/Roma tent-dwellers. The results of hepatitis tests in Municipalities of Nea Liosia and Aspropyrgos of Attica District, are significant: 99.0% of the population has been exposed to hepatitis A in addition to Hepatitis B 50.0% and 18.0% are carriers while the healthy remainder of 32.0% are aged 10-18, most of which go to school. These percentages are high in comparison to the rest of the population. Comparative data from other European cities show that percentages of Gypsies-Roma tent dwellers in Greece with health problems are higher (42.0% for the women, 32.0% for the men).

In a research conducted by the Ministry of Employment and Social Insurance and the Pan-Hellenic inter- municipality network for the support of Greek Gypsies - Network ROM in 2000 there were the following findings:

- One in two persons of Gypsies-Roma households (44.6%) suffered from a chronic health problem. The more common diseases included cardiovascular (18.1%), respiratory diseases - mainly asthma (13.9%), mental illnesses - mainly melancholy and depression (12.1%) and neurological diseases - mainly epilepsy (6.8%).
- The chronic health problems were treated (68.8%) in public hospitals, (16.1%) in private doctors and (12.8%) did not receive medical care.
- 76.6% of the patients who had a chronic health problem were also on medication while 21% did not take any drugs.
- 70% had serious dental problems and 10% hardly visited regularly a dentist.
- 26% washed daily and systematic their teeth, 38.5% rarely and 30% never.
- 70% of interviewed Gypsies stated that they had a health book and 77.8% that they had a health book for their children.
- Of the women interviewed 60% knew about PAP tests and half of them had the procedure at least once. Also, 45% knew about breast screening and 10% had the procedure at least once.

- 60% of women had given birth up to 4 children, 96% stated that the place of childbirth was the hospital and the rest the house.
- 46% of women were attended by a doctor at the hospital or health centre during their pregnancy, 20% by a private doctor and 32% did not have any medical attendance.
- 65% of women do not take any measure of contraception, 7.5% use the pill or spiral and 6% have been sterilized.
- 12.7% of women smoked more than two packets of cigarettes per day, 32.4% one to two packets, 26.7% one packet, 7.1% less than one packet or occasionally and 21% did not smoke at all.
- Vaccination data for women:

Type of vaccine	3.1.1.1 Yes (%)	No (%)	I do not know/ answer (%)
Hepatitis	47.7	35.2	17.0
Tuberculosis	35.2	35.7	29.1
Tetanus	38.7	35.0	26.4

- Vaccination data for children:

Type of vaccine	3.1.1.2 Yes (%)	No (%)	I do not know/ answer (%)
Poliomyelitis	55.0	16.5	28.5
Triple	58.7	15.9	25.4
Hepatitis	61.3	17.0	21.6
Rubella/Measles/ Mumps	42.8	18.8	38.4
Tuberculosis	46.8	19.5	33.7

Although Gypsies-Roma women give birth in a public hospital they rarely return for follow-up care. Only a small percentage of Gypsies-Roma follows pre-natal care (NGO Efxini Poli 2003).

Many of the above health problems of Gypsies-Roma are connected to unemployment, poverty, poor housing, hygiene and nutrition. These problems are major contributors to the marginalization and social exclusion of this

population resulting in a multitude of health problems, physical and mental (Dousas 1997:167-170).

Policy measures in public health and health care services of minorities:

- Application of non-discriminatory measures (Law 3304/2005).
- Creation of Information Centres (Greek initials: ΚΕΠ) on Health and Social Solidarity in every district (Law 3329/2005).
- The enactment of the state's obligation to develop Integrated Action Plans for the integration of persons legally in Greece respecting their diversity (Law 3386/2005).
- The financial support of the state to NGO's on minorities.

### **Interventions for Greek Gypsies – Roma**

- Specific measures are aimed at improving the housing conditions including financial aid and housing loans (Ministry of Employment and Social Protection 2005:42).
- Mobile units providing vaccinations to children and gynecological exams for women living in camps (Ministry of Employment and Social Protection 2005:43).
- A special project has been instituted of 37 Medi-social Centres in the regions of Gypsies-Roma settlements. These Medi-social Centres provide services of prevention, primary health care, and social care services for the integration of Gypsies-Roma (Ministry of Employment and Social Protection 2005:43).

### **An example of NGO good practices**

The NGO, KLIMAKA provides a number of services for the social integration of immigrants, refugees and minorities. It provides medical and psychosocial services with an aim at reducing inequalities in health and social care. It operates two Multicultural Day Care Centers in the Attica district one serving the Gypsies-Roma and the other Greek Muslims. During the period of operation 2001-2005, there were a total of 4,026 visits to the centers (NGO, KLIMAKA, 2006)

## **Views from Stakeholder organizations**

### **1. Medical Centre for the rehabilitation of torture victims**

[www.mrct.org](http://www.mrct.org)

The Medical Centre was founded in 1989 providing diagnosis and treatment of physical and mental sequel of torture. Legal support is also provided.

For the care of refugees the Centre collaborates with the public hospitals and with a number of volunteer or private sector doctors. The undocumented refugees (without legal documents) are served by the volunteer doctors.

Main reported problems of refugees in the collaboration with the public hospitals:

- Language difficulties in communicating with doctors.
- Refusal of certain hospitals to carry out high cost examinations and interventions i.e. CAT scans.
- Meeting high costs of dental treatments.
- Difficulties in receiving free drugs from public hospitals claiming it is out of stock in their pharmacy.
- Inappropriate behavior by medical, nursing and administrative staff.

### **2. DOCTORS OF WORLD (Médecins du Monde) – Greek Branch**

[www.mdmgreece.gr](http://www.mdmgreece.gr)

In 2005-06, the European Observatory on access to medical care from the Doctors of World conducted research in 7 countries on immigrants without residence permits. Countries participating in the study include Belgium, Spain, France, Greece, Italy, Portugal and the United Kingdom with a total of 835 immigrants of which 112 in Greece.

### Main findings for Greece:

- Political asylum seekers in Greece have the same rights of access to care as the Greek nationals under the stipulation that they are able to provide documentation of their status which is often difficult to do in the beginning of the long administrative process.
- Immigrants without residence permits – access to care is limited to certain emergency procedures and including prenatal care and treatment of infectious diseases.
  - Only 6.9% of those interviewed meet the eligibility criteria for care-long administrative procedures and gaps in eligibility.
  - Inadequate information on access to care – i.e. free HIV testing and treatment, vaccinations, and on the location of available services
  - Inadequate living conditions – 92.6% living below the poverty level, 40% live in unsafe housing and 11.0% live on the streets.
  - First contact with health professionals- mostly for emergency care though it was reported that the health problems range from mental health needs gastrointestinal, orthopedic gynecological problems and one third suffers from a chronic disease.
  - Fear of authorities-including language difficulties, confusion with administrative procedures, fear of discrimination, and cultural biases.
  - Costs of care

### **3. NGO KLIMAKA**

The NGO KLIMAKA serves the Greek Gypsies-Roma and the Greek Muslims.

The NGO reported that the main problems encountered by this group:

- Difficulties in social integration ie employment, education access to care and other benefits
- Mental health needs and social support – stigmatization of persons with mental disorders
- Poor living conditions- poor hygiene
- Lack of integration of health and social care services
- Poor reproductive health- inadequate vaccination of children
- Language barriers in communicating with health and social care professionals

### **3.2 Older People with Functional Limitations**

#### **Introduction**

*In 2004, life expectancy at birth in Greece was 76.6 years for males and 81.5 for females, among the highest in EU-25 and showing a significant increase since 1995. Healthy life expectancy was above the respective EU-25 averages, 66.7 years against 64.5 years for males and 68.4 against 66 years for females. At the same time, total health expenditure, as a percentage of GDP, seems to have stabilized in recent years and in 2004 was above the EU-25 average, 9.8% against 8.87% (WHO-HFA database). On the other hand, per capita spending on health in purchasing power parity is below the EU-25 average, at 2,011 in 2003 against 2,266, while the high level of private health care expenditure – accounting for almost half of the total expenditure (48.3% in 2004 against 24.1% EU-25 average) – may signal inequities in access for vulnerable groups. (Commission staff working document) Joint Report on Social Protection and Social Inclusion Brussels, 22.02.2007 SEC (2007) 272)*

These figures indicate some of the seemingly contradictory data reflecting dimensions of health and health services as they affect older people in Greece. In attempting to examine and understand the specific barriers in using services

experienced by older people with functional limitations, several problems arise with regard to this target group and the organisation of health services:

- There are no national data on numbers and percentages of disabilities in the performance of ADL amongst Greek >65 year olds. The small amount of data available is taken from non-representative samples of older people in a few studies with different aims. Detailed data from the EUROFAMCARE study (Triantafillou et al, 2006) on dependent older people's need for help, both in specific ADL as well as in all the broader areas of their daily lives, shows the extent of support provided by informal family carers and the very small percentages of help provided by services. (see Annex 2) This study also gives data on use of services and costs of care for dependent older people and their family carers, providing further confirmation that the "burden" of care for dependent older people in Greece is born primarily by the informal care sector.
- Data is available on hospital admissions and discharges in 10 year age groups and gender and type of illness only, thus providing very limited information on the use of secondary/hospital health services by older people with functional limitations (NSSG 2001). As described in section 1.1, the fragmentation and non-unification of the primary health care sector means that data on the use of primary health care services are very limited, though some indications exist that the major PHC centers are heavily used by older people.
- The lack of general practitioners, also described in section 1.1, has implications in the continuity of care, particularly important for older people with functional limitations, since there are no permanent medical records kept in the public primary health care sector.
- There are no specialist geriatric services, as this is not a recognized specialty in Greece and there is only limited geriatric and gerontological training for health and social care personnel

## **Health Care Sectors**

Against this background, whilst for older people with functional limitations acute hospital and out-patient care remains "a free service available to all citizens", the availability of and access to PHC remains problematic and, as for all the population, dependent on their health insurance coverage. As substantive users of the public national health system older people with functional limitations are particularly affected by staffing deficiencies at all levels in existing services.

- Primary Health Care (PHC) including continuity of care

There is no tradition of keeping patient records from PHC practitioners and indeed few older people have a general practitioner who is responsible for their overall health care. The Ministry of Health has submitted plans for the introduction of electronic health records during 2007-2013. Currently patients and their families keep their own records of health histories, test results, diagnoses etc. and are responsible for informing and coordinating between different health care personnel and sectors.

- Secondary, acute hospital health care

In a study on older people's use of the Emergency Department in a large state general hospital in Athens, >70 year olds were found to attend the department with over twice the frequency of <70 year olds and were also more likely to be subsequently admitted and to be referred for another opinion (Triantafillou J., Mestheneos E. 1994). The emergency ambulance service EKAB can be summoned by anyone calling 166 and the ambulance staff decide on the nearest appropriate hospital to access (see also section Barriers, Age Discrimination). Hospital referrals for out-patient appointments are made by patients themselves, either with the advice of a doctor or on their own initiative, and patients and their families thus act as consumers of services, with a certain amount of freedom of choice and not limited by the "gate-keeping" function of PHC doctors as in many EU countries.

Despite the principle of universal access to hospital health care services through the NHS, older people with functional limitations experience particular problems with using the services. The lack of nursing personnel means that during in-patient admissions, dependent older people almost always need the constant help of another person, usually a family member or paid "special nursing aid", the latter being privately employable on an 8 hourly shift basis. This accounts for one major cost in using hospital health services. While part of these costs may be refunded by some of the insurance funds for a limited period of time, families or the older person have to make immediate out of pocket payments to cover essential nursing care.

- Mixed health and social care

The KAPI centres (Open Care Community Centres for Older People), piloted in 1978 and adopted into policy from 1984 onwards, represent the main axis of health and social care provision for older people in Greece, based on the aim of maintaining older people as active, independent citizens participating in their local communities and living in their own homes for as long as possible. Financial support, including staff salaries, is provided by the Local Municipal Authorities and the popularity of the centres has ensured their continued support by successive governments and the steady expansion of the number of centres to its present day total of over a 1000, with some municipalities having several KAPIs.

From the outset the Centres were pioneers in their understanding of and focus on the social aspects of health, together with health promotion and disease prevention programmes aimed at maintaining physical and mental health amongst the older members. Membership of and participation in the Centres' activities is voluntary and a nominal fee is paid yearly, which is frequently waived in cases of need. Staff are a mixture of health and social care personnel, usually with a full time social worker, health visitor or visiting nurse, physiotherapist, occupational/ergo therapist, visiting doctor and other part-time specialists and volunteers. Services offered are primarily recreational, social and limited primary health care programmes. An initial deficit of the KAPI centres, their lack of provision for the frail and dependent section of the elderly population, was partly remedied through the attachment to many of the Centres of the Home Care programmes which often run in parallel with the KAPIs.

In the opinion of the authors, the KAPI centres represent a prime example of partially integrated health and social care services for older people. It is the only service designed specifically for older people, and has developed into a fairly comprehensive network throughout Greece. Furthermore, it has the potential to relieve overstretched and often inappropriately used primary and secondary health care services by offering a complementary and

appropriate service for older people in their local environments, of particular importance for older people with functional limitations. However, the KAPI primary care services are not integrated into the regular mainstream health services and remain a “Cinderella” service dependent on the enthusiasm and commitment of individual practitioners. The potential for their expansion and integration into the PHC sector, with benefits to both older patients and practitioners, cost reduction and the relief of the overburdened hospital out-patient departments, has never been realised by any government so far and the health services and integrated health and social care provision of the KAPIs remain under-exploited. There is also a lack of evaluation of the KAPI services and of the effectiveness of the KAPIs in improving health amongst older members. (Kyriopoulos et. at 2000)

A more recent planned development is that of the KIFIs – Day Care Centres for dependent older people with 54 being listed in 2006 ([www.50plus.gr](http://www.50plus.gr)) but with no evaluation on their real usage and operation including sources of funding. (Ministry of Health 2005)

### **Barriers to use of health services**

Physical, bureaucratic and financial problems, as well as age discrimination and lack of information on services, constitute the main barriers to access and use of health services for older people with functional limitations in Greece. The low incomes of older people and the predominance of older women means that many have no direct access to their own transport and are dependent on others or on public transport for accessing public services. This is a major problem for people with functional limitations. Though taxis are relatively cheap they are still beyond the means of many older people. Ambulance transport for hospital appointments and regular treatment sessions e.g. renal dialysis can be arranged but usually entails long waits and most patients use this only as a last resort. Despite attempts before the 2004 Olympic Games to improve access to the built urban environment for people with disabilities in the region of Attica and other areas hosting events, there remain major unsolved problems of everyday mobility encountered by older people with functional disabilities which limit their ability to use services independently. Inadequate and dangerous pavements,

inaccessible due to their use for parking cars and motor bikes, force pedestrians to walk in the road at risk to life and limb, and pose insuperable barriers to the free mobility of disabled people of all ages.

[http://www.pezh.gr/english/intro\\_en.htm](http://www.pezh.gr/english/intro_en.htm)

- **Physical barriers**

*Example 1:* In rural areas which have a high proportion of older people, although there is usually relatively easy access to a newly qualified doctor performing an obligatory year of service in rural areas, distance from the nearest Health Centre is often a frequent barrier to access to full PHC services, leading to critical delays in investigating symptoms, diagnosing and managing effectively potentially treatable diseases. This is further exacerbated, particularly in rural areas, by the lack of health promotion and disease prevention programmes, including information, screening and early diagnosis of specific conditions common in older people e.g. diabetes, glaucoma, breast and prostate cancer.

Distance from appropriate and accessible PHC services in both urban and rural areas may also force older people to make “inappropriate” use of hospital out-patient and in-patient services (Triantafillou, Mestheneos 1991)

*Example 2:* Frequently older people find it physically difficult to access health insurance offices for the inspection and validation of their prescriptions and tests (stairs, small and frequently inoperative lifts). Despite attempts to improve disabled access in recent years, relocation or the development of new offices does not always consider this issue of access e.g. a civil service insurance office in Piraeus was re-located from the 1<sup>st</sup> to the 5<sup>th</sup> floor in the block with inadequate lift access, thus increasing the problems for all the disabled. There appear to be no guide-lines to insurance funds as to the criteria and considerations to be used for the appropriate selection of new premises.

- **Bureaucratic and organisational barriers**

*Example 1:* The outdated and limited criteria used during assessment procedures for the awarding of disability pensions, benefits and services have been a major barrier to a fair and equitable allocation of these resources. Thus data from the two major health insurance funds (IKA and OGA) on disability pensions do not accurately reflect levels of disability in the general population of older people. A European study (Iredale 2000) indicated that Greek older women reported the highest levels with some disability in the then 15 MS although the proportion of those responding that they suffered from severe disability was near to the EU average. Thus, many older people with severe disabilities requiring the constant help of another person are not eligible for public support and the difficulties in the application procedures represent a further major barrier to access by both older people and their carers. In a recent sample survey of family carers of older dependent people, despite very high levels of disability in activities of daily living (one third being highly dependent and a further third moderately dependent) only 2% of the carers reported any financial support from the State (Triantafillou et al, 2006). Recent attempts by IKPA (Institute for Social Protection and Solidarity, Ministry of Health and Social Solidarity), to radically upgrade and simplify assessment procedures in line with the WHO International Classification of Functioning, Disability and Health – ICF <http://www.who.int/classifications/icf/en/>, (and covering older people who become disabled) have not yet been implemented. (See also Section 3.4. and <http://www.ikpa.gr/html/ajiolog.htm> )

*Example 2:* Obtaining both new and repeat prescriptions for both acute and chronic conditions takes an inordinate length of time involving many steps e.g. make appointment, visit doctor, receive prescription, visit insurance office and wait in a long line for validation stamp from inspector (who may reject the prescription), visit pharmacy, pay percentage, receive drugs. Additionally, the lack of GPs with overall responsibility for continuity of care means that most older people with multiple health problems are forced to attend several different specialists for their drug prescriptions. There have been attempts to reduce barriers for some chronic conditions by the

introduction of longterm/3 month prescriptions and a reduction of the standard 25% patient contribution to 10% or 0% for very limited categories of illness (cancer, insulin-dependent diabetes etc.). Some drugs in limited amounts and frequency can be prescribed by the doctor and supplied directly from the pharmacy without requiring further bureaucratic validation.

*Example 3:* Data from the EUROFAMCARE Greek national survey of 1014 family carers of dependent older people showed that bureaucratic procedures were frequently reported as a major obstacle to the access and use of any existing services (Triantafillou et al 2006).

*Example 4:* The KAPI centres - the authors believe that the main barrier to the more effective functioning of the KAPIs is the non-integration of their health care services into the mainstream primary health care services, the main problem being that whilst the latter are centrally funded, the KAPIs are municipally funded. This barrier could be removed by minor modifications to the NHS law, but it requires political vision and commitment to improving the service to this vulnerable segment of the population (see also section 3.4).

- **Financial barriers**

Despite the relatively large proportion of the GDP given to Greek pensions, there are large inequalities in their distribution and approximately 28.1% of pensioners in 2003 were assessed as still in poverty. (Ministry of Health 2005) This makes the amount that older people have to spend on health care particularly burdensome.

*Example 1:* Co-payments of 10-25% for multiple essential prescription drugs is a high financial burden for older people on limited pensions (“We receive our pensions to pay for our pills!”) as well as very limited and bureaucratically difficult-to-obtain cover for essential equipment (catheters, oxygen, pharmaceuticals for bed sore prevention and treatment, disposable incontinence napkins etc.).

*Example 2:* Additional, non declared payments to doctors (and other health care staff) may be expected in return for speedier, better and more personal services, to a greater or lesser extent throughout all the health care sectors (Mossialos et al 2005 a., Triantafillou et al 2006).

*Example 3:* Problems in Local Authorities financing of Home Care services to cover all those with needs for help and support, mainly accounts for their limited provision which, of necessity, focuses on the poorest and most isolated older people without available family support. These services, run by the municipalities since 1998 and providing an essential free service allowing frail older people to remain in their home environment for as long as possible, have been very positively evaluated (Amira et al 2002) but are under constant threat of reduction or closure due to a lack of clarification in their sources of financial support i.e. between the health and social care sectors and between central and local government budgets. While there has been a recent attempt to extend the service to help working family carers, mainly women, to remain or enter the labour market, there is as yet no evidence that this policy has been effectively implemented with positive outcomes for carers and the dependent older people they care for.

- **Age Discrimination**

There is no available scientific data on the prevalence of age discrimination in the use of and access to health services and the following statement, made by the head of the cardiology department in a large State Hospital in Athens, during an interview conducted as part of a study on older people's use of the hospital Emergency Department. (Triantafillou J., Mestheneos E. 1994) suggests that older people are in no worse a situation than the general population:

*“No, there is no discrimination either for or against older people in the Greek health service – there are no specialist geriatric services and old people suffer the vagaries of the health system along with the rest of the Greek population, regardless of their age!”*

Nonetheless, the one resource of time, which many older people have in relative abundance, is disproportionately spent on battling their way through the system with or without the help of family members, largely dependent on the goodwill of any sympathetic staff and with few specific measures designed to help them.

On the other hand, information from the Director of a residential home for older people on the response of the emergency ambulance service (EKAB) to emergency requests from Elderly Care Units, indicates the existence of some age based discrimination in practice, with priority being given to younger age groups (personal communication with author J.T.).

- **Lack of information on availability of services**

The Greek National Survey of family carers, conducted within the framework of the EUROFAMCARE study, highlighted the need for information on services as well as on the health condition of the older cared for person, as a major recommendation in the support of family carers (Triantafillou J et al 2006). One result has been the setting up of the web site in 2006 of [www.50plus.gr](http://www.50plus.gr) that gives information both for family carers and about the actual services currently available.

- **Other special services**

The original lack of services for those with dementia and Alzheimer type diseases, affecting older people in particular, has partly been met in recent years with the development by NGOs of initiatives to support and inform patients and their families. These are financially supported by the public sector but continue to rely heavily on volunteer support. Currently some day care centres, one residential unit, training and advice for family carers are available in major towns in Greece (see [www.50plus.gr](http://www.50plus.gr) for links to the 3 main providers and below for an interview with the Athens Association for Alzheimer's Disease and Related Disorders NGO)

The following services are all of vital importance for the health and well-being of older people, and available widely on a private basis with some very limited provision in the public sector. These include: Dental care, Ophthalmological

and optical services; Hearing aids and acoustic problems; Physiotherapy and rehabilitation.

### **Stakeholders View**

Interview with a representative of the Athens Association for Alzheimer's

Disease and Related Disorders NGO <http://www.alzheimerathens.gr/>

*1. What is the Association's target group?*

Elderly people, family members, health professionals and volunteers wanting to know more about Alzheimer's disease as well as willing to lobby for specific benefits, funded research etc.

*2. What is offered by the Association?*

The association offers a fully functional day centre for older people and their families living in the centre of Athens. Older people should be diagnosed as mildly or moderately cognitively impaired with no severe mobility problems. They are classified in groups according to their cognitive level and participate in memory enhancement programmes, physical activities, art therapy, speech and occupational therapy, medical and nursing treatment and light meals.

Within the centre facilities the association offers family support groups, volunteer training, memory assessment and evaluation, medical care, information and guidance

*3. What is offered by the state for patients with dementia in terms of financial support, services to patient, family support etc.?*

The state offers the funding of the day care programme. Other services provided by the state and specifically orientated to elderly people suffering from dementia and their families are scarce.

*4. Are there any barriers to use of health services by dementia patients and what problems may be encountered?*

No clear mapping of available services as well as lack of strategic planning on behalf of the Ministry of Health which is the largest service provider. Other problems include reduction of financing, access to services, untrained staff, lack of staff.

*5. Are there any special concessions to Alzheimer patients and their families?*

In the last year, by ministers' decision, the Alzheimer patients and their families do not pay anything for their medication. All other costs, including nursing home placement are covered by the family.

*6. What would improve access to services?*

The strategic planning of services, development of transport for elderly people, information and adequate staffing of services, development of new centres, carer benefits would improve access to services.

*7. Anything else you would like to emphasize or propose?*

Assessment of the needs of elderly people with dementia and their families, according to their financial situation, health condition, cognitive level, functional ability, family proximity and geographic location.

### **3.3 *People with mental health disorders: the issues***

Mental health care was traditionally provided in Greece by 9 large psychiatric hospitals, and the reform of mental health care commenced relatively late, in the mid-80s (see also section 4). So far, 3 have closed and have been replaced by community residential facilities offering varying degrees of care, according to need. There are now 22 psychiatric departments (with beds) in general hospitals for adults, and 4 for children, with a further 13 hospitals having liaison and outpatient facilities. There are also 35 Mental Health Centres and 10 Child guidance clinics. The pattern of mental health care has changed, although there is still a long way to go, and there is some evidence that there has been a retreat in mentality as far as the reform is concerned. These changes are laid out in the policy document *Psychoargos*.

The somatic health of people with mental disorders is not well documented in Greece, although it is known that the oral health of institutionalized populations is poor, and there are verbal reports of the poor general health of residents in psychiatric hospitals. Many health problems came to light when people moved out of the psychiatric hospitals into community care settings, due to the individual care they received in the new settings. Prisoners with mental disorders are thought to be particularly at risk, but this is not documented.

Given the problems of access to health services for the general population, it is to be expected that people with mental disorder will find it even harder to obtain care. One of the advantages of the community residential facilities is the possibility for residents to obtain care through the actions of the facility staff. Most people, upon leaving the psychiatric hospital, were able to reactivate health insurance entitlements which had fallen into disuse during their long term in-patient stay. Gaps in coverage are dealt with by the issue of a “welfare” insurance entitlement, which allows for complete health care, with no cost sharing. Cost-sharing is waived for those with a chronic or serious mental disorder, although what is meant by chronic or serious is variably interpreted by different health funds. The scope of the health basket is no different for this group. Geographical barriers due to residence in isolated psychiatric hospitals are not present, due to the fact that the large psychiatric hospitals are gradually

being replaced by community facilities. In Greece, the difficulties faced by isolated rural or island populations are common to those both with and without mental disorder. Mental health care is provided for these populations through the Mobile Units, which is a small group of mental health professionals who travel to isolated areas providing information and care.

The main barriers to general healthcare faced by those with mental disorder are the organizational barriers and the stigma of mental illness. It is not universal, but it is common that people with a diagnosis of mental disorder will be refused admission to a general hospital for a general health problem. The stigma against mental illness in the general population has slightly improved over the years since the reform started, but it is still marked. It is also marked in general health care staff, and unfortunately in mental health staff. These difficulties are compounded by the fact that service user organizations are in their infancy, and are not yet involved in advocacy. There is also no information on health literacy in this group, nor were efforts to improve it identified.

### **3.4 Conclusions**

The public policies that have tackled the most important challenges in improving quality of and access to health care for migrants are the establishment of eligibility criteria for residence permit and for the provision of social insurance including family members of migrants. Other public initiatives include the provision of free medical care and hospitalization to all migrants, who have been infected by HIV or other infectious diseases.

The most vulnerable group is the undocumented migrants who do not have a residence permit and thus social insurance with women and children facing a multitude of health and social care problems. This group would greatly benefit from the provision of free primary and secondary care through the NHS.

For asylum seekers and refugees the most important policy in improving access to care is the provision of free public health services - medical, pharmaceutical and hospital care. Nevertheless, there is a gap of access to services during the

long waiting period of processing eligibility documents. Attention has to be focused on developing initiatives for the provision of health and social care services during this period of establishing eligibility in addition to simplifying the process. This is a problem also common to immigrants especially during their reapplication for work or residence permits.

Public policies that have improved access to care for minorities include the provision of free public health services (medical, pharmaceutical and hospital care) through the NHS. Other public initiatives are the creation of Information Centres on Health and Social Solidarity in every district. In addition, mobile units have been developed to provide vaccinations to children and gynecological exams for women living in Roma-camps. Furthermore, 37 Medi-social Centres have been established in the regions of Gypsies-Roma settlements providing prevention services, primary health care, and social care services for the integration of Gypsies-Roma.

The free Roma-camp gypsies is one of the most vulnerable groups living without basic facilities (water, electricity, toilet, bath, etc) facing a variety of health risks related to their poor living conditions. The other vulnerable group is a small group of Muslims in Trace who have not reacquired the Greek citizenship due to various legislative “gaps” and do not have access to public health services.

The most promising contributions in improving access to health and social care for all of the groups mentioned above are the social inclusion initiatives through the third Community Framework Support (2000-2006) with the financial support of the state and the European Union. A variety of services have been developed many through the local authorities or through NGO's ranging from the provision of primary health care services, social support and counseling, Greek language courses and numerous others.

One of the main challenges for these groups is centered around establishing eligibility status for health and social services. The legal and administrative processes have to be streamlined with a focus on having ready solutions for the gaps that may exist in fulfilling requirements for health and social care. Another major challenge is related to the cultural biases and language difficulties

experienced by these population groups and by the health and social care professionals they come in contact with. Services providing translators and mediators to overcome the language difficulties in communicating with professionals in addition to the education of administrative staff about stereotypes, bias, xenophobia and multicultural communities would greatly reduce barriers to access for these groups.

An example of good practice is the services provided by the NGO, Klimaka described in section 3.1.

Whilst the disabled of all ages have received more public attention over the past 3 years, mainly since the issue of access became important during the 2004 Olympic Games, concrete evidence of improved access to services for older people with functional limitations is lacking. Though the disabled have in the past 20 years become well organized as a pressure group and have political representation in Parliament, on the whole disabled older people have been neglected by both politicians and the disabled groups and have no access to comprehensive assessment, rehabilitation and treatment plans to improve their own and their families' quality of life.

There are no public policies specifically for older people with functional limitations, as this group is included within general policies for people with disabilities. Nevertheless, Home Care Services for the support of dependent people of all ages are used almost exclusively by older people and usually operate via the municipalities in parallel with the KAPI centres. Despite being very positively evaluated and fulfilling an essential community care need, the Home Care Services are fragmented, non-comprehensive, over-stretched and under-funded. Recurrent discussions and political agreement that these services are of vital importance have produced no solutions in terms of increased and guaranteed funding from central government and longer-term staff contracts. A clear policy directive is also needed on the maintenance and extension of home-care services to include the support of both working carers e.g. sons and daughters, and older family carers e.g. spouses and siblings caring for dependent older relatives, rather than the currently prevailing priority given of necessity to isolated and impoverished older people.

The EUROFAMCARE study showed clearly that a major disincentive to the use of many available support services by family carers is their cost as well as fears about a poorer quality of care than that which they themselves could provide; this includes the use of residential care (Elderly Care Units) either on a temporary respite or permanent care basis. Thus the issue of training of staff and quality control of all such services is of paramount importance in any health and social care policies designed to support older people with functional disabilities and their families.

On the other hand, outdated assessment procedures for the allocation of financial support for dependent people cause particular difficulties for older people, with the result that very few dependent older people with heavy care needs receive such allowances either as disability pensions or benefits. An excellent solution to this problem has been put forward by IKPA, the welfare organization, with a comprehensive plan for the radical re-organization of the assessment process, but this has still not been implemented, due to bureaucratic obstacles (see also section 3.2).

The lack of an integrated primary health care sector, with fragmented and unequal service provision through the various health insurance funds is a remaining challenge and needs a comprehensive solution. Furthermore, the lack of GP's means that older people with functional disabilities are forced to attend multiple specialists for their multiple pathologies. The incorporation of the KAPI and Home Care services within the mainstream primary health care sector would be of immediate benefit for older people with functional limitations and relieve pressure on over-stretched and often inappropriately used hospital health services, particularly emergency and out-patient services.

In addition, the absence of specialist geriatric services means that older people with functional limitations are denied access to secondary health care providers specializing in their particular needs and have no powerful advocates within the health service to promote their best interests. The implementation of specialists training and the recognition of geriatrics as a medical specialty in its own right would bring immediate benefits in the health care of older people with functional limitations.

The KAPI centres described in section 3.2 is an initiative of good practice for older people with functional limitations. With their focus on health promotion, disease and disability prevention, combined with the psychological and social aspects of health, they are in an ideal position to provide integrated health care for older people in their local communities. The provision of Home Care services and associated Day-Care Centers (KIFI) via the KAPI's further completes their holistic provision of services for older people with functional limitations, but their overall success is provisional upon the upgrading and integration of these services into the mainstream primary health care sector, needing political vision leading to policy changes and good long-term planning.

Another initiative of good practice would be the implementation of the detailed plans prepared by IKPA for the reform of the disability assessment process so that older people with functional limitations needing substantial amounts of care would receive some financial and practical support to reimburse their families or paid carers for essential care provision.

Finally, the demands of the EU and the EC for detailed documentation, concerning the development of a national plan with respect to health services and long term care as well as plans concerning social exclusion, has obliged successive governments to develop explicit plans of action. The fact that they agree to review the implementation of earlier plans, thus justifying any EU funding allocated to them, as well as working towards agreed objectives using the Open Method of Coordination, has been a significant motivating force in improving the formulation of health policy and actions to support older people in general.

Although there are no specific policies geared towards improving access for people with mental health disorders the policy enshrined in the Psychoargos programme has at its heart the principle of mainstreaming and empowerment. Within this policy, the development of community mental health services has led to easier access to mental health services, which in turn is helping to reduce stigma and discrimination. The Psychiatric Units in General Hospitals have been important in reducing the stigma within general hospitals by increasing the visibility of mental disorders and mental health, and integrating services for

general and mental health problems into one system. Community housing units have been important in reducing stigma at the neighborhood level, and have improved the access of residents to general health care. Mobile Units operate by making maximum use of available facilities (such as social clubs for the elderly, local government facilities, schools etc) and thus reduce overheads to a minimum. They have a significant role to play in isolated and areas with difficult access.

As the main barrier to access is found to be the stigma and discrimination associated with mental disorder, the reform of mental health services is considered essential to improving access to general health care. Greece's experience of mental health reform (both developing community services, and closing psychiatric hospitals) is very recent. Although this experience is not relevant for countries with a longer history of mental health reform, it has been very useful for the beneficiary countries of the Stability Pact (see [www.seemph.ba](http://www.seemph.ba)) where Greece was the main donor for the Mental Health Project "Enhancing Social Cohesion through Strengthening Community Mental Health Services in South East Europe", also providing considerable technical and scientific input. This expertise can be utilized by countries that are in the early stages of mental health reform. In this context, Greece, through the development of community services, has also been particularly inventive in finding innovative ways of exploiting minimal funds and resources, by liaison with and maximum use of existing social and administrative networks and services.

## **4 Country information for the case study on mental health**

### ***4.1 Introduction***

Before addressing the issue of equity of access to general health care for people with mental disorders in Greece, it is necessary to consider four more general aspects. First, there are difficulties in access for all citizens, given that

access is often complicated by issues related to “connections” and/or the paraeconomy. This reinforces the easier access to health services which is enjoyed by the more articulate middle-class patient. Secondly, the high level staff in health service administration (both in the Regional Health Services, and in the hospitals) is appointed politically. This means that hospital CEOs are often not trained in health service administration. They are also subject to frequent change, with every change of the Minister of Health. Results of a recent study on “Hospital Governance in Europe” will soon be available (<http://www.hospitalgovernance.org>). This study found that Greece had by far the highest number of changes of CEO of all participating countries. This has obvious repercussions for continuity, and implies that mental health issues have to be presented afresh with every change of CEO. The third issue is the relatively recent commencement of the reform of mental health services in Greece compared to many other European countries. Before the mid-80s, mental health care was provided almost exclusively by the psychiatric hospitals, and in the private sector, by clinics operating in much the same way as the psychiatric hospitals, with somewhat better hotel facilities (although they had, and still have, bars on the windows). Out-patient care, with few exceptions, was provided by private practitioners, who had been trained within the asylic system. Finally, there is no specified or ring-fenced budget for mental health.

### **Legislation (see Annex 3)**

The legislation in force until 1973 dates from 1862 with the law *on the establishment of lunatic asylums* (Συνήγορος του Πολίτη, 2007a). According to this law, people could be admitted to the asylum at the request of their relatives, or on the order of public authorities, such as the police. This law was replaced by Act 104/1973 *on mental health and the care of the mentally ill*. Voluntary admission was now allowed, but in contrast to the earlier legal framework, where the in-patients could apply directly to the courts for their release, this law allowed the psychiatrists to control the length of hospital stay.

Article 21 of the Act 1397/83, which established the National Health System, was devoted to the establishment of the necessary structures for the implementation of the new policy on mental health services. This Act provided

for the establishment of Mental Health Centres, Psychiatric Units in General Hospitals, and the community structures required to allow the deinstitutionalization of long-term residents in the 9 psychiatric hospitals throughout Greece. Constantopoulos and Yannulatos (2004) describe the process of reform up to 2004. The current legal framework on mental health is formed by the Act 2071/92 *Modernization and Organization of the Health System*, in which greater protection was provided for people admitted compulsorily. This was followed by Act 2519/97 *Development and modernization of the Health System, hygiene services, regulations on drugs and other provisions*, and finally the Act 2716/99 *Development and modernization of mental health services and other provisions*. Act 2716/99 supported the development of sectorised community mental health services, as a necessary prerequisite for the continuing process of deinstitutionalization. An Office for the Protection of the Rights of the Mentally Ill was established within the Ministry of Health reporting directly to the General Secretary of the Ministry of Health, and a Special Committee for the protection of the rights of people with mental disorders (hereinafter called Special Committee) was set up, composed of 1 psychiatrist, 1 child psychiatrist, 2 social workers, 1 other mental health professional and two legal experts. Members are selected by the Minister of Health. Some two years later, two representatives of user organizations were also included in the membership. The rights of people with mental disorders which are specifically protected by this committee include the right to respectable living conditions in Mental Health Units, the right to individual specialist treatment, the right to contest in court involuntary admission, to speak in private with a legal representative, to have access to the information which concerns him/her in his/her file, the right to protect his/her property and possessions, and the right to social inclusion. There is no specific mention of the right to equity of access to general health care, although this would certainly be in line with the spirit of the law.

The anti-discrimination Act which was passed in 2005 3304/05 *Implementation of the principle of equal treatment, regardless of race, nationality, religious or other beliefs, disability, age or sexual orientation*, does not make specific reference to people with mental disorders.

Finally, Article 28 of the Act 3418/05 *The Code of Medical Ethics* outlines the ethical requirements for psychiatrists in their behaviour towards people with mental disorders, but does not refer to the behaviour of doctors of other specialties.

## **Policies**

The first National Policy was established through Regulation 815/84 of the EEC, and gave Greece access to considerable financial and expert support to proceed with the reform of mental health services. This Regulation was extended as Regulation 4130/88. Following this, the Programme “Psychoargos” was approved for co-funding by the EU in 1997. This is a rolling ten year plan which is revised every five years. The latest version is from 2001, and is referred to as “Psychoargos Phase B”. The revision due in 2006 is not yet complete. The philosophy which underlies Psychoargos supports the development of a comprehensive network of mental health services throughout the whole country, and the rehabilitation of long-term residents in the psychiatric hospitals, and finally the closure of the psychiatric hospitals. There is no reference to the issue of access to general health care, although access is implied, through the establishment of Departments of Psychiatry in the General Hospitals, and also the Mobile Units which provide care to areas with difficult access to health services. Psychoargos is not only a national policy document, but also an action plan. The implementation of the actions detailed in the plan is monitored and supported by the Monitoring and Support Unit for Psychoargos Phase B (MSU) ([www.msu.gr](http://www.msu.gr)). Table 1 gives a brief indication of the number of services currently available through the reform.

By the end of 2006 there were 410 residential facilities throughout Greece, created since 1988, 31% of which are run by NGOs (there are 33 NGOs involved in Psychargos Phase B programme) and 69% by state psychiatric or general hospitals. There are 3,112 residents in these facilities. This is the equivalent of 2.85 places per 10,000 citizens, or 3.36 places per 10,000 citizens over 15, using the total population figure of 10,934,097 (9,274,198 over 15) from the general population census of 2001 ([www.statistics.gr](http://www.statistics.gr)). Three psychiatric hospitals (Petra Olympou, Chania and Corfu) have already closed

(the first in January 2004 the second in February 2006 and the third in October 2006) and their staff have moved to the community mental health facilities while Attica Mental Health Hospital for Children and Tripoli psychiatric hospital are planned for closure by the end of 2007. It is anticipated that by the year 2015 Attica, Dromokaiteio and Salonika psychiatric hospitals will have closed.

There are four National Action Plans on Social Inclusion (2001-3, 2003-5, 2005-6, 2006-8). They make some reference to equity of access to health services for socially excluded groups, but specific mention of mental health is only made briefly in the second NAP (see section 1).

The MSU produces an annual report for the Ministry of Health which is circulated internally. This report refers to the activities of the Unit in each year, and the progress of the implementation of the Psychoargos programme, but does not include information on the mental health of the population, nor on issues of access to general health services.

There are indications that opinions in policy making circles are turning against the reform of mental health services, and that there has been a retreat in mentality. For example, the Deputy Minister of Health and Social Solidarity was quoted in Parliament as having said that the Americans were not stupid when they decided not to close the asylums. ([www.parliament.gr/ergasies/praktika/pdf/es12032007.pdf](http://www.parliament.gr/ergasies/praktika/pdf/es12032007.pdf)). The Central Health Council passed a resolution (not ratified in law) that the membership of the Mental Health Sector Committees (initially composed of NHS mental health staff) would be changed to one NHS psychiatrist, one private psychiatrist and one representative of a private clinic (Annex 5). Fortunately, this decision was withdrawn following the reaction of the Department of Mental Health of the Ministry of Health and professionals involved in the reform. As mentioned above, there has also been a delay in the revision of Psychoargos, which was due in 2006. It is also disturbing that at the Attica and Dromokaiteio psychiatric hospitals, private security firms have been employed to secure the perimeter.

*Table 1: Mental Health Units in April 2007*

<b>Structure type</b>	<b><i>n</i></b>
Hostel	<b>88</b>
Boarding home	<b>111</b>
Apartment	<b>211</b>
Day Centre	<b>22</b>
Mobile Mental Health Unit	<b>16</b>
Home Care Units	<b>2</b>
Autism Units	<b>9</b>
Alzheimer Units	<b>6</b>
Mental Health Centre	<b>35</b>
Child Guidance Centre	<b>10</b>
Psychiatric Unit in General Hospital (with beds)	<b>22</b>
Outpatient Clinics in General Hospital	<b>35</b>
Psychiatric Unit for children in General Hospital (with beds)	<b>4</b>
Outpatient Clinics for children in General Hospital	<b>3</b>
Short Stay Hostel	<b>2</b>
Psychiatric Hospital	<b>5</b>
Child Psychiatric Hospital	<b>1</b>

**Total****575**

*Source: Monitoring and Support Unit Psychoargos Phase B*

### **Plans and Programmes**

There is a national anti-stigma programme, run by the University Mental Health Research Institute ([www.epipsi.gr](http://www.epipsi.gr)). This programme researches population attitudes to mental disorder, in particular schizophrenia, it runs educational events for mental health professionals, services users and their families, and other groups (eg high school students), it informs and cooperates with the media and has produced a number of publications, it coordinates a network of volunteer “stigma busters”, and advocates for and promotes the rights of people with mental disorders. No formal evaluation is available, although a number of publications aim to raise the awareness of the scientific community (Οικονόμου & Σταλίκας, 2006, Μέρτικα et al, 2006, Οικονόμου et al, 2006a, Οικονόμου et al, 2006b, Οικονόμου, 2007) while others are related to the monitoring of the stigmatizing activity of the press (Οικονόμου, Χαρίτση & Δημητριάδου, 2006), reporting educational activities and their effect on attitudes (Economou et al, 2005), or monitoring stigma in the population (Economou et al, 2005, Economou et al, 2007).

### **Research**

There are no national research activities regarding equity in access to health care for people with mental disorders.

### **Health Services**

Some of the psychiatric hospitals have a general medical department, which includes not only internal medicine, but may also include surgical, dental, and radiology services. Many of these services have shrunk considerably as a result of the reform, the closure of 3 psychiatric hospitals, and the reduction in size of the remainder. If a person’s condition was serious, they would usually be

referred to mainstream services in general hospitals, and nowadays, they would be encouraged to use mainstream services.

### **Civic Society**

Recent years have seen the emergence of some NGOs representing service users and their families. Specifically, three NGOs representing service users were identified. At this point it is important to mention that the terminology “users” is problematic. In Greek, user is understood by all to mean drug user. Alternatives have been suggested, but as yet no universally accepted term has been found. The term which is more commonly accepted at the moment is *liptis* (λήπτης) which most closely translates as recipient. This is rather unfortunate because it implies a degree of passivity which may reflect the current situation, but is not ideal for the future. Several local organizations exist representing families of service users, and they have formed one national umbrella organization. There is also a recently established Observatory for the rights of people with mental disorders. These organizations are still in the phase of development, and as yet do not have a very high status – although their very existence is a positive sign. The fact that two representatives from user NGOs are members of the Special Committee is an important step on the road to the recognition of the need to involve service users in the planning and quality control of services, but there is still a long way to go. NGOs have not initiated specific actions to secure equal access to general health care.

### **Public Opinion**

The stigma associated with mental disorder is still present in Greece. There are a number of research papers published on this matter. Madianos and coworkers (1987) used the Opinion about Mental Illness scale with a large community sample in the Athens area, and found considerable fear and rejection, particularly among the older respondents with a lower socioeconomic status, and less formal education, although the need for more humane treatment of the mentally ill was also recorded. At a later date, Madianos et al (1999) compared a sub sample of this study with a matched sample taken in 1994. They found that opinions were more positive on all five factors of the scale, and they suggest that this may be due to the community mental health services which

had commenced operation in the areas studied. More recent studies include the work of Stylianidis, Pantelidou & Chondros (Στυλιανίδης, Παντελίδου & Χονδρός, 2005) Zissi (2006) and Economou et al (submitted). The study by Stylianidis and colleagues took place in the county of Evoia, where the NGO Association for Regional Development and Mental Health has been very active in providing community mental health services. This study measured mental health in the ambulant general population, and also attitudes towards “madness”, mental illness and depression. High levels of psychopathology were found in the general population, with 29% recorded as currently suffering from at least one mental disorder. Dangerousness was closely associated with the image of madness and also of mental illness. However, despite this, 40% expressed their first choice of help if they felt unease or worry would be to consult a mental health professional – in other participating countries a physician was the first choice. This may reflect in part the acceptance of the community services in their region, but also may reflect the relative unavailability of primary health care services and general practitioners in Greece. It was also of note that the psychiatric hospital was not the first choice for treating the madman (15%), the mentally ill (10%) or the depressed person (3%), with medication and social support being the preferred treatments both for madness and for mental illness. For depression, social support was thought to be appropriate – and this is important in the light of the fact that of the respondents found to be suffering from depression, only 13% had received treatment. Zissi (2006) used a qualitative approach with 100 people from a rural area, with the use of vignettes describing various cases with mental disorder. The anxiety vignette was not considered to be a case of mental disorder, and this is consistent with the findings of Stylianidis and colleagues, whose respondents considered anxiety to be a normal phenomenon. Negative symptoms of schizophrenia were more likely to be considered to be related to childhood problems and personality, while positive symptoms of schizophrenia were more likely to be understood in terms of pathology and genetic explanations. The sex of the vignette actor was found to be important, with stronger reactions elicited with female cases – indicating that men are not more heavily stigmatised than women in Greece. Appropriate help was considered to be the psychologist, with the psychiatrist being more appropriate only for the

vignettes depicting paranoia and schizophrenia with positive symptoms. Economou et al (submitted) used the Alberta Pilot Study Questionnaire Toolkit in a nationwide household interview survey about attitudes towards schizophrenia. Television was found to be the main source of information about schizophrenia which was portrayed in a negative manner. Respondents had either misinformation or very little information about prevalence and causal factors, and people with schizophrenia were seen as of lower intelligence, dangerous to the public, a public nuisance, and unable to hold a regular job. Schizophrenia is often thought to mean “split personality”. Two out of three reported that they would maintain a friendship with someone diagnosed with schizophrenia, and three out of four that they would not feel ashamed if someone in the family was diagnosed with schizophrenia, but 92.1% said they would not marry someone with schizophrenia, half would be disturbed if they worked with someone so diagnosed, and a third would feel afraid to even start a conversation with a person with schizophrenia. These findings would suggest that there is room for improvement, and that educational interventions might be beneficial in correcting misperceptions.

There are other examples of behaviours which come to the attention of the Ombudsman, suggesting a high degree of stigmatization in the general public. A tax record number (a necessary prerequisite for making a tax declaration) was not issued to hostel residents upon their request. Upon investigation, this was found to be due to the attitudes of tax office staff (“you don’t understand”, “what are you going to do with it”) who were concerned that they might get into some kind of mess if something went wrong later. This episode had a positive result, in that a meeting called by the Ombudsman, which was attended by representatives from the Ministry of Economy and Finance, amongst others, led to the production of a circular informing tax offices that hostel residents are entitled to be issued with a tax record number (Συνήγορος, 2007b). Another example is the case of the eviction of people with mental disorders from a sheltered apartment, on the grounds that the flat was in fact a clinic, and as such could not be part of a block of residential flats. This case was won by the plaintiffs, but as a result, the Ombudsman produced a report (something which is not strictly within their remit when the courts are involved), laying out the

position of the Ombudsman in this case. Although it was too late for the residents of the particular sheltered apartment, this report has subsequently been used to prevent further evictions (Συνήγορος, 2004).

The role of the media is generally thought to be negative. The media is driven by sensationalism, and any good practices can be demolished with one sensational story. Economou et al (Οικονόμου, Χαρίτση & Δημητριάδου, 2006) examined the written press in 2001 and again in 2005. They found both literal and metaphorical use of the term schizophrenia. The literal use of the term was often in a negative and stigmatizing context, emphasizing violence and criminality. There was a slight improvement in the number of neutral reports in the second sample. With regard to the metaphorical use of the term, it is used to mean “contradiction”, “illogicality”, “chaotic conditions” at both times. In 2001 it also appears with the meanings “dangerousness, conscienceless, wildness” while in 2005 it is used for “overreaction, extreme behaviour”.

## **4.2 Methods**

Several searches were performed to find available literature.

- Medline search using keywords *Greece* and *stigma* gave 4 results, none of which was useful.
- Medline search using keywords *Greece*, *attitudes*, and *mental* gave 33 results, of which 11 were useful
- Medline search using keywords *Greece* and *health* gave 1763 results, of which 39 were useful (plus 6 in common with the previous search)
- Hand search of the two main scientific journals published in Greek *Encephalos*, and *Tetradia Psychiatrikis*, gave 7 useful articles
- Complemented by a staff-controlled electronic search of the two Greek language databases (current, and pre-1999) maintained by the library of the University Department of Psychiatry, Athens. A further two articles were retrieved

Many of these articles were useful background reading, and some are referenced in this document, where appropriate.

Several interviews were held with experts, officials and stakeholders. A full list is included in Annex 4. Those interviewed include two former Directors of the Department of Mental Health of the Ministry of Health (the position was vacant at the time of writing), a senior investigator from the Ombudsman for Health, representatives of the Monitoring and Support Unit for Psychoargos Phase B, the current and former WHO mental health counterparts, the director of the anti-stigma campaign, representatives from the 3 user NGOs, the president of the national umbrella family NGO, representatives of a large NGO with extensive action and experience in the provision of community mental health care, and telephone conversations with the President of the Special Committee and with a representative of the Observatory for the Rights of People with mental disorders. Many of those interviewed also provided supporting documentation. Obviously, many more people could have provided expert input, but time constraints did not allow for further exploration at this stage.

### ***4.3 Access to general health care for people with mental disorders***

The health status of people with mental disorders has not been well documented in Greece. No data are available on health determinants in this group.

Studies of oral health (Triantos, 2005, Kossioni & Karkazis, 1999, Karkazis & Kossioni, 1993) in institutionalised elderly, or mentally handicapped children (Mitsea et al, 2001) reveal very poor oral health in these groups, with Kossioni & Karkazis reporting that oral health is worse in those with a concurrent mental disorder. There is no information for those living in psychiatric hospitals.

A belief was expressed by some respondents that since the introduction of the newer antipsychotic drugs, there has been an increase in the number of cases of both aggressive and rare carcinomas, and also autoimmune diseases. As there are no cancer registries in Greece it is difficult to examine this belief. It is obviously important to know whether or not this is true, but it is equally

important to understand the impact that such a belief may have if it is widespread.

Causes of death of those living in deinstitutionalised community settings during 2005 are reported in Table 2. On 31/12/05, there were a total of 793 residents in 55 settings (470 men and 323 women with a mean age of 59.91).

*Table 2: Causes of death of residents in community residential units, 2005*

Recorded cause of death	n	%
Cardiorespiratory causes	23	57.5
Infections	5	12.5
Vascular causes	5	12.5
Cancer	1	2.5
Necrosing pancreatitis	1	2.5
Duodenal ulcer	1	2.5
Renal failure	1	2.5
Drowning	1	2.5
Suicide	1	2.5
Missing	1	2.5
Total	40	100

*Source: Monitoring and Support Unit Psychoargos Phase B*

There is one report on the crude mortality rate of people with mental handicap admitted to Leros PIKPA asylum over the period 1961-91 (Perakis et al, 1995), which gives a figure of 59.2 deaths per 1,000 person-years, more than 20 times the rate for the general population at that time. There was also one verbal report which could not be substantiated by documentation, which prior to the

commencement of the reform of mental health services, the life expectancy of residents in the Attica Psychiatric Hospital was 67-68 years of age.

The situation for mentally ill prisoners is thought to be particularly difficult. There is a psychiatric wing in one of the largest prisons, where conditions are thought to be very difficult. However, despite repeated applications, the Special Committee has not been granted permission to visit. This service comes under the jurisdiction of the Ministry of Justice rather than the Ministry of Health, with all the bureaucratic hurdles this implies.

#### ***4.4 Barriers in access to general health care for people with mental disorders***

##### **Gaps in coverage**

Gaps in coverage do not represent a major barrier. Insurance funds are linked to occupation. If someone has worked, and becomes disabled as a result of mental disorder, they will receive a disability pension and their insurance cover will continue. If someone has not worked when they become ill, they will be insured as a dependant person through the health insurance of their nearest relative – usually a parent. If someone is destitute, they will be entitled to “Welfare insurance”. This entitles them to hospital services and medication without cost-sharing. Primary health care services are free for all citizens. Many of the people who were long-term residents in the psychiatric hospitals were able to activate insurance to which they were entitled but had not been using, when they left the hospital to live in the community during the process of the reform. Private health insurance in recent years has become available for people with mental disorders, but the premiums are prohibitively high. It was also mentioned that a mental disorder might be concealed in order to obtain coverage, and there are instances where insurance companies contest a person’s right to health coverage by challenging the date of onset of the mental disorder. Residents in psychiatric hospitals were and are entitled to care outside the institution, whether they go to services run by their insurance fund, or to

NHS services. If their insurance status is unclear, the social work department of the psychiatric hospital will undertake to clarify the situation.

### **Scope of the health basket**

There is no discrimination between people with or without mental disorder as far as the spectrum of health services to which they are entitled is concerned. Data are not available to indicate whether in fact they receive the same services or not. This did not seem to be a big concern for respondents, who felt that by and large, people probably received the same services. Rehabilitation, handicap and social benefit entitlements are the same for the whole population.

### **Cost sharing**

This is felt to be a minor barrier. Primary health care services are free for all citizens. Hospital services require cost sharing, but this is not thought to be a substantial barrier, because those with a very low income, or the uninsured, are entitled to "Welfare Insurance" which means that cost sharing requirements are waived. The paraeconomy is a more serious barrier, as it is widely known, although extremely difficult to document, that informal payments are often required by medical or other staff in order to obtain appropriate health care. It should be noted that this problem is by no means limited to the health sector.

### **Geographical barriers**

There are serious geographical barriers to obtaining health or other services for the rural and island populations, regardless of the presence of mental disorder or not. In mental health this has been addressed to some extent by the development of the mobile units.

This is not a barrier for the residents in psychiatric hospitals, as the remaining psychiatric hospitals are not in remote areas and someone resident in a psychiatric hospital that required care would be accompanied to the general hospital with transport arranged, so this would not be a barrier.

### **Organizational barriers**

This is one of the serious barriers to general health care faced by people with mental disorders. It is not a universal barrier, but it is common for hospitals to insist on psychiatric hospitalization, even when the mental health problem is in remission or well controlled. The document provided in Annex 6 involves the anonymous case of a woman who had drunk hydrochloric acid during the course of a depressive episode. She was not properly examined, nor were proper records kept, in three separate large general hospitals, with the result that the burns in her gastrointestinal tract were not diagnosed. When she was finally hospitalized in a private clinic, an attempt at surgical correction of the damage was not able to save her life. Another case is also mentioned of a person with mental disorder who is a resident in a boarding house. He was diagnosed with tuberculosis, but was discharged back to the boarding house after four days in a general hospital. Although he was still ill, and despite the fact that staff members and other residents Mantoux tests converted to positive, and that one staff member who was pregnant was told to have a chest X-ray after delivery and before breast feeding, it was not possible for the staff to arrange his admission to any hospital for nearly a month. He was finally admitted compulsorily to a psychiatric hospital which no longer has a medical department. (Annex 7). In places where hostels and other community living arrangements are well established, cooperation with general health services is beginning to improve. Staff from mental health units approach this problem first for the individual concerned, but then go on to arrange meetings with hospital administration in order to establish pathways to care for people with mental disorders. There are no national guidelines, and no national policy. Each area or service deals with the problem in an isolated way. All the sheltered living units have arranged regular contact with general physicians – in fact this was found to be more important than contact with psychiatrists. An example of good practice in this case would be the units which were established when the Chania Psychiatric hospital was closed. A written protocol describes the process for managing physical illness in residents. There is no example of cooperation between health services and organizations representing service users to improve access to care, and no active interventions were identified to empower and mainstream the healthcare of people with mental disorders. In this context, it is important to mention that although it was not expressly stated

when the Psychiatric Units in General Hospitals were established, one of the goals was the normalization of mental health care, and the desensitization of general health personnel. For Health Centre staff, this normalization process operates in conjunction with the mobile units and the community services provided by them (Στυλιανίδης, 1992, Γκιωνάκης, Καψάλη & Στυλιανίδης, 1992, Στυλιανίδης & Παντελίδου, 2006).

### **Supply-side responsiveness**

Some studies have addressed the issue of the attitudes of general hospital staff towards people with mental disorders (Αλεβίζος, Μαδιανός & Στεφανής, 1983, Τριποδιανάκης, Σαραντίδης & Θεοδωροπούλου, 1990, Μαντάς και συν. 1994). The first of these took place before the introduction of psychiatric units in general hospitals, the second at the time of opening of a unit in the hospital involved, and the third in a hospital with a functioning psychiatric unit. These studies all indicate that discriminatory attitudes are prevalent in general hospital personnel, and all studies agree that contact with people with mental disorders reduces discriminatory attitudes - authoritarian attitudes in particular. The exception to this was the first study which found high levels of an authoritarian approach in psychiatric nursing staff.

Many respondents expressed the view that stigmatizing is more likely amongst mental health personnel. A general view is held that although social inclusion may be accepted by healthcare personnel, in practice their behaviour would indicate that this acceptance is very superficial. Annex 8 is a documented complaint about the behaviour of a hospital doctor towards a person with mental disorder. Another indication of staff attitudes to difference would be the case of discriminatory treatment of Albanian patients. Albanian people are at high risk of negative appendectomies, and it is suggested that they are used for “practice” by trainee surgeons (Tatsioni et al, 2001). People with mental disorders are also more likely to face barriers if they wish to see their file, indicating a staff attitude which is not geared towards empowerment (Πανάγου, 2006). There is no information on interaction between health professionals and people with mental disorder. Once again the role of staff from sheltered housing units or staff from

Psychiatric Departments of General Hospitals is important in changing local attitudes, but this effort has not been systematically recorded or applied.

E-health services are not widespread, and therefore do not yet represent a barrier for people with mental disorders. Information on health care provision or entitlement is not generally available in an easy-to-understand format, although some health centres have produced pamphlets for local use. Most people glean their information from friends or relatives, and this would also apply to people with mental disorders. For those in sheltered housing, this applies “by proxy” with the care staff often being in a position to assist through their own “connections”. In fact, due to these connections, it was even suggested that this specific population may have better access than the general population in some cases. It has been found that when people move out of the psychiatric hospital into community residential settings, illnesses which were present but not detected may come to light and be dealt with. (Examples quoted include scabies and breast cancer)

Health promotion activities are not directed at people with mental disorders, other than on an individual basis through their therapeutic relationships. It is interesting to note that a pharmaceutical company which markets one of the atypical antipsychotic agents offers a free period of two months to those on any psychotropic medication wishing to attend the Diet and Vitality Centre of a large private clinic. This may be related to a number of law suits in America by people who gained a lot of weight when taking the particular medication. The information about the availability of this service has been distributed to psychiatrists, but not yet to NGOs representing service users or their families.

### **Health literacy and user attitudes**

It was not possible to find any information about health literacy in this group. No qualitative research has been reported, and no actions to improve health literacy were discovered, other than individual actions through therapeutic relationships.

#### ***4.5 Policy initiatives and their impact on access to general health care for people with mental disorders***

There are no policies specifically aimed at improving the access to general health care for people with mental disorders, and none are being planned. However, as part of the reform of mental health services in Greece, Mental Health Centres, Psychiatric Units in General Hospitals and Mobile Units have been developed. Coverage is not yet comprehensive, but large areas of the country are served by these new units. There is evidence that in areas served by these units, attitudes towards people with mental disorders are changing, and this, through the mainstreaming of mental health care has as a benevolent side effect the improvement of access to general health services. Respondents felt that in practice, access has improved as a result of the reform. This is complemented by the fact that people living in the various forms of community housing units are receiving individualised care which leads to greater vigilance and higher detection rates for physical disorders. General medical care within the community housing units is provided by regular visits from physicians, and where necessary, residents are accompanied by a staff member to general hospital services. Staff members act as advocates within the general health system, to ensure adequate care. They also act when adequate care is not forthcoming (see Annexes 7 & 8). Residents may also visit their local insurance fund services, due to the easier geographical and transport access associated with living in the community.

The aim of the National Health System was to provide health care for all with minimal cost at the time of receipt of services, regardless of socioeconomic status. In practice, due to cost sharing on the one hand, and the paraeconomy on the other, those with low socioeconomic status do not have easy access. Cost sharing for medication varies, but those with chronic conditions pay a lower rate, and medications for chronic mental disorder are exempt from cost sharing. The uninsured are entitled to “Welfare Insurance” which allows free hospital services and medication (without cost sharing). There are bureaucratic hurdles associated with this type of insurance, an example of which would be the filling of prescriptions. Medication must be obtained from hospital pharmacies, which means that someone attending a service without a

pharmacy (Mental Health Centres, Mobile Units) would need to go to the nearest hospital to obtain their medication. Some hospital pharmacies insist on prescriptions being written and officially stamped by medical staff of the hospital, which in effect means that two appointments are required, one in the community based unit, and one in the hospital. Welfare insurance does provide a safety net for those with a low income, and certainly does improve access for people with mental disorder.

## **4.6 Conclusions**

### **Significant barriers**

The most significant barrier to health care access for people with mental disorder was unanimously felt to be the stigma and discrimination associated with mental ill health. Stigma is found in the general population, but perhaps more importantly in the health service administrative staff, the health care staff, and also the mental health care staff. Self-stigmatization is also a factor which makes it difficult for the person with mental disorder to assert his/her rights to care. Many psychiatrists are institutionally trained and do not welcome the empowerment of service users. Doctors within the general health system tend to operate in a paternalistic way and empowerment of service users is not encouraged. User organizations are in the very early stages of development (in both the general and the mental health fields) and are mainly involved in provision of information and mutual support. Often they are associated with a powerful professional, who acts as a leader rather than an enabler. Activities related to raising awareness and to advocacy are not yet the norm. It was also suggested that psychiatrists have a lower status than other doctors.

Other barriers to access include the lower socioeconomic status of people with mental disorders, and their lack of knowledge about available services and their entitlements. It was also mentioned that the mental health reform did not arise as a demand from the population, but rather as a requirement of the European Union, and as such was never fully owned by the government, the professionals, the community, nor by the services users.

### **Most significant policy level interventions**

Although there are no specific policies geared towards improving access, the policy enshrined in the Psychoargos programme has at its heart the principles of mainstreaming and empowerment. Within this policy, the development of community mental health services has led to easier access to mental health services, which in turn is helping to reduce stigma and discrimination. The Psychiatric Units in General Hospitals have been important in reducing the stigma within general hospitals by increasing the visibility of mental disorders and mental health, and integrating services for general and mental health problems into one system. Community housing units have been important in reducing stigma at the neighbourhood level, and have improved the access of residents to general health care. Mobile Units are comprised of a small group of mental health professionals who travel to places without mental health services, staying for a short period of time, and offering information and clinical services. They operate by making maximum use of available facilities (such as social clubs for the elderly, local government facilities, schools etc) and thus reduce overheads to a minimum (Στυλιανίδης & Παντελίδου, 2006). They have a significant role to play in isolated and areas with difficult access.

### **Dissemination to the European level**

Specific policies or programmes aimed at improving access to general health services for those with mental disorder do not exist in Greece. However, as the main barrier to access is found to be the stigma and discrimination associated with mental disorder, the reform of mental health services is considered essential to improving access. Greece's experience of mental health reform (both developing community services, and closing psychiatric hospitals) is very recent. Although this experience is not relevant for countries with a longer history of mental health reform, it has been very useful for the beneficiary countries of the Stability Pact (see [www.seemph.ba](http://www.seemph.ba)) where Greece was the main donor for the Mental Health Project "*Enhancing Social Cohesion through Strengthening Community Mental Health Services in South East Europe*", also providing considerable technical and scientific input. This expertise can be utilized by countries that are in the early stages of mental health reform. In this

context, Greece, through the development of community services, has also been particularly inventive in finding innovative ways of exploiting minimal funds and resources, by liaison with and maximum use of existing social and administrative networks and services (Στυλιανίδης & Παντελίδου, 2006).

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## Addendums

### **ANNEX 1**

The [Madrid International Plan of Action on Ageing 2002 \(MIPAA\)](#) was adopted by the Second World Assembly in Madrid in April 2002 and in September 2002, the United Nations - Economic Commission for Europe ([UN-ECE](#)), of which Greece is a Signatory, adopted a [Regional Implementation Strategy \(RIS\)](#) at the Berlin Ministerial Conference.

Commitment 7: Quality of Life, Health and Well-being, provides a comprehensive set of guidelines for countries to use in formulating policies and practices to improve and maintain health amongst their older citizens, including the following:

In order to meet the challenges of ageing populations, including older persons with disabilities, it is crucial that social and health services place increased emphasis on health promotion, disease prevention and physical and mental rehabilitation, which incorporates a life-long approach to positive health. The continuum of care provision needs to be from the primary care sector to the secondary and tertiary care sectors, fully utilizing the skills of all health care providers. It is crucial that social and health services promote independence and assist older persons to participate fully in all aspects of society.

<http://www.monitoringris.org/skel.php?id=27#A7>

Towards this end the WHO has developed a number of documents specifying how healthy active ageing can be promoted throughout the lifespan <http://www.who.int/ageing/publications/active/en/> and whilst some sporadic initiatives to promote active ageing exist in Greece, in the absence of a clear and comprehensive policy commitment there are neither incentives nor practical aids to help health and social care personnel, Local Authorities and all the many sectors involved, to achieve these objectives.

**ANNEX 2****Table 1: Who helps the older person to meet their needs?**

<b>Type of help</b>	<b>N =</b>	<b>The interviewed carer (%)</b>	<b>Other informal carers (%)</b>	<b>Service/ Support organisations (%)</b>
<b>DOMESTIC CARE</b>	875	86.1	33.3	8.1
<b>EMOTIONAL/PSYCHOLOGICAL/SOCIAL</b>	912	95.8	48.8	8.1
<b>HEALTH CARE</b>	896	93.0	32.8	14.1
<b>MOBILITY</b>	728	92.9	35.7	6.9
<b>FINANCIAL MANAGEMENT</b>	803	90.9	25.3	1.7
<b>CARE ORGANISATION &amp; MANAGEMENT</b>	741	88.0	25.8	5.3
<b>PERSONAL CARE</b>	667	92.2	8.1	6.9
<b>FINANCIAL SUPPORT</b>	532	87.6	26.9	2.4

(More than one answer was possible, so percentage values, which were calculated on the total number of subjects who reported the specific need and answered this question, do not sum up to 100.)

**Table 3: For which areas of need would family carers like to have more help for the cared for older person?**

	<b>N =</b>	<b>%*</b>
<b>DOMESTIC CARE</b>	855	55.7
<b>EMOTIONAL/PSYCHOLOGICAL/SOCIAL</b>	896	63.8
<b>HEALTH CARE</b>	892	55.3
<b>MOBILITY</b>	716	60.1
<b>FINANCIAL MANAGEMENT</b>	795	36.9
<b>CARE ORGANISATION &amp; MANAGEMENT</b>	733	62.5
<b>PERSONAL CARE</b>	660	55.3
<b>FINANCIAL SUPPORT</b>	528	74.2

\* Percentage values refer to the positive answers on the reported total number of valid answers to this question.

## **ANNEX 3**

### **Legislation**

#### *Act ΨΜΒ/1862, On the establishment of lunatic asylums*

With this Act, the asylum was established as the place for the seclusion of the mentally ill. It allowed for admission of individuals following application by relatives, or placement in the asylum by the authorities, based in both cases on a medical report describing the condition and the need for treatment and admission to the asylum. The person so admitted could apply to court for release, which could then be granted without further bureaucracy. (Greek Ombudsman, 2007a)

#### *Act 104/1973, On mental health and the care of the mentally ill*

Under this Act, people could be admitted voluntarily, involuntarily, and compulsorily (for dangerous mentally ill persons). Discharge was entirely at the discretion of the psychiatrists, which often resulted in long-term admissions.

#### *Act 1397/1983, National Health System*

This is the Act which founds the National Health System, to provide free, comprehensive, equitable and universal health care for the whole population. Mental health services were to be provided by Mental Health Centres, Psychiatric Departments in General Hospitals, and Psychiatric Hospitals.

#### *Act 2071/1992, Modernization and Organization of the Health System*

This is the first reference to the sectorisation of mental health services, with the establishment of a Mental Health Sector in each county (which was however not implemented). This was also the Act which established the National Council for Medicine and Ethics within the Ministry of Health.

*Act 2519/1997, Development and modernization of the National Health Service, organization of hygiene services, regulations on pharmaceuticals and other provisions*

A service for the protection of patients' rights was established in the Ministry of Health. Also a three member committee was to be established in every hospital for the protection of citizens' rights.

*Act 2716/1999, Development and modernization of mental health services and other provisions*

This is the first Act of the modern State which is devoted to mental health. It affirms that the State is responsible for the provision of mental health services, including promotion and prevention, diagnosis, treatment and care, and psychosocial rehabilitation and social inclusion. Mobile units were also established to serve areas with difficult access. Hostels, boarding houses, sheltered apartments, and foster families for the alternative living arrangements for the deinstitutionalization of the long-term hospitalized, were also defined in the Act, as were the various forms of workshops and cooperatives which would support the process of deinstitutionalisation and social integration. Services were to be fully sectorised, and each Sector would be supported by a 5-member Mental Health Sector Committee. An office for the protection of the rights of people with mental disorders was established within the Ministry of Health, and the 7-member Special Committee for the Protection of the Rights of people with Mental Disorders was also established. This Act also outlined the standards required of the private clinics in order for them to accept compulsory admissions.

*Act 3418/2005, Code of Medical Ethics*

Article 28 of this Act, *the doctor and mental health care*, refers to the duties and obligations of psychiatrists but does not refer to doctors of other specialties. The psychiatrist must offer the best available treatment while respecting the human dignity, human rights and fundamental freedoms of people with mental disorders. Promotion of mental health is

encouraged. The psychiatrist is obliged to ensure his/her continuing education not only in mental health but also in the protection of dignity and fundamental freedom, and in the avoidance of the use of force. The least restrictive alternative treatment must be selected, and the psychiatrist must educate and supervise other health professionals working with him/her. The person with mental disorder is to be regarded as a partner in management decisions, who must be fully informed about his/her condition. The psychiatrist also ensures the right of people with mental disorders to practice their religious or other customs, and upholds the law regarding compulsory treatment. People with mental disorders are also protected from exploitation for personal, economic, academic, research, political or other reasons. The psychiatrist also ensures the non-stigmatization of people with mental disorders by the mass media. There is no mention of access to general health services, although this would certainly be within the spirit of the law.

*Act 3304/05 Implementation of the principle of equal treatment, regardless of race, nationality, religious or other beliefs, disability, age or sexual orientation*

This Act aims to protect the implementation of the right to equal treatment regardless of racial or ethnic origin, to combat discrimination on the grounds of religious or other beliefs, disability, age, and sexual orientation in the fields of work and employment, and to promote the principle of equal treatment. No specific mention is made of people with mental disorders, and they can be assumed to fall within the category of “disability”.

## **ANNEX 4**

### **Participants**

The following people were interviewed (16) or contacted by telephone (2) for the preparation of this case study.

Alexandra **Askouni-Stroumpou**, Paediatrician, President, Panhellenic Federation of Associations of Families for Mental Health

Ioannis **Chilakos**, Representative, Annagenisi

Panagiotis **Chondros**, Association for Regional Development and Mental Health

Athanassios **Constantopoulos**, Former WHO National Counterpart, Mental Health

Anna **Emmanouilidou**, Observatory for Rights in Mental Health

Georgios **Giannouloupoulos**, Representative, Alkyonides

Nikos **Gionakis**, Monitoring and Support Unit Psychoargos Phase B

Dimitris **Hondros**, Monitoring and Support Unit Psychoargos Phase B

Athena **Karatzogianni**, Representative, Rights and Obligations of People with Mental Disorders

Kalliopi **Mavratzotou**, Director of the Department of Mental Health 2001-2007, Ministry of Health

Marina **Oikonomou**, Scientific Director, Programme against the Stigma of Mental Illness

Aimilia **Panagou**, Senior Investigator, Greek Ombudsman

Sofia **Stouraitou**, Association for Regional Development and Mental Health

Stelios **Stylianidis**, Association for Regional Development and Mental Health

Pavlos **Theodorakis**, WHO National Counterpart, Mental Health

Vlassis **Tomaras**, Chairman, Special Committee to ensure the protection of the rights of people with mental disorders

Petros **Yannulatos**, Director of the Department of Mental Health 1994-2001, Ministry of Health

Athanasia **Zerva**, Representative, Annagenisi

## ANNEX 5

### Decision of the Central Health Council concerning the construction of the Map of Mental Health Services, Decision 4, 204<sup>th</sup> meeting, 21.9.06

ΕΛΛΗΝΙΚΗ ΔΗΜΟΚΡΑΤΙΑ  
ΚΕΝΤΡΙΚΟ ΣΥΜΒΟΥΛΙΟ ΥΓΕΙΑΣ

Αθήνα 30.10.2006  
Αριθμ. Απόφ. 4 της 204ης  
Ολομ./21.9.2006

#### Α Π Ο Φ Α Σ Η

#### «Σχετικώς με την σύνταξη του Χάρτη Παροχής Υπηρεσιών Ψυχικής Υγείας»

Η Ολομέλεια του Κεντρικού Συμβουλίου Υγείας στην 204η Συνεδρίασή της στις 21.9.2006, έχουσα υπόψη:

- α) τις προτάσεις του Αντιπροέδρου της Επιτροπής Ψυχικής Υγείας του ΚΕ.Σ.Υ. κ. Δημ. Βαρτζόπουλου, Ψυχιάτρου και Προέδρου της Β' Δ.Υ.ΠΕ Κ. Μακεδονίας, τις οποίες κατέθεσε προς συζήτηση στην Επιτροπή σχετικώς με την δημιουργία ψυχιατρικών δικτύων σε αντικατάσταση των παλαιών Νοσ/μείων, καθώς και με την υποβολή νέων Οργανισμών των Ψυχιατρικών Νοσ/μείων και σειράς ενεργειών προς υλοποίησή τους
- β) την γνώμη της Επιτροπής Ψυχικής Υγείας του ΚΕ.Σ.Υ. σχετικά με την σύνταξη του Χάρτη Παροχής Υπηρεσιών Ψυχικής Υγείας, η οποία εμπεριέχεται στα πρακτικά Συνεδρίασής της στις 13.4.2006 (Θέμα 2ο) και
- γ) την εισήγηση της Εκτελεστικής Επιτροπής του ΚΕ.Σ.Υ.,

**αποφάσισε τ' ακόλουθα:**

#### **1. Γενικές Υπηρεσίες**

Δημιουργία νέων τομέων παροχής γενικών ψυχιατρικών υπηρεσιών- ένας τομέας ανά νομό. Στην Αθήνα και στην Θεσσαλονίκη, η κατανομή τους γίνεται βάσει των πληθυσμιακών δεδομένων, όπως και των αναγκών του ΣΟΤΥ. Ανά τομέα δρουν συμβουλευτικά επιτροπές ψυχικής υγείας τριμερούς σύνθεσης (ΕΣΥ – ιδιώτες ιατροί – ιδιωτικές κλινικές). Καταργούνται οι παλαιές ΤΕΨΥ και τροποποιείται ο Ν.2716. Οι τομείς εποπτεύονται και ελέγχονται βάσει του Ν.3329/05 από τις ΔΥΠΕ.

Ανά υπεύθυνο τομέα δημιουργούνται:

- ✓ Τμήμα οξέων, Intensive care units εντός αυτών
- ✓ Ξενώνας βραχείας νοσηλείας

- ✓ Κλινική ημέρας – κέντρο ημέρας – κοινωνικές δράσεις
- ✓ Παιδοψυχιατρικό εξωτερικό ιατρείο

Τα Κέντρα Ψυχικής Υγείας εντάσσονται στα Αστικά Κέντρα Υγείας. Οι ιδιωτικές κλινικές εμπλέκονται ιδίως στις αναγκαστικές νοσηλείες.

Δημιουργούνται παιδοψυχιατρικές κλινικές, ιατροπαιδαγωγικά κέντρα, κέντρα ημερήσιας φροντίδας παιδιών & εφήβων με ειδικές ανάγκες καθώς και ξενώνες για παιδιά και εφήβους. Η κατανομή ανά νομό ή περιφέρεια γίνεται αναλόγως των αποτελεσμάτων σχετικής επιδημιολογικής μελέτης.

## **2. Ειδικές Υπηρεσίες**

Κατανομή ανά την χώρα των ειδικών ψυχιατρικών υπηρεσιών. Δημιουργούνται πέντε (5) Δικτύων Ειδικών Ψυχιατρικών Υπηρεσιών με χρήση όπως υπάρχουν δομές των παλαιών Ψυχιατρικών Νοσοκομείων με δυνατότητα ανάλογη των αποτελεσμάτων της επιδημιολογικής μελέτης:

- ✓ Κλινικές δυσιάντων περιστατικών (προερχόμενων από τους ξενώνες βραχείας νοσηλείας)
- ✓ Κλινικές μέσης ασφάλειας (κλειστές)
- ✓ Τμήματα οργανικών ψυχοσυνδρόμων & ψυχογηριατρική: διαγνωστικές δομές – κέντρα ημέρας – κλινικές μακράς νοσηλείας εντός του Νοσοκομείου
- ✓ Διαμερίσματα – ξενώνες (ανοικτοί) – οικοτροφεία (κλειστά) των νέων (προερχόμενων από τις κλινικές δυσιάντων) χρόνιων ψυχικά ασθενών εκτός ή και εντός του Νοσοκομείου.
- ✓ Ολοκληρωμένες ψυχιατροδικαστικές υπηρεσίες: διαγνωστικές δομές κλινικές υψηλής ασφάλειας οξέων & χρόνιων περιστατικών

Επιπλέον, να δημιουργηθεί κοινή επιτροπή με το Υπ.Δικαιοσύνης προκειμένου διερεύνηση των ακόλουθων σχετικών προβλημάτων:

- ✓ Αντιμετώπιση των παραβατών με μειωμένο καταλογισμό
- ✓ Αντιμετώπιση των παραβατών των νόμων περί ναρκωτικών
- ✓ Δημιουργία εξειδικεύσεως στην Ψυχοιατροδικαστική

Ειδικές παιδοψυχιατρικές υπηρεσίες (ειδικά εξωτερικά ιατρεία, κινητές μονάδες, ειδικές κλινικές)

Ένταξη στα ψυχιατρικά δίκτυα και των προνοιακών δομών του Κράτους.

Διοίκηση προερχόμενη από τον διοικητικό ιστό των υφιστάμενων ψυχιατρείων

#### **Διαδικασία υλοποίησης:**

1. Η Επιτροπή καταρτίζει γενικό επιχειρησιακό σχέδιο ποιοτικών στόχων, η ποσοτική διάσταση των οποίων εξαρτάται από τα επιδημιολογικά δεδομένα
2. Κατάθεση των νέων Οργανισμών των Ψυχιατρικών Νοσοκομείων (όπως αυτός του ΨΝΘ)
3. Ανάθεση από τον Υπουργό ΥΓΚΑ της εκπόνησης της επιδημιολογικής μελέτης στους Διοικητές των ψυχιατρικών Νοσοκομείων

Αντικείμενο της έρευνας

- Περιστατικά των τελευταίων πέντε (5) ετών ανά δημόσιο (ανά μορφή κλινικής και δομή) και ανά ιδιωτικό (& ΜΚΟ) ίδρυμα: δημογραφικά χαρακτηριστικά, εξέλιξη ψυχοπαθολογίας & βαθμού λειτουργικότητας / αυτονομίας
- καταγραφή σημερινών δομικών αναγκών ανά μορφή κλινικής & δομή
- πρόβλεψη ζήτησης υπηρεσιών παλαιάς και νέας μορφής

Παράλληλη δραστηριότητα σε συνεργασία με το Υπ.Δικαιοσύνης για τις ψυχιατροδικαστικές υπηρεσίες.

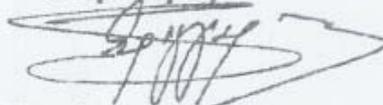
#### **Εσωτ. Διανομή:**

- 1) Γραφείο Υπουργού Υγείας και Κοιν. Αλληλεγγύης
- 2) Γραφείο Υφυπουργού Υγείας
- 3) Γραφείο Γεν. Γραμματέα Υγείας
- 4) Γραφείο Ειδικής Γραμματέως Ψυχικής Υγείας και Κοιν. Ένταξης

#### **Αποδέκτης προς ενέργεια**

Δ/ση Ψυχικής Υγείας

Για το ΚΕ.Σ.Υ.  
Ο Πρόεδρος



Κυριάκος Στριγγάρης

## **ANNEX 6**

**Letter to the Office of the Ministry of Health from the Ombudsman regarding the case of a person with depression who died two months after drinking hydrochloric acid, having been briefly admitted to three large general hospitals in Athens where she was not diagnosed with internal burn injuries**

24 Νοεμβρίου 2006

Αριθμ. Πρωτ. 5069.3/24.03.2005

Ειδικός Επιστήμονας: Πανάγου Αιμιλία

Τηλ.: 210 72.89.746

Fax : 210 72.89.739

### Προς

1. Υπουργείο Υγείας και Κοινωνικής Αλληλεγγύης

Γραφείο Υπουργού

Αριστοτέλους 19

101 87 Αθήνα

2. Νοσηλευτικό Ίδρυμα

Μετοχικού Ταμείου Στρατού (ΝΙΜΤΣ)

Μονής Πετράκη 10

115 21 Αθήνα

3. Γενικό Νοσοκομείο Αθηνών

«Ο Ευαγγελισμός»

Υψηλάντου 45-47

106 76 Αθήνα

4. Γενικό Νοσοκομείο Αθηνών «Λαϊκό»

Αγ. Θωμά 17

113 64 Αθήνα

**ΘΕΜΑ: «Πόρισμα ΣΤΠ σχετικά με τις συνθήκες νοσηλείας της αποθανούσης ..... σε τρία δημόσια Νοσοκομεία Αθηνών»**

Ο Συνήγορος του Πολίτη στο πλαίσιο των αρμοδιοτήτων του κατά το άρθρ. 103 § 9 του Συντάγματος και τον Ν.3094/2003 έλαβε και εξέτασε αναφορά της κ. .... με αρ. πρωτ. 5069/24.03.2005, σχετικά με τις συνθήκες νοσηλείας της μητέρας της ..... σε τρία νοσηλευτικά ιδρύματα της Αθήνας.

**I. ΙΣΤΟΡΙΚΟ**

Σύμφωνα με τα στοιχεία της αναφοράς, η ασθενής ....., ετών 71, με ιστορικό καταθλιπτικής συνδρομής έκανε απόπειρα αυτοκτονίας με κατάποση υδροχλωρικού οξέος στις 28/12/2004. Διακομίστηκε στο Νοσηλευτικό Ίδρυμα Μετοχικού Ταμείου Στρατού (ΝΙΜΤΣ) όπου μετά από πολύωρη παραμονή σε φορείο μεταφέρθηκε σε εξάκλινο δωμάτιο. Μετά από τριήμερη νοσηλεία της ασθενούς και παρότι εξακολουθούσε να παραπονείται για κάψιμο και πόνο στον θώρακα και το στομάχι, εκδόθηκε εξιτήριο στις 31/12/2004 με διάγνωση εξόδου «βελτίωση υγείας» και πρόταση μεταφοράς της ασθενούς σε νοσοκομείο που να παρέχει δυνατότητα ψυχιατρικής παρακολούθησης της ασθενούς λόγω του ψυχιατρικού ιστορικού της.

Η ασθενής μεταφέρθηκε με το ΕΚΑΒ στο Νοσοκομείο «Ευαγγελισμός» στις 31/12/2004 όπου και παρέμεινε μέχρι τις 3/1/2005. Αρχικά, η ασθενής εισήχθη στην ψυχιατρική κλινική του Νοσοκομείου «Ευαγγελισμός» αλλά στη συνέχεια, μετά από πιέσεις των συγγενών της που υποστήριζαν ότι τα προβλήματα της ασθενούς εξακολουθούσαν να είναι παθολογικά (κάψιμο και πόνος στο στομάχι και τον θώρακα) και όχι ψυχολογικά, εισήχθη σε παθολογικό τμήμα του Νοσοκομείου. Μετά από την ολιγόημερη νοσηλεία της ασθενούς εκδόθηκε εξιτήριο και στη συνέχεια επέστρεψε στην οικία της ακολουθώντας φαρμακευτική αγωγή και ειδική διαίτα όπως της συνέστησαν οι γιατροί του «Ευαγγελισμού».

Σε τηλεφωνική επικοινωνία που είχε η κόρη της, κ. ...., με ψυχίατρο και παθολόγο του «Ευαγγελισμού» στις 6/1/2005 ανέφερε ότι η ασθενής εξακολουθούσε να υποφέρει από συμπτώματα επιγαστρικού άλγους και αίσθημα δυσφορίας και έτσι κλείστηκε ραντεβού για εξέταση της ασθενούς στις 11/1/2005, δηλαδή 5 ημέρες μετά την έκφραση ανησυχίας των συγγενών για την πορεία της υγείας της ασθενούς, όπου αποφασίστηκε να μειωθεί η φαρμακευτική αγωγή. Στις 27/1/2005 η κ.

..... επικοινωνήσε και πάλι με παθολόγο του Νοσοκομείου «Ευαγγελισμός», ενημερώνοντάς τον ότι η κατάσταση της υγείας της μητέρας της δεν βελτιωνόταν, δεδομένου ότι η ασθενής εξακολουθούσε να εμφανίζει τάσεις προς έμετο με δείγματα σκούρου σάλιου. Ορίστηκε νέο ραντεβού για εξέταση της ασθενούς στις 3/2/2005 (δηλαδή, 7 ημέρες μετά και τη δεύτερη τηλεφωνική κρούση ανησυχίας των συγγενών), όπου οι γιατροί του Νοσοκομείου «Ευαγγελισμός» εξέτασαν την ασθενή και συνέστησαν, λόγω μη υποχώρησης των συμπτωμάτων που την ταλαιπωρούσαν, την επείγουσα μεταφορά της στο εφημερεύον Νοσοκομείο «Λαϊκό». Πράγματι, η ασθενής μεταφέρθηκε στο Γεν. Νοσοκομείο Αθηνών «Λαϊκό» με αναφερόμενο επιγαστρικό άλγος, αίσθημα δυσφορίας στο επιγάστριο και με καφεοειδείς εμέτους.

Τελικά, η ασθενής διακομίσθηκε στο Ιατρικό Αθηνών στις 3/2/2005 όπου υπεβλήθη σε κλινικό και εργαστηριακό έλεγχο. Όπως προκύπτει από το ενημερωτικό σημείωμα του Δ/ντή της Χειρουργικής Κλινικής του Ιατρικού Αθηνών, κ. Κοζαδίνου Ι., στις 10/2/2005 αποφασίστηκε η διενέργεια χειρουργικής επέμβασης και ενώ η μετεγχειρητική πορεία της ασθενούς ήταν ομαλή, στις 25/2/2005 παρουσίασε μεγάλη αιμορραγία και σημεία ολιγαιμικού shock. Μετά τη διακομιδή της στην ΜΕΘ κατέληξε της 28/2/2005 λόγω διάχυτης ενδαγγειακής πήξης και καρδιακής ανακοπής.

## **II. ΕΝΕΡΓΕΙΕΣ ΤΟΥ ΣΥΝΗΓΟΡΟΥ ΤΟΥ ΠΟΛΙΤΗ**

A) Ο Συνήγορος του Πολίτη στα πλαίσια διερεύνησης της αναφοράς απέστειλε στις 17/5/2005 επιστολές (αρ. πρωτ. 5069/05/17.05.2005) με θέμα: *«Ενημέρωση σχετικά με τις συνθήκες νοσηλείας της αποθανούσης ..... και αποστολή ιατρικού φακέλου στον Συνήγορο του Πολίτη»* προς τους Διοικητές και των τριών εμπλεκόμενων νοσηλευτικών ιδρυμάτων, δηλαδή του Νοσηλευτικού Ιδρύματος Μετοχικού Ταμείου Στρατού (ΝΙΜΤΣ), του Γενικού Νοσοκομείου Αθηνών «Ο Ευαγγελισμός» και του Γενικού Νοσοκομείου Αθηνών «Λαϊκό». Οι επιστολές της Αρχής κατέληγαν όπως διερευνηθούν οι συνθήκες νοσηλείας της ασθενούς, αποσταλούν εγγράφως οι απόψεις των εμπλεκόμενων ιατρών στην αντιμετώπιση του περιστατικού, χορηγηθούν άμεσα αντίγραφα του ιατρικού φακέλου της ασθενούς που τηρείται στα αρχεία και όπως εξετασθεί το ενδεχόμενο διενέργειας ΕΔΕ.

B) Σε συνέχεια της διερεύνησης της υπόθεσης ο Συνήγορος του Πολίτη απέστειλε στις 14/10/2005 επιστολή (αρ. πρωτ. 5069/05/14.10.2005) με θέμα: *«Παροχή πληροφοριών σχετικά με την αντιμετώπιση περιστατικών κατάποσης υδροχλωρικού οξέος»* προς τη Δ/ντρια του Ελληνικού Κέντρου Δηλητηριάσεων,

κα. Βαλτή Ηλ., ώστε να πληροφορηθεί από τον καθ' ύλην αρμόδιο φορέα για τις παρενέργειες από κατάποση υδροχλωρικού οξέος και τους τρόπους ιατρικής αντιμετώπισης .

Γ) Επίσης, στην από 14/7/2005 καταγγελία με αρ. πρωτ. 74815 της κ. .... και ..... προς τον Υπουργό Υγείας και Κοινωνικής Αλληλεγγύης, οι συγγενείς της θανούσης δεν έλαβαν για ένα έτος καμία απάντηση ή ειδοποίηση. Η Αρχή επικοινωνήσε επανειλημμένα με υπαλλήλους του Υπουργείου Υγείας αναζητώντας τον υπεύθυνο χειριστή της υπόθεσης και τους λόγους της αδικαιολόγητης εκκρεμότητας απάντησης στην ανωτέρω καταγγελία από την υπηρεσία. Μόλις τον Μάρτιο του 2006 πληροφορήθηκε τηλεφωνικά από τον κ. Κατσαούνο ότι στο σύστημα καταχώρησης των αναφορών του Υπουργείου δεν υπήρχε το πλήρες κείμενο της καταγγελίας με αποτέλεσμα να μην έχει επιληφθεί κανείς την εξέταση της καταγγελίας. Ο Συνήγορος του Πολίτη στις 9/3/2006, αμέσως μετά την ενημέρωση σχετικά με την καθυστέρηση απάντησης στην καταγγελία της κ. .... από το Υπουργείο Υγείας, απέστειλε με φαξ την εν λόγω καταγγελία, υπ'όψιν του κ. Κατσαούνου. Μετά πάροδο 2 και πλέον μηνών, σε τηλεφωνική επικοινωνία της ειδικής επιστήμονος στον Συνήγορο του Πολίτη, κ. Πανάγου, με την κ. Στάθη στο Υπουργείο Υγείας, η Αρχή πληροφορήθηκε ότι η υπόθεση εξακολουθεί να εκκρεμεί. Η καταγγελία στάλθηκε και πάλι άμεσα με φαξ, υπ'όψιν του κ. Κατσαούνου, στις 17/5/2006. Στη συνέχεια και για να αποφευχθεί πιθανή επιπλέον καθυστέρηση, η Αρχή ενημέρωσε το Γραφείο Συνεργασίας με τον Συνήγορο του Πολίτη που υπάγεται στον Γενικό Γραμματέα Πρόνοιας του Υπουργείου Υγείας και Κοινωνικής Αλληλεγγύης. Ακολούθησαν συχνές τηλεφωνικές επικοινωνίες με τον κ. Γκλεζάκο και την κ. Απουσίδου κατά τις οποίες η Αρχή ζητούσε την άμεση αποστολή εγγράφου προς τον ΣτΠ και την καταγγέλουσα, κ. ...., σχετικά με την πορεία διερεύνησης της υπόθεσης από πλευράς Υπουργείου Υγείας. Τελικά, στις 21/7/2006 η Αρχή έλαβε φαξ από το Γραφείο Συνεργασίας με τον Συνήγορο του Πολίτη του Υπουργείου Υγείας, σύμφωνα με το οποίο η καταγγελία των κ.κ. .... και ..... έχει διαβιβαστεί στο Σώμα Επιθεωρητών Υπηρεσιών Υγείας και Πρόνοιας (Σ.Ε.Υ.Υ.Π.) με αρ. πρωτ. 2337/2006. Σε τηλεφωνική επικοινωνία που είχε η συνεργάτης μου κ. Πανάγου με τον Επιθεωρητή του Σώματος κ. Μόρφη, ενημερωθήκαμε ότι η ανωτέρω καταγγελία διαβιβάστηκε στο Σώμα Επιθεωρητών Υπηρεσιών Υγείας και Πρόνοιας (Σ.Ε.Υ.Υ.Π.) στις 12/7/2006.

Δ) Ο Συνήγορος του Πολίτη απέστειλε στο Σ.Ε.Υ.Υ.Π. την υπ'αρ. πρωτ. 5069.2/7.8.2006 επιστολή στην οποία εκθέτει αναλυτικά τα δεδομένα που προέκυψαν από τη διερεύνηση της υπόθεσης και ζητά, εφόσον διερευνηθούν

επίμαχα σημεία και εκφραστούν τεχνικές κρίσεις επί των θεμάτων αυτών, να του κοινοποιηθεί το πόρισμα του Σώματος. Μέχρι στιγμής η Αρχή δεν έχει λάβει καμία απάντηση από το Σ.Ε.Υ.Υ.Π.

### **III. ΕΝΕΡΓΕΙΕΣ ΤΗΣ ΔΙΟΙΚΗΣΗΣ**

Σε απάντηση των ανωτέρω εγγράφων της Αρχής προς τα εμπλεκόμενα με την υπόθεση νοσηλευτικά ιδρύματα της Αθήνας, οι Διοικήσεις των Νοσοκομείων ανταποκρίθηκαν εγγράφως με επιστολές. Συγκεκριμένα, το Γενικό Νοσοκομείο Αθηνών «Λαϊκό» με την υπ' αριθ. πρωτ. 7460/28.6.2006 επιστολή, το Νοσηλευτικό Ίδρυμα Μετοχικού Ταμείου Στρατού (ΝΙΜΤΣ) με το υπ' αριθμ.Φ. 464/6110/4.7.2005 έγγραφο και το Γενικό Νοσοκομείο Αθηνών «Ο Ευαγγελισμός» με το υπ' αριθ. πρωτ. 10263/8.6.2005/5.9.2005 έγγραφο .

Σε απάντηση του ανωτέρω εγγράφου της Αρχής προς το Ελληνικό Κέντρο Δηλητηριάσεων, η Αρχή έλαβε έγγραφο (αρ. πρωτ. 748/3.11.2005) με το οποίο της χορηγούνται αναλυτικότερα πληροφορίες σχετικά με τους τρόπους αντιμετώπισης αυτών των περιστατικών .

Μετά την πάροδο ενός έτους και συνεχών πιέσεων από την Αρχή και τους καταγγέλλοντες, το Υπουργείο Υγείας & Κοινωνικής Αλληλεγγύης διαβίβασε την καταγγελία στο Σ.Ε.Υ.Υ.Π. (αρ. πρωτ. 2337/12.7.2006).

### **IV. ΔΙΑΠΙΣΤΩΣΕΙΣ ΤΗΣ ΑΡΧΗΣ**

#### **1) Σχετικά με το Νοσηλευτικό Ίδρυμα Μετοχικού Ταμείου Στρατού (ΝΙΜΤΣ)**

Α) Στην υπ' αριθμ. Φ.464/6110/4.7.2005 απαντητική επιστολή του Νοσοκομείου προς την Αρχή, η οποία υπογράφεται από τον Γενικό Δ/ντή Ταξ/χο (ΥΙ) Παναγιώτη Δροσινόπουλο, αναφέρονται μεταξύ άλλων ότι, το περιστατικό διακομίσθηκε στο Τμήμα Επειγόντων Περιστατικών (ΤΕΠ) μέσω ΕΚΑΒ στις 28/12/2005 λόγω λήψης χημικής ουσίας και υποβλήθηκε άμεσα σε βασικό κλινικό και εργαστηριακό έλεγχο, ο οποίος αξιολογήθηκε ως «φυσιολογικός». Η παρατεταμένη όμως, παραμονή της ασθενούς στο χώρο του ΤΕΠ στο απαντητικό έγγραφο της Διοίκησης προς την Αρχή δικαιολογείται ως εξής: «...λόγω ενδεχόμενης χημικής οισοφαγίτιδας-γαστρίτιδας και άλλων επιπλοκών κατεβάλετο προσπάθεια ανεύρεσης κλίνης σε Μονάδα

**Εντατικής Θεραπείας (ΜΕΘ) άλλου Νοσοκομείου αφού η ΜΕΘ του Νοσοκομείου μας παρουσιάζει πληρότητα».**

Γίνεται λοιπόν προφανές από την επίσημη δήλωση της Διοίκησης προς την Αρχή, ότι το περιστατικό της ..... αξιολογείται ως ιδιαίτερος σοβαρός. Οι ιατροί προσπαθούν να τοποθετήσουν την ασθενή σε Μονάδα Εντατικής Θεραπείας λόγω των επιπλοκών που ενδεχομένως προκαλεί η λήψη καυστικών ουσιών. **Ενώ όμως, διαπιστώνεται ενδεχόμενη χημική οισοφαγίτιδα-γαστρίτιδα και άλλες επιπλοκές, η ασθενής υποβλήθηκε μόνο σε βασικό κλινικό και εργαστηριακό έλεγχο και όχι σε πιο εξειδικευμένες διαγνωστικές εξετάσεις. Αναφέρεται επίσης, ότι «δεν έγινε έλεγχος ανωτέρου πεπτικού συστήματος λόγω απόλυτης αντένδειξης»** χωρίς όμως να αιτιολογούνται οι λόγοι αντένδειξης μιας τέτοιας ιατρικής πράξης, η οποία θα μπορούσε ενδεχομένως να αποκαλύψει βλάβες στην υγεία της ασθενούς, των οποίων η ύπαρξη και έκταση δεν μπορούσε να προκύψει από τον βασικό κλινικό και εργαστηριακό έλεγχο.

**Β) Η ιατρική γνωμάτευση που εκδόθηκε στις 31/12/2004, ημερομηνία εξιτηρίου της ασθενούς από το ΝΙΜΤΣ, έχει υπογραφεί από την ειδικευόμενη ιατρό της Γ' παθολογικής κλινικής, κ. Τατιάνα Ταταρίδου, και όχι από ειδικευμένο ιατρό. Η γνωμάτευση αναφέρει ότι η ασθενής πάσχει «από χημική δηλητηρίαση (aquaforte) και καταθλιπτική συνδρομή και πρέπει να μεταφερθεί σε νοσοκομείο που να παρέχει τη δυνατότητα ψυχιατρικής παρακολούθησης».**

Γ) Στην απάντηση του Νοσοκομείου ΝΙΜΤΣ προς την Αρχή αναφέρεται ότι: «...Η ασθενής σε καλή κατάσταση και με άριστη αιματολογική και βιοχημική εικόνα διακομίσθηκε με σύσταση συχνής γαστρεντερολογικής παρακολούθησης την 31/12/2004, μέσω ΕΚΑΒ, στην Ψυχιατρική Κλινική του Νοσοκομείου «Ευαγγελισμός», αφού το ΝΙΜΤΣ δεν διαθέτει Ψυχιατρική Κλινική». Παρά ταύτα, η «σύσταση» που αναφέρει το έγγραφο του Νοσοκομείου **δεν προκύπτει από τα έγγραφα που εστάλησαν στην Αρχή και δεν αναγράφεται στην ιατρική γνωμάτευση που προαναφέρθηκε. Από τη γνωμάτευση αυτή αλλά και την απάντηση της Διοίκησης προς την Αρχή φαίνεται να δίνεται ιδιαίτερη βαρύτητα στο ψυχιατρικό και όχι στο παθολογικό πρόβλημα της ασθενούς, λόγω της χημικής δηλητηρίασης. Επίσης, στην επιστολή του Νοσοκομείου δεν αναφέρονται τα ονόματα των θεραπόντων ιατρών στην αντιμετώπιση του περιστατικού.**

Δ) Με την υπ' αρ. πρωτ. 5069/05/17.05.2005 επιστολή της η Αρχή ζητούσε –εκτός των άλλων - από το Νοσοκομείο να αποσταλούν εγγράφως οι απόψεις των θεραπόντων ιατρών στην αντιμετώπιση του περιστατικού και να εξετασθεί το ενδεχόμενο διενέργειας ΕΔΕ. Τα ανωτέρω ερωτήματα/αιτήματα της Αρχής δεν απαντήθηκαν ούτε ικανοποιήθηκαν από την Διοίκηση του ΝΙΜΤΣ, παρότι η απάντηση της Διοίκησης μνημονεύει ως σχετικό έγγραφο την από 14.6.2005 αναφορά Δ/ντού της Γ' Παθολογικής κλινικής, κ. Τέγου Κ.

Ε) Τέλος, πιθανώς εκ παραδρομής, στο διαβιβαστικό έγγραφο του Νοσοκομείου ΝΙΜΤΣ δεν αναγράφεται σωστά το επώνυμο της ασθενούς, δηλαδή αντί ..... αναφέρεται ως ....., ενώ στα συνημμένα φ/α των αιματολογικών εξετάσεων που υπεβλήθη η ασθενής κατά τη νοσηλεία της στο Νοσοκομείο αναφέρεται σωστά το επώνυμό της. .

## **2) Σχετικά με το Γενικό Νοσοκομείο Αθηνών «Ο Ευαγγελισμός»**

Α) Στην υπ' αριθμ. πρωτ. 10263/8.6.2005/5.9.2005 απαντητική επιστολή του Νοσοκομείου προς την Αρχή, η οποία υπογράφεται από τον Διοικητή, κ. Τούμπη Μ., αναφέρονται μεταξύ άλλων ότι, «η ασθενής ..... προσήλθε στο Παθολογικό Ιατρείο του Τμήματος Επειγόντων Περιστατικών (ΤΕΠ) τις βραδινές ώρες της 31/12/2004, ημέρα εφημερίας του Δ' Παθολογικού Τμήματος στην οποία ήταν υπεύθυνη η Αναπληρώτρια Δ/ντρια του Τμήματος κ. Γ. Υφαντή. Κατά τη διάρκεια της νοσηλείας της στο Δ' Παθολογικό Τμήμα, η ασθενής επανεκτιμήθηκε από τους Ψυχιάτρους του Νοσοκομείου στις 3/1/2005. Συστήθηκε άμεση επανεισαγωγή στην Ψυχιατρική Κλινική του Νοσοκομείου, την οποία αρνήθηκαν τόσο η ίδια όσο και ο σύζυγος και η κόρη της, παρά την εμπειριστατωμένη ενημέρωσή τους για την αναγκαιότητα, εκούσιας ή κατόπιν εισαγγελικής εντολής άμεση εισαγωγή και νοσηλεία σε Ψυχιατρική Κλινική. Όπως προκύπτει από το αρχείο του Δ' Παθολογικού Τμήματος, η ασθενής εξήλθε στις 3/1/2005, με τη διάγνωση «**Απόπειρα αυτοκαταστροφής-λήψη υδροχλωρικού οξέος-ψυχωσική συνδρομή**». Ένα μήνα μετά την έξοδό της από το Νοσοκομείο, δηλαδή στις 3/2/2005, εξετάστηκε μετά από ραντεβού στο εξωτερικό παθολογικό ιατρείο του Δ' Παθολογικού Τμήματος από την κ. Βαδάλα, για γαστροπληγικούς εμέτους και διάχυτο κοιλιακό άλγος από 2ημέρου. Επειδή στην αντικειμενική εξέταση διαπιστώθηκαν παθολογικά ευρήματα από την κοιλία, συστήθηκε η άμεση εισαγωγή της στο εφημερεύον Νοσοκομείο.

**Όσον αφορά τον φάκελο της ασθενούς, αυτός βρίσκεται και φυλάσσεται στο Αρχείο, στο περιεχόμενο του όμως ευρέθησαν μόνον φύλλα νοσηλείας της από το Ψυχιατρικό Τμήμα».**

Στο ενημερωτικό σημείωμα του Δ/ντή του Δ΄ Παθολογικού Τμήματος του Ευαγγελισμού, κ. Διαμαντόπουλου, προς τον Διοικητή του Νοσοκομείου, κ. Τούμπη, αναφέρεται μεταξύ άλλων ότι «Η αναφορά της κ. .... παρελήφθη από την Κλινική μας στις 9/6/2005 από τη Γραμματεία του Τμήματος. Την επομένη 10/6/2005, ο φάκελος της ασθενούς ζητήθηκε από το Αρχείο δεδομένου ότι τόσο στο βιβλίο του θαλάμου 509, όσο και στο Μητρώο των ασθενών του Τμήματος μας φαίνεται ότι ο φάκελος έχει κλειστεί και εστάλη στο Αρχείο. Στις 13/6/2005 ενημερωθήκαμε, ότι ο φάκελος της ασθενούς δεν βρέθηκε στο Αρχείο, γι αυτό και έγιναν επανειλημμένες τηλεφωνικές επικοινωνίες με την υπεύθυνη κ. Μπακέα. Στη συνέχεια συνεργείο του Αρχείου του Νοσοκομείου έψαξε σε όλους τους χώρους της Κλινικής μας, παρά το γεγονός ότι οι φάκελοι που βρίσκονταν στο Δ΄ Παθολογικό Τμήμα είχαν ήδη ελεγχθεί από τους ιατρούς. Στις 17/6/2005 μας παραδόθηκε ο φάκελος της κ. ....(με αριθμό φακέλου 629975), που βρέθηκε στην Ψυχιατρική Κλινική, ο οποίος όμως δεν περιείχε κανένα από τα φύλλα της νοσηλείας της ασθενούς στο Δ΄ Παθολογικό Τμήμα».

Από το Βιβλίο Μητρώου του Τμήματος Επειγόντων Περιστατικών προκύπτει ότι το περιστατικό της ..... χαρακτηρίζεται ως «επείγον» με αναγραφόμενη διάγνωση «λήψη καυστικής ουσίας προ 3ημέρου».

Σύμφωνα με τον Κώδικα Ιατρικής Δεοντολογίας (Ν. 3418/2005), άρθρο 14 «Τήρηση ιατρικού αρχείου»: «1. Ο ιατρός υποχρεούται να τηρεί ιατρικό αρχείο, σε ηλεκτρονική ή μη μορφή, το οποίο περιέχει δεδομένα που συνδέονται αρρήκτως ή αιτιωδώς με την ασθένεια ή την υγεία των ασθενών του. Για την τήρηση του αρχείου αυτού και την επεξεργασία των δεδομένων του εφαρμόζονται οι διατάξεις του ν. 2472/1997 (ΦΕΚ 50 Α΄). 2. Τα ιατρικά αρχεία πρέπει να περιέχουν το ονοματεπώνυμο, το πατρώνυμο, το φύλλο, την ηλικία, το επάγγελμα, τη διεύθυνση του ασθενή, τις ημερομηνίες της επίσκεψης, καθώς και κάθε άλλο ουσιώδες στοιχείο που συνδέεται με την παροχή φροντίδας στον ασθενή, όπως ενδεικτικά και ανάλογα με την ειδικότητα, τα ενοχλήματα της υγείας του και το λόγο της επίσκεψης, την πρωτογενή και δευτερογενή διάγνωση ή την αγωγή που ακολουθήθηκε. 3. Οι κλινικές και τα νοσοκομεία τηρούν στα ιατρικά τους αρχεία και τα αποτελέσματα όλων των κλινικών και παρακλινικών

εξετάσεων. 4. Η υποχρέωση διατήρησης των ιατρικών αρχείων ισχύει [...] για μία εικοσαετία από την τελευταία επίσκεψη του ασθενή».

Στην περίπτωση της νοσηλείας της ..... στο Νοσοκομείο «Ευαγγελισμός» δεν προκύπτει ότι τηρήθηκε ιατρικό αρχείο από το Δ΄ Παθολογικό Τμήμα, όπως προβλέπεται στις ανωτέρω διατάξεις νόμου. Αυτό έχει ως αποτέλεσμα να δυσχεραίνεται η αξιολόγηση της νοσηλείας της ασθενούς κατά την πρώτη εισαγωγή της στο Νοσοκομείο «Ευαγγελισμός» και κατά πόσο το είδος και η ποιότητα της ιατρικής φροντίδας που της παρασχέθηκε είχαν ως αποτέλεσμα την δεύτερη εισαγωγή της στο Νοσοκομείο στις 3/2/2005, όπου εξετάστηκε επείγοντως με συμπτώματα «γαστροπληγικών εμέτων και διάχυτο κοιλιακό άλγος από 2ημέρου. Επειδή στην αντικειμενική εξέταση διαπιστώθηκαν παθολογικά ευρήματα από την κοιλία, συστήθηκε η άμεση εισαγωγή της στο εφημερεύον Νοσοκομείο».

### **3) Σχετικά με το Γενικό Νοσοκομείο Αθηνών «Λαϊκό»**

Στην υπ' αριθμ. πρωτ. 7460/28.6.2006 απαντητική επιστολή του Νοσοκομείου προς την Αρχή, η οποία υπογράφεται από τον Υποδ/ντή Διοικητικού, κο. Κωφοτζούλη Π., και τον Πρόεδρο της Τριμελούς Επιτροπής Προστασίας του Πολίτη, κο. Αλεξίου Δημ., αναφέρονται μεταξύ άλλων τα εξής: «1) Στις 3/2/2005 προσήλθε στο εξωτερικό Παθολογικό ιατρείο της Α΄ Προπαιδευτικής Παθολογικής Κλινικής του Νοσοκομείου μας η ασθενής ..... , ετών 71, συνοδευόμενη από συγγενικό της πρόσωπο (κόρη της). 2) Οι ιατροί του Παθολογικού ιατρείου, Μαρίνου Κυρ., ειδικευόμενη, και Δάϊκος Γεώργιος, Επίκουρος Καθηγητής, αφού πήραν το ιστορικό της ασθενούς προχώρησαν σε εξετάσεις: Ηλεκτροκαρδιογράφημα, Γενική αίματος, Ταχύτητα Καθιζήσεως, Βιοχημικός έλεγχος, Ακτινογραφία Θώρακος σε όρθια θέση και U/S ήπατος χοληφόρων. Στη συνέχεια κρίθηκε αναγκαία η εισαγωγή της ασθενούς λόγω υποψίας στενώσεως ή διατρήσεως ή φλεγμονής από λήψη καυστικής ουσίας προ μηνός περίπου. Ετέθη Levain που απέδωσε 200cc γαστροπληγικό περιεχόμενο, αλλά αφαιρέθη αμέσως λόγω διέγερσης της ασθενούς. Ετέθη ορός 1000 cc N/S προς ενυδάτωση και χορηγήθηκε Losec. [...] Η εισαγωγή δεν πραγματοποιήθηκε επειδή η κόρη της υπέγραψε ότι δεν επιθυμεί την εισαγωγή της και ότι θα την μεταφέρει στο Ιατρικό Κέντρο, όπερ και έγινε. 3) Θεωρούμε, μετά τα παραπάνω, ότι η ασθενής αντιμετωπίστηκε ορθά και ως εκ τούτου δεν συντρέχει λόγος ένορκης διοικητικής εξέτασης.

Οι εξετάσεις της ασθενούς εδόθησαν στην κόρη της προς διευκόλυνση της επανεκτίμησης όπου θα πήγαιναν και να μην επιβαρυνθούν με νέες εξετάσεις. 4) Σας αποστέλλουμε αντίγραφο Μητρώου εξωτερικών ιατρείων».

Τα ανωτέρω στοιχεία που αναφέρονται στην επιστολή του Νοσοκομείου προς την Αρχή προκύπτουν από τα αναγραφόμενα στο βιβλίο Μητρώου εξωτερικών ιατρείων, δεδομένου ότι δεν τηρήθηκε και σε αυτή την περίπτωση ιατρικός φάκελος για την ασθενή, όπως προβλέπεται στις διατάξεις νόμου που προαναφέρθηκαν (Ν. 3418/2005, άρθρο 14 «Τήρηση ιατρικού αρχείου»).

#### **4) Σχετικά με το Υπουργείο Υγείας και Κοινωνικής Αλληλεγγύης**

Σύμφωνα με το άρθρο 4 του Κώδικα Διοικητικής Διαδικασίας (Ν. 2690/99) «Διεκπεραίωση υποθέσεων από τη Διοίκηση»: «1. α. Οι δημόσιες υπηρεσίες, οι οργανισμοί τοπικής αυτοδιοίκησης και τα νομικά πρόσωπα δημόσιου δικαίου, όταν υποβάλλονται αιτήσεις, οφείλουν να διεκπεραιώνουν τις υποθέσεις των ενδιαφερομένων και να αποφαίνονται για τα αιτήματά τους μέσα σε προθεσμία πενήντα (50) ημερών, εφόσον από ειδικές διατάξεις δεν προβλέπονται μικρότερες προθεσμίες. Η προθεσμία αρχίζει από την κατάθεση της αίτησης στην αρμόδια υπηρεσία και την υποβολή ή συγκέντρωση του συνόλου των απαιτούμενων δικαιολογητικών, πιστοποιητικών ή στοιχείων. Αν η αίτηση υποβληθεί σε αναρμόδια υπηρεσία, η υπηρεσία αυτή οφείλει, μέσα σε τρεις (3) ημέρες, να τη διαβιβάσει στην αρμόδια και να γνωστοποιήσει τούτο στον ενδιαφερόμενο. Στην περίπτωση αυτή η προθεσμία αρχίζει από τότε που περιήλθε η αίτηση στην αρμόδια υπηρεσία. Για υποθέσεις αρμοδιότητας περισσότερων υπηρεσιών, η προθεσμία του πρώτου εδαφίου παρατείνεται κατά δέκα (10), ακόμη, ημέρες. 2. Αν κάποια υπόθεση δεν μπορεί να διεκπεραιωθεί μέσα στην προθεσμία της προηγούμενης παραγράφου, η αρμόδια υπηρεσία οφείλει να γνωστοποιήσει εγγράφως στον ενδιαφερόμενο: α) τους λόγους της καθυστέρησης, β) τον υπάλληλο που έχει αναλάβει την υπόθεση και τον αριθμό τηλεφώνου του, για την παροχή πληροφοριών, γ) τα δικαιολογητικά που τυχόν λείπουν, καθώς και δ) κάθε άλλη χρήσιμη πληροφορία. [...] 5. Η υπηρεσία στην οποία υποβάλλεται η αίτηση χορηγεί στον ενδιαφερόμενο απόδειξη παραλαβής όπου περιλαμβάνονται ο οικείος αριθμός πρωτοκόλλου, η προθεσμία εντός της οποίας υφίσταται υποχρέωση προς διεκπεραίωση της υπόθεσης, καθώς και η επισήμανση ότι, σε περίπτωση υπέρβασης των χρονικών ορίων που καθορίζονται στις παραγράφους 1 και 2 του παρόντος άρθρου, παρέχεται δυνατότητα αποζημίωσης κατά τις ρυθμίσεις των παραγράφων 7 και 8 του άρθρου 5 του Ν. 1943/1991 (ΦΕΚ 50 Α')».

Η καταγγελία των ..... και ..... (τέκνων της .....) προς το Υπουργείο Υγείας & Κοινωνικής Αλληλεγγύης με αρ. πρωτ. 74815 και ημερομηνία παραλαβής 14/7/2005, διαβιβάστηκε από τη Διοίκηση στην Υπηρεσία σας (Σ.Ε.Υ.Υ.Π.) μετά πάροδο ενός έτους (αρ. πρωτ. 2337/12.7.2006). Επίσης, στην απόδειξη παραλαβής της καταγγελίας από το Υπουργείο Υγείας περιλαμβάνεται μεν ο αριθμός πρωτοκόλλου του εισερχομένου στην Υπηρεσία εγγράφου αλλά δεν αναγράφονται η προθεσμία εντός της οποίας υφίσταται υποχρέωση προς διεκπεραίωση της υπόθεσης, καθώς και η επισήμανση ότι, σε περίπτωση υπέρβασης των χρονικών ορίων παρέχεται δυνατότητα αποζημίωσης κατά τις ρυθμίσεις των παραγράφων 7 και 8 του άρθρου 5 του Ν. 1943/1991, όπως προβλέπουν οι προαναφερόμενες σχετικές διατάξεις νόμου.

#### **5) Σχετικά με τις πληροφορίες που εστάλησαν στην Αρχή από το Ελληνικό Κέντρο Δηλητηριάσεων**

Στο πληροφοριακό υλικό του Κέντρου Δηλητηριάσεων σχετικά με τα κλινικά συμπτώματα από την κατάποση καυστικών υγρών και τους τρόπους αντιμετώπισης αυτών των περιστατικών, αναφέρεται μεταξύ άλλων ότι η κατάποση υδροχλωρικού οξέος προκαλεί διαβρωτικά εγκαύματα στο γαστρεντερικό σύστημα. Τα συμπτώματα περιλαμβάνουν πόνο, ερεθισμό, ναυτία, καφεοειδείς εμέτους, αίσθημα δίψας, δυσκολία στην κατάποση, σιαλόρροια, πυρετό, ανησυχία, νεφρίτιδα, καθώς και εγκαύματα, εξέλκωση και διάτρηση του γαστρεντερικού συστήματος.

Επίσης, στους τρόπους αντιμετώπισης αναφέρεται η άμεση αναγκαιότητα για διάλυση του οξέος με κατάλληλα μέσα (π.χ. νερό ή γάλα) και η ενδοσκοπηση ως απαραίτητη διαδικασία το συντομότερο δυνατόν (ακόμη και μέσα στο πρώτο 24ωρο), εφόσον το επιτρέπει η κατάσταση της υγείας του ασθενούς. Αναφέρεται επίσης πως, δεδομένου ότι η κατάποση καυστικών υγρών μπορεί να προκαλέσει σοβαρές βλάβες στο γαστρεντερικό σύστημα χωρίς εντυπωσιακά αρχικά συμπτώματα, η ενδοσκοπική εκτίμηση συνιστάται σε κάθε ασθενή με ιστορικό κατάποσης ισχυρού οξέος ακόμα και εάν ήταν ασυμπτωματικός.

Στην περίπτωση της ....., δεν διενεργήθηκε ενδοσκοπική εξέταση σε καμία από τις νοσηλείες της στα τρία Νοσοκομεία, παρότι η ασθενής και οι συγγενείς της ανέφεραν επιμονή των δυσάρεστων συμπτωμάτων και επέμεναν για περαιτέρω έλεγχο της ασθενούς σε Παθολογικό και όχι σε Ψυχιατρικό Τμήμα Νοσοκομείου.

Τέλος, αξίζει να σημειωθεί ότι σε ενημερωτικό σημείωμα του ιατρού κ. Κοζαδίνου, Δ/ντή Χειρουργικής Κλινικής του Ομίλου Ιατρικού Αθηνών Π. Φαλήρου, αναφέρεται ότι: **«Η ασθενής ..... προσεκομίσθη στο Ιατρικό Αθηνών, Κλινική Π. Φαλήρου την 3/2/2005 μετά από έντονους γαστροπληγικούς και αιμορραγικούς εμέτους, επιγαστρικό φόρτο και διάχυτο κοιλιακό άλγος... Η ασθενής υπεβλήθη άμεσα σε κλινικό και εργαστηριακό έλεγχο όπου διαπιστώθηκε διάχυτη αιμορραγούσα βλενογονική βλάβη τόσο του οισοφάγου όσο και του στομάχου και εκτεταμένες εγκαυματικές βλάβες στο κάτω τριτημόριο του οισοφάγου και καθ' όλη την έκταση του στομάχου καθώς και πλήρης πυλωρική στένωση... Αποφασίστηκε η διενέργεια χειρουργικής επέμβασης, η οποία έλαβε χώρα την 10/2/2005. Κατά τη διάρκεια της χειρουργικής επέμβασης διαπιστώθηκαν βαριές βλάβες και έντονο οίδημα του βλεννογόνου του στομάχου του λεπτού και παχέος εντέρου (...). (Η ασθενής) κατέληξε την 28/2/2005 λόγω διάχυτης ενδαγγειακής πήξης και καρδιακής ανακοπής».**

Δηλαδή από τον εργαστηριακό έλεγχο που πραγματοποιήθηκε στο ιδιωτικό πλέον νοσοκομείο διαπιστώθηκε ότι η ασθενής ..... είχε υποστεί σοβαρές βλάβες στην υγεία της, λόγω της κατάποσης του υδροχλωρικού οξέος που στα ως άνω δημόσια νοσοκομεία δεν είχαν διαγνωσθεί με ενδοσκοπική εξέταση, ώστε να αποφασισθεί η τυχόν απαιτούμενη για την αποκατάσταση της υγείας της ειδική θεραπεία περιλαμβανομένης και της χειρουργικής επεμβάσεως.

## **V. ΣΥΜΠΕΡΑΣΜΑΤΑ**

Εκτιμώντας τα ανωτέρω στοιχεία που προέκυψαν κατά την έρευνα της υπόθεσης ο ΣτΠ καταλήγει στα εξής συμπεράσματα:

1) Στην αντιμετώπιση του περιστατικού της θανούσης ..... δεν εξαντλήθηκαν όλα τα πρόσφορα διαγνωστικά μέσα (π.χ. ενδοσκόπηση), ώστε να διαπιστωθούν έγκαιρα οι βλάβες και η έκταση αυτών που η ασθενής είχε υποστεί από την κατάποση υδροχλωρικού οξέος και να αντιμετωπιστούν καταλλήλως και εγκαίρως από τα νοσηλευτικά ιδρύματα ΝΙΜΤΣ και Ευαγγελισμός.

2) Κατά παράβαση του άρθ. 14 του Ν. 3418/2005, «*Τήρηση ιατρικού αρχείου*», δεν τηρήθηκε ιατρικός φάκελος για την ασθενή ..... ούτε στο Νοσοκομείο «Ευαγγελισμός» ούτε στο Νοσοκομείο «Λαϊκό». Ειδικότερα, τα στοιχεία σχετικά με την εξέταση της ασθενούς στα εξωτερικά ιατρεία του Νοσοκομείου «Λαϊκό» προκύπτουν από τα αναγραφόμενα στο βιβλίο Μητρώου εξωτερικών ιατρείων, δεδομένου ότι «*οι εξετάσεις της ασθενούς εδόθησαν στην κόρη της προς διευκόλυνση της επανεκτίμησης*». Σύμφωνα με το Ν. 1599/1986 «Περί Σχέσεων Κράτους – πολίτη» και τον Κώδικα Διοικητικής Διαδικασίας Ν. 2690/1999, προβλέπεται ότι για να λάβει ο ασθενής γνώση του ιατρικού φακέλου πρέπει να υποβάλλει γραπτή αίτηση. **Το δικαίωμά του ασκείται είτε με επί τόπου μελέτη είτε με χορήγηση αντιγράφου.**

3) Η ιατρική γνωμάτευση που εκδόθηκε στις 31/12/2004, ημερομηνία εξιτηρίου της ασθενούς από το ΝΙΜΤΣ, έχει υπογραφεί από ειδικευόμενη ιατρό της Γ' παθολογικής κλινικής, κ. Τατιάνα Ταταρίδου, και όχι από ειδικευμένο ιατρό. Η υποχρέωση του δημοσίου συστήματος υγείας να παρέχει κατάλληλη για την κατάσταση της υγείας του ασθενή φροντίδα δεν τηρήθηκε, αν ληφθεί υπόψη ότι ο ειδικευόμενος ιατρός είναι στο στάδιο της εκπαίδευσης (αρχικό ή προκεχωρημένο) χωρίς μάλιστα να έχει αξιολογηθεί οριστικά η ικανότητά του να ασκεί αυτόνομα την ιατρική.

4) Η υπ' αριθ. πρωτ. 74815/14.7.2005 καταγγελία των τέκνων της θανούσης ..... και ..... προς το Υπουργείο Υγείας & Κοινωνικής Αλληλεγγύης καθυστέρησε αδικαιολόγητα για ένα έτος να διαβιβαστεί στην αρμόδια υπηρεσία ελέγχου του Υπουργείου, και συγκεκριμένα στο ΣΕΥΥΠ, κατά παράβαση του άρθ. 4 του Κώδικα Διοικητικής Διαδικασίας (Ν. 2690/99). Προκαλεί ερωτηματικά πώς μια καταγγελία που αναφέρεται σε θάνατο ασθενή χάθηκε και χρειάστηκε να την κοινοποιήσει η Αρχή στο Υπουργείο. Επίσης, το Υπουργείο δεν ενημέρωσε νόμιμα τους πολίτες για τον χρόνο διεκπεραίωσης της καταγγελίας και για τη δυνατότητα αποζημίωσής τους σε περίπτωση υπέρβασης των χρονικών ορίων διεκπεραίωσης υποθέσεων από τη Διοίκηση, όπως προβλέπονται στις παραγράφους 1 και 2 του άρθ. 4 του Κώδικα Διοικητικής Διαδικασίας (Ν. 2690/99).

Κατόπιν τούτων παρακαλούμε να μας γνωρίσετε τις απόψεις σας και τις ενέργειες στις οποίες προτίθεστε να προβείτε

1. Όσον αφορά τη διερεύνηση της παράλειψης των ως άνω νοσοκομείων να προβούν στις κατάλληλες εξετάσεις (ενδοσκοπικό έλεγχο) για τη

διάγνωση της έκτασης της βλάβης της υγείας της ασθενούς από την κατάποση υδροχλωρικού οξέος.

2. Ως προς το αν η χειρουργική επέμβαση αποτελούσε ενδεδειγμένη για την κατάσταση της υγείας της ασθενούς θεραπεία, ενόψει μάλιστα της επιμονής των συμπτωμάτων που παρουσίαζε. Στην περίπτωση αυτή θα πρέπει να διερευνηθεί η ευθύνη των νοσοκομείων για τη μη έγκαιρη χορήγηση της ιατρικώς ενδεδειγμένης θεραπείας και η αιτιώδης συνάφεια του θανάτου με την παράλειψη διάγνωσης και κατάλληλης θεραπείας .
3. Παρακαλούμε για τις ενέργειες τις οποίες προτίθεστε να αναλάβετε όσον αφορά τα ζητήματα που ανακύπτουν ως προς τη λειτουργία των νοσοκομείων (τήρηση αρχείου, γνωμάτευση υπογεγραμμένη από ειδικευόμενο γιατρό, καθυστέρηση διαβίβασης του φακέλου και ενημέρωσης των πολιτών).

Παρακαλούμε να έχουμε το συντομότερο δυνατόν τις απόψεις σας ενόψει της καθυστέρησης που έχει ήδη σημειωθεί κατά την εξέταση της καταγγελίας που υπεβλήθη στο Υπουργείο.

Για κάθε περαιτέρω διευκρίνιση θα είμαστε στη διάθεσή σας.

Με εκτίμηση

Δ.Ν. Πατρίνα Παπαρρηγοπούλου

Κοινοποίηση:

- Σώμα Επιθεωρητών Υπηρεσιών Υγείας και Πρόνοιας  
Σ.Ε.Υ.Υ.Π.  
Πειραιώς 205  
118-53 Αθήνα
- Υπουργείο Υγείας και Κοινωνικής Αλληλεγγύης  
Γενικό Γραμματέα Πρόνοιας  
Γραφείο Συνεργασίας με τον Συνήγορο του Πολίτη  
Αριστοτέλους 19  
101 87 Αθήνα

Κυρία .....

.....

172 37 Υμηττός

Συνημμένα:

- 1) Επιστολές ΣτΠ (αρ. πρωτ. 5069/05/17.05.2005) με θέμα: *«Ενημέρωση σχετικά με τις συνθήκες νοσηλείας της αποθανούσης ..... και αποστολή ιατρικού φακέλου στον Συνήγορο του Πολίτη»* προς τους Διοικητές και των τριών εμπλεκόμενων νοσηλευτικών ιδρυμάτων, δηλαδή του Νοσηλευτικού Ιδρύματος Μετοχικού Ταμείου Στρατού (ΝΙΜΤΣ), του Γενικού Νοσοκομείου Αθηνών «Ο Ευαγγελισμός» και του Γενικού Νοσοκομείου Αθηνών «Λαϊκό».
- 2) Απαντητικές επιστολές των 3 εμπλεκόμενων νοσηλευτικών ιδρυμάτων, δηλαδή του Νοσηλευτικού Ιδρύματος Μετοχικού Ταμείου Στρατού (ΝΙΜΤΣ), του Γενικού Νοσοκομείου Αθηνών «Ο Ευαγγελισμός» και του Γενικού Νοσοκομείου Αθηνών «Λαϊκό».
- 3) Επιστολή ΣτΠ (αρ. πρωτ. 5069/05/14.10.2005) με θέμα: *«Παροχή πληροφοριών σχετικά με την αντιμετώπιση περιστατικών κατάποσης υδροχλωρικού οξέος»* προς τη Δ/ντρια του Ελληνικού Κέντρου Δηλητηριάσεων, κα. Βαλτή Ηλ.
- 4) Διαβιβαστικό έγγραφο του Ελληνικού Κέντρου Δηλητηριάσεων (αρ. πρωτ. 748/3.11.2005) και πληροφοριακό υλικό σχετικά με την αντιμετώπιση περιστατικών κατάποσης οξέων.
- 5) Ενημερωτικό σημείωμα Δ/ντή Χειρουργικής Κλινικής Ιατρικού Κέντρου Αθηνών, κ. Κοζαδίνου Ι.

## **ANNEX 7**

### **Excerpts from a report on a person with mental disorder who was refused treatment for tuberculosis in a general hospital**

This report is in my possession, but due to its personal nature, only a few excerpts will be included here to give an idea of the difficulties faced by the staff of the boarding house in their attempt to find a hospital bed for the resident (something which took a month, and resulted in admission of the resident to a psychiatric hospital).

“...η διευθύντρια της πνευμονολογικής του είπε ότι θέλουμε να ξεφορτωθούμε τον ένοικο. ...”

*“... the head of the chest clinic had told him that they wanted to get rid of the resident. ...”*

“...Η μόνη οδηγία, που παίρνουμε από το [...] είναι να μην βγούμε στα κανάλια ...”

*“... The only instruction we got from the [Authorities] was not to go to the television channels ...”*

“...Στις αλλεπάλληλες τηλεφωνικές συνδιαλέξεις με την κυρία [...], αντιλαμβάνομαι ότι όλοι έχουν συννενοηθεί στην [name of city] και στο υπουργείο για εισαγγελική κι εγκλεισμό στο Δαφνί. Η κυρία [...] αλλά κι ο αντιπρόεδρος του [...] με ενημερώνουν ότι θα χρειαστεί απομωνομένο δωμάτιο, κι αρνούνται την παροχή ασθενοφόρου ...”

*“... In my repeated telephone conversations with Mrs [...], I realized that everyone in [city] and the ministry had decided on compulsory admission to Dafni Psychiatric Hospital. Mrs [...] and the vice president of the*

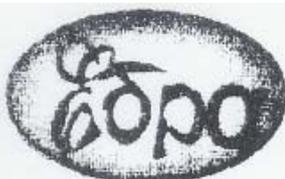
*[Authorities] informed me that he would need an isolated room, and they refused to provide an ambulance ...”*

“...η απάντηση από την κυρία [...], « κανείς δεν διαθέτει ασθενοφόρο για ένα άνθρωπο που δεν αξίζει, έχω άλλα περιστατικά που αξίζουν ασθενοφόρου» ...”

*“... Mrs [...]’s answer was “nobody has an ambulance for someone who doesn’t deserve one, I have other cases who are deserving ...”*

## ANNEX 8

### Complaint about the behaviour of a hospital doctor towards a person with mental illness and anaemia



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Περιστέρι 17/5/2007  
Αρ.πρωτοκ.:38

Προς ΥΥΚΑ  
ΥΠΟΨΗ :-ΥΠΟΥΡΓΟΥ Κου Αβραμόπουλου  
-υφυπουργού Κου Γιαννοπούλου  
-υφυπουργού Κου Κωνσταντόπουλου  
-ειδικής γραμματέως κας Μ. Τροχάνη

### ΔΙΑΜΑΡΤΥΡΙΑ

Κύριοι,  
βρίσκομαι στη δυσάρεστη θέση να σας καταγγείλω την ανάρμοστη συμπεριφορά ενός γιατρού επιμελητή Παθολογικού τμήματος του Α' Θεραπευτηρίου ΙΚΑ στο Νοσοκομείο Παπαδημητρίου (δεν ήθελε να δώσει το όνομά του) προς ένα ένοικο του οικοτροφείου μας και των συνοδών αυτού.  
Συγκεκριμένα σήμερα το πρωί και μετά τις οδηγίες της ειδικής παθολόγου με την οποία συνεργαζόμαστε καλέσαμε το ΕΚΑΒ για να διακομιστεί ένας ένοικος του οικοτροφείου ΣΤΠΠΟΚΡΑΤΗΣ Γ' που βρίσκεται στο Ίλιον σ' ένα εφημερεύον νοσοκομείο προκειμένου να εξεταστεί περαιτέρω ο ασθενής διότι είχε παρουσιάσει χαμηλό αιματοκρίτη (24) και θα μπορούσε να τεθεί σε κίνδυνο η ζωή του. Ο επιμελητής της Α' Παθολογικής αντέδρασε έντονα μόλις αντιλήφθη ότι ο ένοικος έπασχε από σχιζοφρένεια με αποτέλεσμα να δημιουργήσει σύγχυση και στον ένοικο αλλά και στους άλλους ασθενείς των εξωτερικών ιατρείων. Επιτέθηκε λεκτικά και στους υπαλλήλους του ΕΚΑΒ που δέχτηκαν να παραλάβουν τον συγκεκριμένο ασθενή και να τον μεταφέρουν στο εφημερεύον νοσοκομείο Παπαδημητρίου. Ωστόσο ο ένοικος είχε πολύ ήπια συμπεριφορά και δεν ήταν σε υποτροπή. Μάλιστα ανέφερε στους συνοδούς του νοίκου (που εργάζονται στο οικοτροφείο) ότι θα διαμαρτυρηθεί στο Υπουργείο για τη μεταφορά τέτοιων ασθενών στο Νοσοκομείο.  
Σχετικά με τα προαναφερθέντα θεωρώ ότι θα πρέπει να λάβετε γνώση του περιστατικού και να μεριμνήσετε με κάθε τρόπο για την αποφυγή τέτοιων καταστάσεων που θίγουν το ίδιο το ΥΥΚΑ και τη προσπάθειά σας για την εξυγίανση του Εθνικού Συστήματος Υγείας. Επίσης θα πρέπει επιτέλους να γίνουν κάποια βήματα για την άρση του κοινωνικού ρατσισμού και του στιγματισμού της ψυχικής νόσου. Η Υγεία αποτελεί αναφαίρετο δικαίωμα όλων των πολιτών.  
Με τιμή

  
Μαρία Κερασόγλου  
Πρόεδρος Δ.Σ. του Κ.Σ.Δ.Ε.Ο «ΕΔΡΑ»