The right to health : a human rights perspective with a case study on Greece

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6 Health Infrastructure

6.1. INTRODUCTION

Generally speaking, under international law States, as primary duty holders, are required to undertake a number of measures (i.e., involving legislative, administrative, policy and other measures) to the maximum extent of their available resources in order to realize the right to health of every individual within their jurisdiction (see Part I).[1] In practical terms, this implies, *inter alia*, that at the national level, States are obliged to adopt a detailed national health plan that is compatible with their right to health binding obligations. Thereto, States have an implicit positive obligation to take measures, *inter alia*, to adopt legislation on the provision of a comprehensive health care delivery towards ensuring the right to health of every individual in an effective manner within their jurisdiction. Notably, it is within this context that the ECtHR in its case law has interpreted this positive obligation as requiring of States to e.g. issue adequate health-care regulations that compel hospitals (public or private) to adopt appropriate measures for the protection of their patients' lives.[2]

Meanwhile, due to different health levels and needs among countries, most actions occur at the national level by way of adopting laws and policies to meet the right to health obligations imposed. As observed in Part I, over the years, there is a growing attention to health systems within the human rights system with respect to their dynamic for promoting population and individual health and realizing the

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1 See, e.g., Article 2(1) CRC: 'States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction…'; Ch.R. Beitz, *The Idea of Human Rights*, Oxford: Oxford University Press 2009, p. 114.

2 See, e.g., *Arskaya v. Ukraine* (Application no.45076/05) ECtHR 5 December 2013, §§ 62-63, 84 and 91; *Calvelli & Ciglio v. Italy* (Application no.32967/96) ECtHR 17 January 2002, § 49.

right to health of every individual (see Part I, section 4.2.3).[3] As such, State's attention to health systems can be a way to create favorable conditions that enable people to maintain and improve their health status as well as prevent health disparities and threats to individuals' health (see Part I, section 3.7). In the meantime, it is widely accepted that health care systems produce better health outcomes when priority is given to primary health care.[4] Elements of primary health care constitute an integral part of the core content of the right to health -albeit a controversial concept requiring due caution- and encompass a wide range of issues, more than health care services, such as health education (Part I, section 3.4). However, the role, the functioning and actual content of primary health care in a country is defined and determined by the prevailing specific national circumstances and particularities. At the same time it must be conceded that States are required to establish a primary health care system that is widely available, accessible, affordable, and of good quality, through the appropriate allocation of existing (even scarce) resources (Part I, sections 3.5 and 4.2.3).

Thus, building on the preceding analysis of Part I, we will examine Greece in relation to its compliance with a specific State obligation to provide health care in the context of implementing the right to health, enshrined in the Greek constitution as well as in international documents that are binding for Greece. This international obligation has set the stage for the adoption of national definitions that reflect their particular circumstances and starting points. Thereby, the aim of this chapter is to examine the parameters set around the aforementioned State obligation within Greek law-policy context through focusing on how the right to health features in the Greek National Health System (NHS). Notably, in terms of this objective, we will focus on the core of the National Health System in Greece (section 6.2) with attention on recent efforts to strengthen the functional framework of primary health care (section 6.3). Subsequently, we will define in section 6.4 to what extent the Greek NHS has integrated in its articulation and functioning

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[3] UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN ESCOR, Commission on Human Rights, 62nd Sess., Agenda Item 10*, UN Doc. E/CN.4/2006/48, 3 March 2006, § 4; See, also, Part I, Section 4.2.3.

[4] See, e.g., CSDH, *Closing the gap in a generation: Health equity through action on social determinants of health. Final Report of the Commission on Social Determinants of Health*, Geneva: World Health Organization 2008, p. 8; UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN HRC, 7th Sess., Agenda Item 3,* UN Doc. A/HRC/7/11, 31 January 2008, §§ 21, 55 and 90.

recognised components of the right to health (the so called 'AAAQ'). Finally, two challenges within the Greek NHS, namely privatization of the provision of health care and public health sector corruption, which signal dangers for the objectives of the right to health, will be addressed in section 6.5. At this stage, it is noteworthy that while acknowledging that the right to health also includes the underlying determinants of health, the analysis in this chapter will focus on 'health care', an important component of the right to health.[5]

6.2. THE NATIONAL HEALTH SYSTEM IN GREECE

6.2.1. SETTING THE SCENE

In 1983, the State's obligation under Article 21 § 3 of the Greek Constitution (see section 5.2.1) as well as under treaty law (e.g., Articles 2 § 1 and 12 ICESCR) was implicitly reflected in the establishment of the Greek National Health System (in Greek: Ethniko Systima Ygeias, ESY), which seemed on its face to be a progressive move towards health equity (see its section entitled 'general principles' - Article 1).[6] Generally speaking, in 1983 the structure and activities of the ESY were designed and planned under the general aim of optimum individual and population health in Greece (see below section 6.2.2), while no explicit references to international law and the Constitution were made within the text of the founding Law of ESY, Law 1397/1983.[7] Nevertheless, in recent years like other European countries, Greece was found to be struggling with the growing costs of its health system in terms of its hardly manageable fiscal problems, while at the same time trying (rather unsuccessfully) to maintain a social welfare State (see below section 6.4).[8] In fact,

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5 UN CESCR, General Comment No. 14: *The Right to the Highest Attainable Standard of Health*, UN Doc E/C.12/2000/4, 11 August 2000, § 11.

6 Of note, prior to the establishment of the ESY by Law 1397/1983, the Greek State under Compulsory Law 965/1937 'Organization of public hospital and sanitary institutions' made an effort towards organizing public care, namely the operation of public hospitals, within a common framework and creating public primary health care.; Note that ICESCR in Greece constitutes a supreme national law, namely Law 1532/1985 (see section 5.1 and Annex 2) and in this respect the CESCR has expressed its appreciation in its concluding observations for Greece regarding the prominent position of the ICESCR within Greek legal order (UN CESCR, CO: Greece, UN Doc. E/C.12/1/Add.97, 7 June 2004, § 4); See infra note 7.

7 Law 1397/1983, 'Establishment of the National Health System (ESY)', *Official Government Gazette* - ΦΕΚ issue A′ 143/07-10-1983; See also, E. Nolte & M. McKee, *Does Health Care Save Lives? Avoidable Mortality Revisited*, London: The Nuffield Trust 2004, pp. 9 and 79.

8 EPHA, *Reforming Health Systems in Times of Austerity -EPHA Position Paper*, Brussels: European Public Health Alliance (EPHA) Publications 2013, pp. 6-7.

WHO in a 2007 report revealed that health systems in many countries 'are on the point of collapse, or are accessible only to particular groups in the population'.[9] Meanwhile, as a way of background (i.e., as to obtain a more complete overview of the Greek State's health infrastructure) an introduction to the core of the ESY with emphasis on its primary care system and its various health reform initiatives will be provided in the below sections.

6.2.2. THE CORE OF THE ESY

As previously mentioned, the Constitution in Greece provided a roadmap for the enaction of relevant health legislation, most notably the establishment of the ESY in the country by Law 1397/1983. Indeed, Article 1 § 2 of Law 1397/1983 stresses that the Greek State has the full responsibility to provide health care equally to the population, irrespective of their financial, social and employment status through an integrated and decentralized national health system.[10] This provision does not recognize a right to health, but rather entails an obligation by using the term 'responsibility' on the part of the State combined with a consideration for the weaker members of the society, which altogether form the basis of the ESY. Moreover, ESY is organized around the main principle of universality in the distribution of health care, embedded in Law 1397/1983. This principle provides that every individual is entitled to access quality health care pursuant to his/her medical needs irrespective of income level or social status. All in all, in 1983 the design of ESY was initially geared towards the provision of comprehensive, equally distributed and good quality health care. Nonetheless, over the years Greece's national health system appears to be in a constant state of reform, as the Greek State seeks to control its hardly manageable and increasing health care costs. Here, it is important to stress that access to health care for certain groups of the population in Greece, such as undocumented migrants, is regulated by specific laws and not under Law 1397/1983 (see Part II, section 7.3). Meanwhile, five principal and interlinked aspects, partly reflecting some aspects of the right to health (see Part I, chapter 3 and section 4.2.3), constitute the core of the ESY and were introduced through the enaction of relevant laws (primarily under Law 1397/1983), as follows:

(i) *Decentralization* in the decision-making and in administrative processes, regulated under Law 1397/1983, Law 2889/2001 and Law 3329/2005. This process

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[9] WHO, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes,* Geneva: World Health Organization 2007, p. 1.

[10] Law 1397/1983, 'Establishment of the National Health System (ESY)', *Official Government Gazette* - ΦΕΚ issue Α′ 143/07-10-1983.

implies that a health system must be responsive to local health needs and accessible to all. As a consequence, the health infrastructure and the accessibility of the population to health care, an essential element of the right to health, can be strengthened. However, the ECSR in its report for Greece expressed its concern about the accessibility of health care facilities in remote and rural areas. Notably, the Committee addressed disparities in health and access to health care for rural and remote populations.[11] At the same time, another issue of concern is that decentralization of health care makes difficult to monitor procurement of medical equipment and of pharmaceuticals, which poses high risks for corruption within the ESY (see below section 6.5.2). Consequently, decentralization proves to be counter effective, as it is not accompanied by a national strategy to combat corruption at local levels.[12]

(ii) *Accountability,* regulated under Law 1397/1983 (administrative monitoring), Law 2071/1992 (administrative monitoring and patients' rights - redress mechanism), Law 2920/2001 (financial and institutional accountability) and Law 3293/2004 (institutional accountability). Such a regulatory framework within the context of health care requires all those involved in the provision of health care to be held accountable for the discharge of their right to health duties. Indeed, without accountability mechanisms, the right to health (care) may become meaningless or ineffective for right holders.[13] In this spirit, the Greek State in an effort to strengthen the accountability process established primarily two significant institutional monitoring structures that accompany the function of the ESY, namely the Greek Ombudsman for Health and Social Solidarity (in Greek: Synigoros Ygeias kai Koinonikis Allilegyis) and the Body of Inspectors for Health and Welfare Services (in Greek: Soma Epitheoriton Ypiresion Ygeias kai Pronoias, SEYYP - applicable also for monitoring the actions and decisions in the private health sector). Of note, their overall mandate is closely linked to the realization of the right to health (care) in that such accountability mechanisms and processes strengthen the justiciability of this right (see Part I, section 4.3). These mechanisms enable individuals to hold the Greek State and other actors within the health sector to account for possible failures to realise their right to health (care) obligations.

More specifically, the Greek Ombudsman for Health and Social Solidarity was established by Article 18 of Law 3293/2004 as an independent authority and has

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11 ESC, ECSR, Conclusions XIX-2 (2009) Greece, Council of Europe, January 2010.

12 European Commission, *Study on Corruption in the Healthcare Sector*, HOME/2011/ISEC/PR/047-A2, Luxembourg: Publications Office of the European Union 2013, p. 245.

13 E. Riedel, 'The Human Right to Health: Conceptual Foundations' in: A. Clapham & M. Robinson (ed.), *Realizing the Right to Health*, Zurich: Rüffer and Rub 2009, pp. 21-39, p. 33.

various measures at his/her disposal.[14] This quasi-judicial authority is responsible for investigating, at his/her own initiative and/or after the submission of a complaint, administrative actions or omissions by organs of public health services, insurance funds, welfare services, namely cases of violations against either an individual's right to health (care), especially as regards to vulnerable population groups (i.e. elderly, poor, persons with disabilities etc.) regardless of nationality; or the legal interests of individuals; or legal entities.[15] In addition, this authority is responsible for providing advice to the Greek Ministry of Health involving the improvement of the operational framework of health care services and the elimination of misallocation of resources and mismanagement in health sector.[16] Nonetheless, the Greek Ombudsman for Health and Social Solidarity can only investigate cases that are not pending before a judicial authority and only if the authority involved and the complainant have failed to resolve the matter together.[17]

As aforementioned, when it comes to national monitoring (accountability) mechanisms, another important regulatory body connected to the realization of the right to health (care) is the SEYYP. The main tasks assigned to SEYYP, under the auspices of the Greek Ministry of Health, are to supervise public and private healthcare sectors on the detection of offences; to identify problems in the

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[14] Law 3293/2004 'Polyclinic of Olympic village, Ombudsman and other provisions', *Official Government Gazette* – ΦΕΚ issue Α′ 231/26-11-2004; Notably, the Constitution of Greece in Article 101A generally provides for the establishment and operation of an independent authority and in Article 103 § 9 stipulates the role of the Ombudsman without further elucidating its duties. Accordingly, Article 103 § 9 provides that 'Law shall specify matters relating to the establishment and activities of the 'Ombudsman', who functions as an independent authority; See also, as regards the Greek Ombudsman founding Law 2477/1997, amended by Law 3094/2003 and PD 273/1999, *Official Government Gazette* – ΦΕΚ issue Α′ 229/03-11-1999 (regulations of the Greek Ombudsman). Note that the Greek Ombudsman is assisted in his duties by Deputy Ombudsmen in charge of the initially four corresponding departments (now six departments), among which the 'Social Protection, Health and Welfare' department established under Article 18 § 4 Law 3293/2004 <www.synigoros.gr>. The Greek Ombudsman and the Deputy Ombudsmen are selected by the Conference of Parliamentary Chairmen under Article 101A § 2 of the Constitution. Additionally, the Deputy Ombudsmen are appointed by the Minister of Interior on the recommendation also of the Greek Ombudsman. As regards the Ombudsman's authority, the Council of State in its 2274/2003 decision (§§ 16 and 18, 16/9/2003) has ruled that the actions and findings of the Ombudsman do not have executive character.

[15] Ibid.

[16] Ibid.

[17] Ibid.; Article 4(4) of Law 3094/2003, *Official Government Gazette* - ΦΕΚ issue Α′ 10/22-01-2003.

administration of health care providers and more generally in the delivery of health care; and to suggest solutions to the Greek Ministry of Health with a view to advancing public health in Greece.[18] In particular, based on its wide mandate it has three areas of work, from which the following forms of supervision can be discerned: 1) supervision of health care providers, namely overseeing the quality of health care services as well as of pharmaceuticals; 2) administrative and financial supervision of health care providers under the authority of the Greek Ministry of Health and 3) supervision of the functioning of welfare institutions, including nurseries, rehabilitation units and elderly care units etc.[19]

All in all, both authorities are generally concerned with promoting public health, improving the quality of health care as well as with strengthening transparency in the relationship between the various actors in the health sector, including ESY health personnel, hospitals, and the recipients of health care. The aforementioned institutions indicate that accountability, which is a core component of the right to health framework, is regarded to be central to enhancing the overall ESY functioning and is implicitly considered as a human rights concept in these institutional initiatives. Particularly, their operational framework refers to redress mechanisms - a critical part of accountability - for those who are victims of discrimination or face violations of the right to health in their engagement within or outside the ESY.[20] However, despite the legislative efforts to integrate a core human rights principle into policy, accountability within the ESY is extremely weak. Persistent corruption within the public health sector, a significant obstacle to the enjoyment of the right to health (see sections 3.7.2 and 6.5.2), constitutes a typical consequence thereof.[21]

(iii) *Integrated organizational framework of health care,* regulated under Law 1397/1983, PD 87/1986, Law 2889/2001 and Law 3329/2005. With main attention to enhancing timely access to quality health care, this framework, in principle, tends to contribute to the reduction of complexity in the procedures as well as to the promotion of participation, accountability and transparency into the design and

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[18] Law 2920/2001 'Creation of SEYYP', *Official Government Gazette* - ΦΕΚ issue Α΄ 131/27-06-2001, as supplemented and amended by: Law 2955/2001, *Official Government Gazette*- ΦΕΚ issue Α΄ 256/02-11-2001, Law 3204/2003, *Official Government Gazette* - ΦΕΚ issue Α΄ 296/23-12-2003, Law 3252/2004, *Official Government Gazette* - ΦΕΚ issue Α΄ 132/16-07-2004 and Presidential Decree (PD) 278/2002, *Official Government Gazette* – ΦΕΚ issue Α΄ 244/14-10-2002.

[19] Ibid., Article 3.

[20] Ibidem supra note 5, GC No. 14, § 59 (emphasis on legal accountability).

[21] Ibidem supra note 12, European Commission.

implementation of health-related policies towards exposing corruption.[22] However, in practice there is a partial implementation of the relevant provisions, which affects adversely the delivery of health care, as will be elaborated in below sections.

(iv) *Primary health care*, regulated under Articles 5 and 14-19 of Law 1397/1983, PD 87/1986, Law 3235/2004, Article 18 of Law 3918/2011 and Law 4238/2014. In principle, various legislative initiatives embraced primary health care over time that tended to draw on the principles of Alma-Ata Declaration.[23] Nevertheless, in practice the impact of these legislative initiatives was rather limited, as Greece failed to implement a comprehensive primary health care integrated with an adequate referral system to secondary and tertiary health care. As a result, this failure led to disproportionate funding in secondary and tertiary health care and hampered the availability of health care, especially in rural and remote areas.[24] As such, in February 2014, the Greek State introduced a reform on the prioritization of primary health care, as will be further elaborated in section 6.3.[25] Meanwhile, it is important to note that in addition to the state provision, primary health care is provided also by private actors under Article 13 of Law 2071/1992.[26] Of note, as an analysis of the functioning of primary health care in Greece is to be found in the subsequent section, it is not necessary to repeat it here.

(v) *Members of the medical profession (i.e., physicians, nurses, pharmacists etc.),* employed by the Greek State to work on a full-time and exclusive basis within the ESY (i.e., state-led hospitals and health centers) primarily under Law 1397/1983, Law 2071/1992 and Law 2889/2001. Here, it must be conceded that the members of the medical profession working in the national health system (ESY) are regarded as state officials due to their state employment status. In fact, in literature it is pointedly submitted that members of the medical profession who form part of the State (i.e., being state officials) are directly bound by human rights law.[27] Meanwhile, it must be also acknowledged that members of the medical

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22 See generally, A.D. Alexiadis, *The NHS at the beginning of 21st century. The Effort of Law 2889/2001*, Thessaloniki: Dimopoulou Publishing 2001.

23 Declaration of Alma Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6- 12 September 1978, § VIII.

24 ESC, ECSR, Conclusions XIX-2 (2009) Greece, Council of Europe, January 2010.

25 Law 4238/2014 on the establishment of a Primary National Health Network (PEDY).

26 Law 2071/1992, 'Modernization and Organization of the Health System', *Official Government Gazette* - ΦΕΚ issue A′ 123/15-07-1992; See section 6.5.1 with regard to the regulation of private health sector on the part of the Greek State by respective Presidential Decrees.

27 See, e.g., B. Toebes, 'Human rights and health sector corruption' in: J. Harrington & M. Stuttaford (ed.), *Global Health and Human Rights: Legal and Philosophical Perspectives*, London: Routledge 2010, pp. 102-134, p. 121.

profession, whether employed by the Greek State (i.e., state officials) or a private health actor (i.e., not directly bound by human rights law - see Part I, section 3.7.1), bear a legal/professional responsibility towards patients under an extensive body of national binding regulations, such as Law 3418/2005 (the Code for Health Deontology).[28] Such regulations strongly focus on the protection of patient's rights in the health care system, including the notion of informed consent and the legal/professional duty of confidentiality, as will be elaborated in section 6.4.2.4. All in all, the medical profession and its suitably trained members play a critical role in the realization of the right to health (care) in the context of guaranteeing the key principles of acceptability and quality of health care services arising from this right (see Part I, sections 3.5 and 4.2.3).[29] Indeed, given the pivotal role of the medical profession and its continuing shortage, the CRC Committee in its 2012 report has recommended Greece '… to strengthen its health infrastructure, including through the recruitment of additional nurses and social workers'.[30] Such concern has been reiterated by the CESCR in its 2015 report for Greece.[31]

From the above analysis, it becomes obvious that the core of the Greek National Health System (ESY) does not expressly engage with human rights concepts, as it was not designed in light of human rights law. Nevertheless, it implicitly builds on human rights standards through its functioning, which aims at obtaining a balance between the population needs and their actual conceptualization to the broader legal and policy context within which the ESY is situated. As observed, in principle several laws have highlighted the significance of the notions of 'participation' and 'accountability' (see Part I, section 3.5) towards enhancing the health system's performance without, though, systematic attention to these, especially with respect to the participation process. More specifically, the notion of 'participation' has been

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[28] Law 3418/2005 'Code of Health Deontology', *Official Government Gazette* - ΦΕΚ issue Α′ 287/28-11-2005; Along similar lines, the nursing personnel is bound by the 'Code of Nursing Deontology' under PD 216/2001, *Official Government Gazette*- ΦΕΚ issue Α′167/25-07-2001; See also, E.A. Alexiadou, *General Principles of Health Deontology*, Thessaloniki: University Studio Press 2012 (provides an elaboration of the legal/professional duties of a number of health professionals in Greece, including doctors, nurses, physiotherapists, dentists, pharmacists etc.).

[29] UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt. UN ESCOR, Commission on Human Rights, 59th Sess., Agenda Item 10*, UN Doc. E/CN.4/2003/58, 13 February 2003, § 95; For an elaborate analysis on the employment status of health professionals in Greece, see, A.D. Alexiadis 2001 (supra note 22).

[30] UN CRC Committee, CO: Greece, UN Doc. CRC/C/GRC/CO/2-3, 13 August 2012, § 53.

[31] UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 35 and 36(b).

set forth through the decentralization process, the integration process and the design of primary health care, however, without further engagement by the Greek State within policy context (see sections 8.3.3 and 8.3.4), primarily due to lack of law enforcement, resulting to the partial implementation of relevant laws. As regards the overall functioning of the health care system, the notion of 'participation' is also embedded in the doctor-patient relationship, namely within the context of health decision-making though the adoption of respective law provisions (see section 6.4.2.4). On the other hand, the notion of 'accountability', while not explicitly, is integrated in the organizational structure of the ESY and, particularly, is conceptualized primarily through two institutional authorities, as aforementioned. In addition, the respective law provisions draw attention to the importance of redress mechanisms accessible to all and of transparency in the functioning of the ESY. Transparency, although not being a human rights principle, is associated with accountability and participation in that it requires public officials, civil servants, managers and directors of organizations to act visibly and promote participation and accountability by reporting on their activities for which the general public can hold them to account.[32] To conclude, the preceding analysis makes also clear that the Greek State has tended to meet the 'obligation to protect' (Part I, section 3.3), namely to regulate the position and activities of the several actors in health care sector, which will be further elaborated in section 6.5.1 as regards the private actors. Last but not least, notions of accessibility, availability and quality (see Part I, section 3.5) underpinning the right to health are in principle primary objectives in the context of laws and policies regulating the ESY. Nevertheless, the analysis of the core of the ESY does not allow for exhaustive conclusions about the application of human rights standards within the ESY, namely whether their implications are duly considered by the Greek State in practice. For that reason, an assessment of the performance of the ESY with respect to its compliance with four essential principles arising from the right to health framework will be applied below (see section 6.4).

6.3. THE PROMINENCE OF PRIMARY HEALTH CARE WITHIN THE ESY

In general, state reform measures in health care provision continue to focus on seeking a balance between the general population's needs and the increasing

[32] See, Transparency International (TI), *Anti-Corruption Glossary,* available at <www.transparency.org/glossary/term/transparency> accessed 17 September 2015; Ibidem supra note 5, GC No. 14, § 55. The CESCR refers to transparency in terms of the formulation and implementation of national health strategies.

demand for health care. In the meantime, primary health care has been regarded to be the first and basic measure in the planning of an effective health system and the minimum level of state protection, irrespective of the state economic status (see Part I, section 3.4).[33] In Greece, primary health care was first established between the years 1983 and 1989, as part of the introduction of the Greek national health system (ESY). Law 1397/1983 constituted the institutional base of primary health care in the country. In fact, the Greek State aimed at introducing primary health care in line with the principles embedded in Alma-Ata Declaration (see Part I, section 2.2.3), reflecting the importance of primary health care, in that: 'Primary health care is essential health care … It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals … with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process'.[34] Therefore, the Greek State tended to design a primary health care infrastructure based on the principles of equity and participation, being delivered primarily through health centers, urban and rural, which would provide preventive care, palliative care and rehabilitation services. Instead, since 2014 health centers, which play a prominent role in the provision of primary health care in the country, were established only in rural and semi-urban areas, providing a restricted number of activities within health care process. At the same time, we should keep in mind for the purposes of our analysis that primary health care, as part of the ESY, coexists with private for-profit providers of primary health care under Law 2071/1992 (see also section 6.5.1).[35]

Meanwhile, in recent years it appears that there was a growing need for prioritization of primary health care within the ESY. In February 2014, the Greek State, under the financial pressure involved in providing universal health coverage and the increasing costs associated with secondary health care, placed greater emphasis on primary health care. Accordingly, a Primary National Health Network (PEDY) was established by Law 4238/2014.[36] Under this new system, each

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[33] UN CESCR, General Comment No. 3: *The Nature of State Parties' Obligations*, UN Doc. E/1991/23, 14 December 1990, § 10; UN, *The Realization of Economic, Social and Cultural Rights: Report of the Special Rapporteur, Danilo Türk, UN ESCOR, Commission on Human Rights, 43rd Sess., Agenda Item 8*, UN Doc. E/CN.4/Sub.2/1991/17, 18 July 1991, § 52(d).

[34] Declaration of Alma Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, § VI.

[35] Ibidem supra note 26.

[36] Law 4238/2014, *Official Government Gazette* – ΦΕΚ issue Α΄ 38/17-02-2014.

individual, regardless of his/her financial, social and insurance status, including uninsured persons, can equally receive primary health care, while no user fees will be charged until its structure and provided health care services will be fully developed and become operational.[37] Additionally, pursuant to Article 1 § 5 of Law 4238/2014 the provided health care within this new system includes, *inter alia,* prevention and immunization programmes, health promotion, primary mental health care, rehabilitation care, family planning, maternal and child care. At the same time, it seems that this list reflects several of the elements which are included in the list of minimum core obligations defined by the CESCR in its GC No. 14 on the right to health (see Part I, section 3.4).

However, this elaborate enumeration of the specific activities to be provided under the new primary health care system coupled with the five-year economic dysfunction and recession may undermine the potential for engagement by the Greek State, even with the best of intentions by the State. In fact, the CESCR in its 2015 concluding observations urged Greece to enhance the infrastructure of primary health care system.[38] All in all, at this primary stage, it is difficult to assess the new system's effectiveness and impact on the general population's health. Nevertheless, such an approach is not applicable to the general functioning of ESY, whose performance as well as key issues surrounding compliance with the right to health framework by the Greek State will be subsequently considered in section 6.4.

6.4. THE ESY IN RELATION TO THE 'AAAQ'

As a framework for measuring the compliance of Greece's ESY with the right to health, we will use GC No. 14 of the UN CESCR and, particularly, four interrelated and essential elements of the right to health, *Availability, Accessibility, Acceptability and Quality* (the so- called '*AAAQ*') (see Part I, section 3.5).[39] As such, these four principles which constitute the practical framework of the right to health will be applied in the following analysis and areas of concern and future steps will be highlighted. Before embarking on our analysis it must be noted that albeit the ESY was not designed in light of human rights law, it is nonetheless assessed whether this health system is in compliance with this human rights framework.

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[37] Ibid., Article 1 § 3; Greek Ministry of Health, Circular Y3/G.P./oik.23726/17-03-2014, § 2 on Implementation Process of Law 4238/2014 – 'Clarifications for the functioning of the Health Units of the PEDY'.

[38] UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 36(d).

[39] Ibidem supra note 5, GC No. 14, § 12.

In general, Greece spent 9.3 percent of its GDP on health care in 2012, equal to the OECD average and down from a high of 10 percent of GDP in 2009 as well as lower compared to other European countries, including Netherlands, France and Germany (all allocating to health over 11 percent of GDP). Notably, the decline of health expenditures is due to Greece's efforts to reduce the budgetary deficit pursuant to the European Commission's, the European Central Bank's and the International Monetary Fund's (collectively known as the Troika and/or the three Institutions, henceforth: the Troika) economic adjustment programme. As to health status, life expectancy at birth in Greece was at 80.7 years in 2012, almost a year higher than the OECD average (80.1). However, life expectancy in Greece remains lower than in several OECD countries (such as Switzerland, Italy, Spain, France, Iceland and Japan), where life expectancy exceeds 82 years.[40] The aforementioned indicators, which will be addressed below in detail, reflect in principle a national commitment to health (care) for every individual and for the population as a whole.

6.4.1. AVAILABILITY OF HEALTH CARE

With regard to *availability*, it has been indicated that sufficient functioning public health and health-care facilities, goods and services as well as programmes must be provided for the whole population given the State's development level (see Part I, section 3.5).[41] Generally, the ESY fulfills partially this requirement, as primary, secondary and tertiary health care is available through a number of general health facilities together, though, with several structural weaknesses.

Certain shortfalls have been detected during the years of the ESY functioning, especially during 2010-2015 years when Greece was hit by the economic crisis, which had an adverse impact on the availability of health care in Greece. Particularly, for specialized treatments, such as cancer treatments, there are long waiting lists within the ESY. These lists are created due to a restricted number of specialist health facilities coupled with a shortage of medical personnel and a lack of financial resources to make the system more effective. It is worth mentioning that there are solely four specialized oncology public hospitals, namely three oncology hospitals in Attiki (southern Greece) and one oncology hospital in Thessaloniki (northern Greece), providing their specialized health care to the general population in Greece.[42] Consequently, this restricted number of specialist

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[40] Organization for Economic Cooperation and Development, *OECD Health Statistics 2014*, Paris: OECD <www.oecd.org/health/healthdata>.

[41] Ibidem supra note 5, GC No.14, §12(a).

[42] See, Greek Ministry of Health, homepage <http://www.moh.gov.gr>; For instance, there are waiting lists for cancer treatment for about six-eight months.

health facilities mainly combined with the lack of medical personnel contributes to the creation of long waiting lists at the expense of the patients' well-being.

In fact, the situation with regard to the length of the waiting lists for hospital treatment has been exacerbated by the increasing demand for public health care, which in turn is caused by the inability of individuals to afford private health care since the emergence of the economic crisis in Greece. In fact, there was an increase in admissions to public hospitals of 24 percent in 2010 compared with 2009 and of 6 percent in 2011 compared with 2010.[43] Meanwhile, the length of the waiting lists, which are increasingly common, has led a number of people, who can afford to pay for their own care, to seek medical treatment either in the private health sector or abroad. For instance, the number of people in a waiting list for an orthopedics' operation was estimated over 2,000 at a public hospital in Athens (i.e. Tzaneio).[44]

Additionally, the availability of health care, including medical personnel and medical equipment, is crucial in rural and remote areas of Greece, which gives rise to the added problem of disparities in physical accessibility. Apparently, there is a lack of health care in rural and remote areas in Greece, due to the inexistence of competitive salaries for medical personnel and occasional shortages of medical equipment and medicines.[45] At the same time, an over-supply of doctors (working mainly in urban areas) coexists with an under-supply of nurses in Greece, resulting in an inefficient allocation of human resources. Particularly, the number of doctors

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[43] Greek Ministry of Health –Secretary General, *Report on Results of the Ministry of Health and of ESY Units 2011*, Athens: Dionikos publications 2012, p. 24.

[44] Analytical Support on Socio-Economic Impact of Social Protection Reforms (ASISP), *Annual National Report 2011: Pensions, Health Care and Long-term Care. Greece,* Brussels: European Commission, DG Employment, Social Affairs and Inclusion, May 2011, p. 18; See, also, 'Blocking in public hospitals: Waiting time up to 6 months for an examination' *Ethnos newspaper* (in greek) (14 April, 2014); For the management of waiting lists see, Council of Europe Committee of Ministers Recommendation No. R (99) 21 on criteria for the management of waiting lists and waiting times in health care, September 1999.

[45] I. Tsiligianni, F. Anastasiou, M. Antonopoulou et al, on behalf of the Cretan Practice based Primary Care Research Network 'G. Lambrakis', the Clinic of Social and Family Medicine, and School of Medicine, University of Crete. 'Greek rural GPs' opinions on how financial crisis influences health, quality of care and health equity' Letter to the Editor. *Rural Remote Health* 2013, 13: 2528; Greek Ministry of Health, *ESYnet, Functional Data of Hospitals*, November 2011; For instance, in February 2013 pharmaceutical companies have decreased supplies at hospitals and pharmacies due to unpaid bills and low profits, see, e.g., Sukkar E, Smith H. "Panic in Greek pharmacies as hundreds of medicines run short" *The Guardian* (27 February, 2013) <http://www.guardian.co.uk/world/2013/ feb/27/greece-blames-drug-companies-shortages>.

per capita increased up to 2008 and reached 6.2 physicians per 1000 population in 2011, nearly twice as much the OECD average of 3.2. On the other hand, there were only 3.3 nurses per 1000 population in 2009, a much lower figure than the OECD average of 8.8.[46] On this issue, the CRC Committee in its report has recommended Greece '… to strengthen its health infrastructure, including through the recruitment of additional nurses and social workers'.[47]

Meanwhile, at the Council of Europe (CoE) level, the European Committee of Social Rights (ECSR) set out in its 'conclusions' for Greece a number of health indicators, in order to evaluate the availability of health care in Greece and ultimately to measure Greece's compliance with its obligations under the right to health embedded, *inter alia*, in Article 11 of the European Social Charter (ESC) (see Part I, section 3.6).[48] More specifically, in Greece the average life expectancy at birth in 2011 was 78.5 for men and 83.1 for women. In 2011 life expectancy was close to the EU average, namely higher for men and equal for women, whereas EU average in 2004 was 75.2 for men and 81.5 for women. Generally, the mortality rate in 2011 was 98.3 per 10.00 inhabitants, while the EU average in 2011 was 111.2 per 10.00 inhabitants. Additionally, the infant mortality rate amounted in 2008 to 26.5 deaths per 10.00 live births and increased in 2011 to 33.5, while the EU rate in 2011 was 57.6 per 10.00. As such, the infant mortality rate despite its increase in 2011 still remained lower compared to the EU rate. With respect to the maternal mortality rate, the ECSR notes that it amounted to 3.76 deaths per 100.000 live births in 2011, which is one of the lowest rates in Europe. In fact, the EU rate was 8.42 per 100.000 live births in 2011.[49]

Additionally, as to the assessment of health care facilities, the average numbers of hospital and psychiatric beds were 591 and 600 per 100000 inhabitants in Europe for 2005 respectively.[50] In Greece, the numbers of hospital and psychiatric beds were 470 and 860 per 100000 inhabitants for 2005 respectively. Moreover, in Greece,

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46 Organization for Economic Cooperation and Development, *OECD Health Statistics 2014*, Paris: OECD <www.oecd.org/health/healthdata>.

47 Ibidem supra note 30, UN CRC Committee, § 53.

48 The ECSR examines states' reports and decides whether or not the situations (national law and practice) in the states concerned are in conformity with the European Social Charter (ESC) (Revised). Its decisions are known as 'conclusions'. ; European Social Charter, 18 October 1961, entered into force 26 February 1965, ETS 35; ESC, ECSR, Conclusions XIX-2 (2009) Greece, Council of Europe, January 2010; ESC, ECSR, Conclusions XX-2 (2013) Greece, Council of Europe, November 2014. Note that the ECSR uses as benchmark the average of all EU countries concerning the indicators applied in its 'conclusions' for Greece.

49 Ibid.

50 Ibid.

with regard to physicians, there were 56310 physicians, equating to 50 physicians per 10000 habitants. Pursuant to the aforementioned figures, the density of health care professionals is comparable to that observed in other European countries and the quantities of health care facilities are considered to be sufficient compared to the EU average. In fact, with respect to the resources spent on health care, the ECSR in its Conclusions enlisted Greece among the countries allocating the highest proportions to health care in Europe in 2006, namely 9.9 percent of GDP.[51] Moreover, with regard to the management of waiting lists for hospital treatment, the ECSR requested Greece to provide additional information on the regulation of access to health care, as there was an evident lack of such information from the part of Greek authorities.[52] At this point, it is noteworthy that the aforementioned health indicators, such as life expectancy, rates of mortality and waiting lists raise also matters of accessibility and quality of health care services (see section 6.4.3).

Nonetheless, mainly since 2010, the Greek Ministry of Health has implemented a number of severe austerity and structural health reform measures as a condition of its 2010 and 2012 loan agreements with the Troika: that public health expenditures must not exceed 6 percent of the GDP; and hospital costs are expected to be reduced by at least 10 percent in 2011 and by an additional 5 percent in 2012 in addition to the previous year.[53] As such, the Greek State faced dramatic reductions in health spending from 2010 onwards, namely four consecutive falls in per capita health spending (10.9 percent for 2009/10, 2.8 percent for 2010/11, 12.2 percent for 2011/12 and 2.5 percent for 2012/13).[54] To implement these stringent reductions, the reform measures taken by the Greek State include, *inter alia*, the merger of public health-care facilities (clinics) –hospitals, rehabilitation care units for persons with disabilities etc., the reduction of hospital budgets and of pharmaceutical expenses.[55] Accordingly, the number of medical institutions providing inpatient

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51 Ibid.

52 Ibid.

53 International Monetary Fund, *Greece: Letter of Intent, Memorandum of Economic and Financial Policies, and Technical Memorandum of Understanding*, International Monetary Fund, 8 December 2010; Law 3845/2010, *Official Government Gazette* - ΦΕΚ issue Α′ 65/06-05-2010; Law 4046/2012, *Official Government Gazette* - ΦΕΚ issue Α′ 28/14-02-2012; ESC, ECSR, Conclusions XX-2 (2013) Greece, Council of Europe, November 2014, p. 16; European Commission, *The Second Economic Adjustment Programme for Greece,* European Economy - occasional papers No.94, Brussels: European Commission March 2012, p. 63.

54 OECD, *Focus on Health Spending- OECD Health Statistics 2015*, July 2015, p. 4.

55 European Commission, *The Economic Adjustment Programme for Greece, Fourth Review - Spring 2011*. Brussels: European Commission, 2011; For more details on the merger of

health care was reduced from 138 in 2010 to 81 in 2011.[56] Additionally, since 2011 there has been an increasing concern at whether a number of prevention programmes for unsafe and illicit drug use, involving injecting drug users (IDUs), could effectively operate due to the on-going reduction of human and financial resources.[57] As a consequence, the number of new HIV infections among IDUs increased from 15 in 2009 to 484 in 2012[58], while tuberculosis among IDUs significantly rose from 5-12 in 2007-2012 (annual incidents) to 24 in 2013, namely doubled compared to past figures.[59] These figures identify an apparent inadequacy of targeted preventive programmes to deal with drug addictions, such as the availability of essential services, involving needle and syringe distribution programmes, distribution of condoms and opioid substitution treatment.[60] As such, there is an urgent need to strengthen preventive care and treatment through an effective allocation of and utilization of available human and financial resources, and a design of appropriate measures to address the health needs of this vulnerable population group on the part of the Greek State (see Part I, section 4.2).

In light of the above, the decrease in public health expenditures and hospital costs has, unavoidably, a direct impact on the level of fulfillment of the State's obligation to provide health care under the right to health and consequently raises great concern under the principle of 'availability' of health care services. As such, it can be maintained that the prevailing national policies (e.g. the lack prioritization

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public health facilities see Article 1 of Law 4025/2011, *Official Government Gazette*- ΦΕΚ issue Α′ 228/02-11-2011 – merger of rehabilitation care units- and Article 1 of Ministerial Decision Υ4α/ΟΙΚ. 122826*, Official Government Gazette* - ΦΕΚ issue Β′ 2674/09-11-2011; Law 4127/2013, *Official Government Gazette* - ΦΕΚ issue Α′ 50/28-02-2013 on hospital budgets, involving pharmaceutical expenses.

56 Ibid.

57 Greek Documentation and Monitoring Centre for Drugs (EKTEPN), *Annual Report on the State of the Problem of Drugs and Alcohol in Greece 2011*, Athens: Research University Institute on Mental Hygiene 2011, pp. 9 and 227; European Centre for Disease and Control, *Joint technical mission: HIV in Greece 28-29 May 2012*, Stockholm: ECDC 2013, p. 18; Such concerns are also expressed by the CESCR, while at the same time noting the increase in the number of HIV infections among injecting drug users, see UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 37.

58 European Centre for Disease Prevention and Control/ WHO Regional Office for Europe, *HIV/AIDS Surveillance in Europe 2012,* Stockholm: European Centre for Disease Prevention and Control 2013, p.29; Ibid., UN CESCR, § 37.

59 G. Spala, *Epidemiological Data for Tuberculosis in Greece*, Athens: Hellenic Centre for Disease Control and Prevention (KEELPNO) 2013.

60 Ibidem supra note 57, ECDC 2013, p. 19; Ibidem supra note 57, UN CESCR, UN Doc. E/C.12/GRC/CO/2, § 38.

of the most pressing health problems of vulnerable groups) implicate a violation of the obligation to secure availability of health facilities, goods, services and programmes pursuant to the right to health, if not justifiable by the Greek State on the basis of allocation of its available (limited) resources. This implies that the Greek State must demonstrate that it has endeavored to fulfil its right to health obligations in light of its available (limited) resources (see Part I, section 4.2).

6.4.2. ACCESSIBILITY OF HEALTH CARE

As observed in Part I (see section 3.5), accessibility encompasses four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability) and access to information, within which explicit reference is made to ensure access to vulnerable and marginalized sections of the population.[61]

6.4.2.1. Non-discrimination

The non-discrimination dimension in accessibility requires health facilities, goods and services be accessible to everyone without discrimination.[62] As such, the non-discrimination dimension is significant to ensuring that the health system is responsive to the needs of all its recipients. In Greece, vulnerable groups in principle have been given extra attention in the provision of health care.[63] Pursuant to Article 1 § 2 of Law 1397/1983, the Greek State is under the obligation to provide healthcare equally to all citizens, irrespective of their financial, social and employment status.[64] In addition, Law 3304/2005 highlights the right to equal treatment of every individual and prohibits any discrimination on the grounds of ethnic, national or racial origin, religious or other beliefs, disability, age or sexual orientation, which has the intention or effect of nullifying or impairing social protection, including access to health care.[65]

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[61] Ibidem supra note 5, GC No. 14, § 12(b).

[62] Ibidem supra note 5, GC No. 14, § 12(b).

[63] Vulnerability is shaped by many factors, such as age, dependency, lack of socio-economic resources, ethnic origin, social, economic or political marginalization, lack of legal status and is connected to the prospects of individuals for enjoyment of the right to health in this particular case (see Part I, section 4.2.3).

[64] Ibidem supra note 10, Law 1397/1983.

[65] Law 3304/2005 on the 'Implementation of the principle of equal treatment, irrespective of race, nationality, religious or other beliefs, disability, age or sexual orientation' has integrated at the national level the Council Directive 2000/43/EC of 29 June 2000 which refers to health care.

Pursuant to the respective law provisions, the distribution of health care cannot be based on discriminatory grounds, such as the ability of individuals to pay, social or national origin, which could have otherwise led to a denial of health care to certain groups of the population (see sections 7.3 and 8.3). In essence, the ESY cannot deny access to health care for any person in serious medical need such as uninsured people, homeless people who are unable to pay for their treatment. Such vulnerable groups mainly emerged as a result of the financial crisis in Greece. Meanwhile, increased irregular migration coupled with the rising and hardly manageable costs of health care has led the Greek State to adopt a law that restricts the accessibility of health care to a certain population group, namely undocumented migrants (see section 7.3.3). The respective Law, though, recognizes an exception to the extent of treatment as to undocumented migrant children and undocumented migrant pregnant women, albeit at a relatively abstract level (see sections 7.3.3 and 7.3.4).[66]

6.4.2.2. Physical accessibility

In addition to non-discrimination, the Greek State is also required to secure that health care is physically accessible for all sections of the population.[67] For that purpose, it is significant that primary health care is delivered through local health centers/mobile units in order to secure the accessibility for vulnerable groups from remote-rural areas, such as Roma children (see chapter 8). At the same time, especially in case of the population groups requiring special attention (e.g., persons with disabilities) adequate access to health facilities-buildings should be provided in light of this principle.[68] Admittedly, a critical concern is the existence of appropriate and upgraded infrastructure which will meet their needs and enable their access, such as provision of curb cuts (ramps), lifts etc. In this spirit, Greece introduced Law 3230/2004, which provides under Article 12 § 10 that public services are under the obligation to take all the necessary measures with a view to ensuring accessibility of persons with disability to public areas, including health facilities. By choosing to implement the above mentioned legislation, Greece has

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66 Article 84 of Law 3386/2005, *Official Government Gazette* - ΦΕΚ issue Α΄ 212/ 23-08-2005, replaced by Article 26(2)(a) of Law 4251/2014, *Official Government Gazette* - ΦΕΚ issue Α΄ 80/01-04-2014.

67 Ibidem supra note 5, GC No.14, § 12(b).

68 Ibid; Article 25(c) of the Convention on the Rights of Persons with Disabilities (CRPD), 30 March 2007, entered into force 3 May 2008, UN Doc. A/RES/61/106 (Note that here physical accessibility is considered within its actual meaning); See also Annex 2.

tended to take account of every individual's needs regarding the physical accessibility of public areas, such as public health facilities (public hospitals).[69]

Meanwhile, in the Conclusions of the ECSR for Greece, much attention is paid to the geographical distribution of health care, which is largely connected to the nature of the Greek geography (i.e. 80 percent of Greece is mountainous and 227 islands in the Aegean, Ionian and Mediterranean seas are inhabited). Given the size and geography of the country, the ECSR in its conclusions expressed its concern about the accessibility of health care facilities in remote, rural areas.[70] Particularly, in Greece there are significant disparities between urban and remote, rural areas in the provision of health care, including the geographical distribution of health personnel and health facilities. At the same time, these inequalities are often connected to inequalities in access to health care for less developed regions or persons belonging to racial/ethnic minority groups within the population, such as the Roma children. Consequently, this state practice may hamper the physical accessibility of health care and can lead to discrimination (even if not overtly) in access to health care, when considering the health status and health care needs, as previously indicated in section 6.4.2.1.

Another critical issue which constitutes a source for concern in light of physical accessibility is the merging of hospitals and rehabilitation care units, as earlier observed, in that patients are required to travel more than before for receiving the necessary care.[71] Note that, recently (2014), the Greek State introduced a new Law on developing a local network of services in order to facilitate access to primary health care, as observed earlier (see section 6.3).[72] Furthermore, with regard to the Roma children and their families, the Greek State established around 30 Centers (former Medico-Social Centers) in their organized settlements, providing preventive and basic health care, in order to cope with the significant disparities in physical access to health care (albeit a temporary measure whose future function is questionable) (see section 8.3.3).[73]

6.4.2.3. Economic accessibility

The issue of economic accessibility (affordability) is also of high importance, as

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[69] Notably, this requirement is also included in the CRPD, which Greece has ratified and incorporated by Law 4074/2012, *Official Government Gazette* - ΦΕΚ issue Α′ 88/11-04-2012.

[70] ESC, ECSR, Conclusions XIX-2 (2009) Greece, Council of Europe, January 2010.

[71] Ibidem supra note 55.

[72] Law 4238/2014, *Official Government Gazette* – ΦΕΚ issue Α′ 38/17-02-2014.

[73] Ibidem supra note 70, p. 11.

health care, including services and drugs, must be affordable to all.[74] This implies that health expenses should not burden excessively individuals, in that access to health care should not be dependent on an individual's ability to pay, but only on medical criteria (i.e., care necessitated by an individual's health condition).[75] In line with the aforementioned, under its founding Law 1397/1983, the ESY does not deny emergency treatment to people without health insurance or unable to pay user fees.[76] At the same time, no legislative provision provides clarity with regard to the vague concept of the term 'emergency' and, thereby, health professionals are left to decide on this issue, namely on a case-by-case basis.[77]

Notably, in September 2013 a health voucher programme financed from European Union structural funds came into effect to cover 230,000 individuals without health insurance for 2013–2014.[78] More specifically, this temporary programme was addressed to individuals who had lost their access to health care due to their unemployment and economic status. The health voucher was used for up to three visits by covering a predetermined package of primary care services during an eight month period and prenatal examinations for pregnant women during a four month period. A critical concern was that this programme offered a narrow basic health care package for a certain period of time and it did not apply to additional health care coverage, as a result patients with more medical needs, such as patients with chronic diseases, pregnant women (need to have access to pre- and post-natal care), were refused in practice added coverage. In essence, this state practice was particularly detrimental to uninsured people with chronic diseases who need supplementary health care and, consequently, it affected the affordability of health care for those persons.

Subsequently, given the serious and extensive consequences of the economic recession on many segments of the population in 2014 the Greek State issued two decisions for cost-free access to hospital and pharmaceutical care for individuals

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74 Ibidem supra note 5, GC No. 14, § 12(b).

75 Ibid.; UN CESCR, *Guidelines on Treaty-Specific Documents to be submitted by the States Parties under Articles 16 and 17 of the International Covenant on Economic, Social and Cultural Rights*, UN Doc. E/C.12/2008/2, 24 March 2009, Annex, § 56(b) and 57(f); See also, Article 13(1) (Revised) ESC.

76 Ibidem supra note 10, Article 1(2).

77 For a definition of the term 'emergency' within Greek case law, see, *inter alia*: Council of State Decisions 632/1999, 866/1997, 5421/1995 and Administrative Court of Athens Decision 4494/2002. Pursuant to the aforementioned court decisions, emergency is defined as a life threatening situation.

78 Greek Ministry of Health, *Health Voucher Programme*, Ministry of Health 2013. <http://www.healthvoucher.gr> (in Greek).

and their family members who have lost their insurance coverage and can no longer afford such coverage. Nonetheless, this measure provides for a complex supervisory procedure -exercised by a number of public authorities at different levels- without covering outpatient laboratory tests, as a result it is difficult to foresee the extent to which individuals can ultimately gain access to such care.[79]

In essence, the ESY cannot be considered economically accessible due to the state practice to require user fees for the provision of publicly funded (mainly funded by the tax system) health care, even before the crisis in 2010.[80] In 2011, though, there was an increase of such user fees and co-payments, i.e., from 3€ to 5€ with regard to regular outpatient visits in ESY (with some exceptions for vulnerable groups, such as patients with chronic diseases, persons with disabilities etc., and for emergency treatment) and in 2014 around 15% and more rise as to the co-payments by the insured for certain medicines.[81] Furthermore, in January 2014 a new user fee per prescription, namely 1€ per prescription, was introduced with some exceptions for vulnerable groups, such as patients with chronic diseases, regulated by respective decisions of the Greek Minister of Health.[82] Moreover, an additional user fee of 25€, namely for inpatient admission to public hospitals, was established to be in effect from January 2014, but the respective legislative provision was never implemented and was ultimately withdrawn due to excessive pressure exerted from the Greek parliament (i.e. the majority of political parties), prominent medical associations and from society in general.[83]

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79 Joint Ministerial Decision Y4a/GP/oik.48985/2014 'Defining the Conditions, Criteria and Process of Access to Health Care for the Uninsured and Financially Weak people', *Official Governnment Gazette*- ΦΕΚ issue Β΄ 1465/05-06-2014; Joint Ministerial Decision G.P./oik56432/28-06-2014, 'Defining the Conditions, Criteria and Process concerning Access to Pharmaceutical Care for Uninsured and Financially Weak People', *Official Governnment Gazette*- ΦΕΚ issue Β΄ 1753/28-06-2014.

80 Joint Ministerial Decisions: A3g/oik./7829/F.15, *Official Governnment Gazette*- ΦΕΚ issue Β΄ 514/11-07-1991(introduction of user fees for outpatient services in public hospitals) and Y3a/G.P.oik.88618, *Official Governnment Gazette*- ΦΕΚ issue Β΄ 1223/20-09-2002 (introduction of user fees for health services provided in health centers).

81 As to the exceptions introduced see, Circular of the Greek Ministry of Health, Y4a/oik.1329/04-01-2011; As to the high prices in medicines see, Ministerial Decision, oik.38733/29-04-2014, *Official Governnment Gazette*- ΦΕΚ issue Β΄ 1144/06-05-2014; Ibidem supra note 55, European Commission 2011; Of note, the 5 € user fee for outpatient visits in ESY was abolished in April 2015 by a Joint Ministerial Decision, A3(g)/GP/oik.23754, *Official Governnment Gazette*- ΦΕΚ issue Β΄ 490/01-04-2015.

82 Article 1(IB.2) (12) of Law 4093/2012, *Official Governnment Gazette*- ΦΕΚ issue Α΄ 222/12-11-2012; Greek Ministry of Health, Circular 863/07-01-2014.

83 Ibid.; See, e.g., 'Strong reactions regarding the 25€ user fee for hospitals' skai.gr news desk

All in all, it must be conceded that the aforementioned measures which mainly came into effect since 2010 have shifted the cost for health care to patients and, thereby, have created economic barriers in access to the national health system in Greece for several segments of the population. As a result, there is a risk that the poorer segments of the society will forgo from seeking medical treatment due to the high user fees in health care delivery.[84] It is notable that the cost of health care in Greece places an excessive financial burden on individuals, especially on poorer households, as access to health care is eventually not based on medical need, but rather on the ability to pay. Indeed, when looking from the perspective of the human rights principle of economic accessibility, the Greek health system cannot be said to promote the effective enjoyment of the right to health (care), as access to this system is beyond the financial means of the majority of the general population. It is on this basis that the CRC Committee in its concluding observations for Greece underlined that 'the right to health and access to health services are not respected for all children'.[85] In fact, the Committee voiced its concern as to the economic accessibility of health care services especially for vulnerable groups of children, such as Roma children, migrant, asylum-seeking and unaccompanied children.[86]

Thereto, in order to comply with its obligation to secure economic accessibility under the right to health, the Greek State must take concrete measures to reduce the excessive financial burden (i.e. to adopt low-cost targeted programmes) on patients belonging to the most vulnerable and socially disadvantaged sections of the population, such as low-income individuals, patients with chronic diseases, children, and women, and ensure that health care remains affordable.[87] To this aim, the cost of health care (i.e. the co-payments) should be borne, at least in part, by the population as a whole with special attention to vulnerable groups, in order medical protection not to become too expensive, affecting equal accessibility to health care.[88]

(02-01-2014) available at <www.skai.gr/news/health/article/2490897/edones-adidraseis-gia-to-eisitirio-ton-25-euro-sta-nosokomeia>

84 UN, *The Realization of Economic, Social and Cultural Rights: Report of the Special Rapporteur, Danilo Türk, UN ESCOR, Commission on Human Rights, 44th Sess., Agenda Item 8*, UN Doc E/CN.4/Sub.2/1992/16, 3 July 1992, § 102.

85 Ibidem supra note 30, UN CRC Committee 2012, § 52.

86 Ibid.

87 See, also, The right to health and the European Social Charter, Information document prepared by the secretariat of the ESC, March 2009, pp. 9-10; Ibidem supra note 33, GC No. 3, § 12.

88 Ibid.; See, e.g., Ibidem supra note 33, UN Doc. E/CN.4/Sub.2/1991/17, § 52(c); Recommendation 1626 (2003) of the Parliamentary Assembly of the Council of Europe on 'the reform of health care systems in Europe: reconciling equity, quality and efficiency', § 5.

6.4.2.4. Access to information

Accessibility also includes the right to seek, receive and impart information on health issues, however not at the expense of the right to privacy which requires confidentiality in all health-related matters.[89] This implies that individuals have a right to be informed about health issues as well as in terms of prevention, treatment and control of epidemic, endemic and other diseases. States are consequently required to design and adopt prevention and education health-related programmes.[90] Generally speaking, information accessibility is almost adequate in Greece, as will be subsequently analysed.[91] Importantly, Article 3 § 2(c) of Law 2519/1997 provides that the public health services under the auspices of the Greek Ministry of Health are responsible for the design and implementation of health education programmes in collaboration with local authorities.[92] Such programmes involve, *inter alia*, the distribution of information material to schools, local communities and at high risk groups and aim to promote health education and raise awareness in society about health-related issues, such as voluntary blood donation, the advantages of breastfeeding, children vaccinations, oral health, diabetes mellitus and smoking, in which knowledge and education must be provided to the general population.

Another critical issue of information accessibility is that the State has an obligation to provide adequate information regarding situations that may endanger general population's health, such as in case of an infectious disease. In 1992, Greece introduced the Hellenic Centre for Disease Control and Prevention (HCDCP-abbreviated in Greek as KEELPNO, former KEEL) under the auspices of the Greek Ministry of Health. Particularly, KEELPNO is responsible for the prevention and control of infectious and chronic diseases through collecting and providing data (Article 26 of Law 2071/1992, PD 358/1992 and Article 20 of Law 3370/2005).[93] Additionally, under respective law provisions KEELPNO has an obligation to

[89] Ibidem supra note 5, GC No. 14, § 12(b).

[90] Ibidem supra note 5, GC No. 14, § 16.

[91] See, ESC, ECSR, Conclusions XX-2 (2013) Greece, Council of Europe, November 2014, p. 16.

[92] Law 2519/1997, 'Development and modernization of the National Health System, organization of the public health services and other provisions', *Official Government Gazette* - ΦΕΚ issue Α΄165/21-08-1997.

[93] Ibidem supra note 26, Law 2071/1992 and Law 3370/2005 'Organization and Functioning of Public Health Services and other provisions' – reorganization of the Hellenic Centre for Infectious Diseases Control- *Official Government Gazette* - ΦΕΚ issue Α΄ 176/11-07-2005. The function and the responsibilities of the organization were regulated by the PD 358/1992, *Official Government Gazette* - ΦΕΚ issue Α΄179/24-11-1992.

organize and implement information campaigns related to Sexually Transmitted Diseases and AIDS as well as to inform the population about several other health issues, including public health promotion and protection, disease prevention, environmental health threats, epidemics etc.[94] Notwithstanding the above, there are striking examples of existing failures in the implementation of the law regulating various features of access to health information. For instance, the CESCR in its 2015 report noted with concern the increase in the number of HIV infections in Greece linked to the need for enhancement of the national preventive strategy, involving awareness-raising activities, and for the provision of adequate funding for such activities.[95] Such observations demonstrate an implementation gap between law and everyday practice on the part of the Greek State concerning the formulation and implementation of comprehensive information raising activities.

Meanwhile, in addition to the promotion of health education and information campaigns, patients are also entitled to get informed about their health status and possible medical treatments by health professionals, while at the same time medical confidentiality is required to be safeguarded. In fact, Article 47 of Law 2071/1992 generally provides for the protection of hospital patients' rights.[96] Accordingly, Article 47 §§ 4 and 5 emphasizes, *inter alia*, that patients (or their legal representatives) have the right to request information concerning their medical situation, which should be comprehensive in order to obtain a complete picture of the medical, social and financial parameters of the proposed treatment plan and participate in the decision-making process.

Likewise, it should be stressed that the Greek State has issued a Law on medical ethics, Law 3418/2005.[97] When it comes to medical interventions, Article 11 of Law 3418/2005 underlines the physician's legal/professional duty to inform the patient about his/her medical condition; the involved health risks; the effectiveness of the proposed treatment plan; and alternative options of treatment in order to take well-informed decisions.[98] In fact, this obligation had been already

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[94] Ibid.; Article 20 of Law 2889/2001 'Improvement and Modernization of the National Health System and other provisions', *Official Government Gazette* - ΦΕΚ issue Α′ 37/02-03-2001 – Prevention of biological and toxic threats- and Article 44 of Law 3204/2003, *Official Government Gazette* - ΦΕΚ issue Α′ 296/23-12-2003 – Data Collection on infectious diseases and Intervention with mobile units for the promotion and protection of public health.

[95] Ibidem supra note 57, UN CESCR, UN Doc. E/C.12/GRC/CO/2, § 38.

[96] Ibidem supra note 26.

[97] It is noteworthy that Law 3418/2005 amended the 1955 Regulation on Medical Deontology and that the 1939 Code on the practice of Medicine remains valid.

[98] Law 3418/2005 'Code of Medical Deontology', *Official Government Gazette* - ΦΕΚ issue Α′ 287/28-11-2005.

established by Law 2619/1998 (Article 5), by which the Biomedicine Convention was incorporated at the national level. Meanwhile, the application of a medical treatment without the prior information of the patient and, thereby, informed consent of the patient (the patient's authorization/ agreement concerning a specific medical treatment) was found by a Greek court to be arbitrary and unlawful, even though the applied treatment was found to be in accordance with the rules of medicine.[99]

6.4.3. ACCEPTABILITY AND QUALITY OF HEALTH CARE

With respect to *acceptability*, it has been underpinned that all health facilities, good and services must be, *inter alia*, respectful of medical ethics and culturally appropriate in addition to gender and life-cycle sensitivity, as well as being designed to respect and protect confidentiality, and improve the health status of those served (Part I, section 3.5).[100] In terms of acceptability, Greece has a long history of requiring its health professionals to adhere to minimum ethical/professional guidelines, involving being respectful of the culture of individuals, minorities and communities. This implies that the varying cultural backgrounds of patients may have to be respected, such as the refusal of a blood transfusion by Jehovah's witnesses, the use of alternative forms of treatment, traditional preventive care, healing practices and medicines by indigenous people.[101] In this regard, the ECtHR has acknowledged that 'the freedom to accept or refuse specific medical treatment, or to select an alternative form of treatment, is vital to the principles of self-determination and personal autonomy. A competent adult patient is free to decide, for instance, whether or not to undergo surgery or treatment or, by the same token, to have a blood transfusion. For this freedom to be meaningful, patients must have the right to make choices that accord with their own views and values, regardless how irrational, unwise or imprudent such choices may appear to others'.[102] The Court, though, further noted that only in case of an indication regarding the need to protect third parties (e.g., mandatory vaccination during an epidemic to prevent the spread of contagious diseases) interference with this freedom is justified.[103]

Meanwhile, primarily under the Code of Health Deontology, Law 3418/2005, the medical profession in Greece is legally bound to serve every individual without

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99 Court of Appeal of Athens 5512/2003, *EllDik* 2004, 45, pp. 197-198 (also available: <www.lawdb. intrasoftnet.com>.

100 Ibidem supra note 5, GC No. 14, § 12 (c).

101 Ibid., § 27

102 *Jehovah's Witnesses of Moscow and others v. Russia* (Application no. 302/02), ECtHR 10 June 2010, § 136.

103 Ibid.

discrimination and meet appropriate standards of skills and (ethical) codes of conduct.[104] Although there might be incidents of individual practitioners who may violate these legal/professional requirements (see section 6.5.2), the vast majority of medical profession upholds high ethical standards and is committed to abstain from unethical and unprofessional behavior. The relationship between a patient and a doctor is critical for the effective health care provision and, thereby, it requires a certain level of trust and communication. Accordingly, Article 47 § 7 of Law 2071/1992, which provides for the protection of hospital patients' rights, stresses that religious beliefs of patients should be respected by the physicians, such as the beliefs of Jehovah's witnesses.[105] Similarly, the nursing personnel is legally bound to care for every individual without discrimination of any kind, regardless of race, national or social origin, religious beliefs or other status, under the Code of Nursing Deontology, PD 216/2001.[106]

Nonetheless, particular concern arose in Greece regarding the medical treatment of migrants, especially undocumented migrants, and the enforcement of a discriminatory practice under Article 54 § 2 of Law 2910/2001.[107] Article 54 § 2 of Law 2910/2001 provided that persons, working, *inter alia,* in the health care sector, were required, under the threat of sanctions, to report the presence of any undocumented migrant, encountered in the course of their work, to police authorities or to immigration officials. However, such a provision justified actions that not only undermined the right of every individual to health (care), but also threatened the medical professionalism of health care providers due to the processing of sensitive personal data without the individual's explicit consent. In particular, the disclosure of information was found to be in conflict with an individual's right to health as well as to constitute an infringement of a patient's right to privacy and of the health professional's duty to medical confidentiality under Law 3418/2005.[108]

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104 Law 3418/2005 'Code of Health Deontology', *Official Government Gazette* - ΦΕΚ issue Α′ 287/28-11-2005.

105 Ibidem supra note 26.

106 PD 216/2001 'Code of Nursing Deontology', *Official Government Gazette*- ΦΕΚ issue Α′ 167/25-07-2001.

107 Law 2910/2001 on 'Entry and Stay of Foreigners in the Greek territory. Possession of Greek Citizenship and other Provisions', *Official Government Gazette* – ΦΕΚ issue Α′ 91/ 02-05-2001. Article 51 § 1 of Law 2910/2001 granted equal access to social protection and social security as nationals only to migrants with legal presence in Greece.

108 Law 3418/2005 'Code of Health Deontology', *Official Government Gazette*- ΦΕΚ issue Α′ 287/28-11-2005; See also, Advisory no. 86/2001 of the Hellenic Data Protection Authority (HDPA), 19 June 2001, § 7. <http://www.dpa.gr> (last accessed 10 November 2013)

At the same time, such a provision was certainly in conflict with the letter of Article 5 § 5 of the Constitution (see section 5.2.1). Importantly, this provision was not employed for serving a public health aim -as in the case of reporting certain contagious diseases- but for achieving a criminal immigration goal. As such, the tool of reporting served to counteract irregular migration. As a result, this legislative provision -disclosure of personal data- deterred undocumented migrants from seeking medical treatment for themselves or for their family members even in serious cases. In fact, they were afraid of being reported and apprehended while accessing health care, with adverse effects on their health and well-being.[109] Nevertheless, in 2005 the respective law provision was abolished by Law 3386/2005 given the concern about the effective enjoyment of the right to health (care) of every individual and about the processing of sensitive data without the individual's explicit consent for purposes other than medical care.[110] Such a situation clearly demonstrates that the Greek State should systematically review and abandon laws and/or policies that negatively affect the 'acceptability' of health care and raise issues of concern in light of this principle.

All in all, confidentiality is a significant principle within health care settings and is of high importance especially in relation to HIV testing, as a potential breach of confidentiality might deter individuals, including in this particular case undocumented migrants, from seeking HIV testing. The ECtHR in its case law has repeatedly expressed concern about the disclosure of medical data and has paid particular attention to the significance of confidentiality of medical data. Accordingly, the Court has stressed that 'the protection of personal data, in particular medical data, is of fundamental importance to a person's enjoyment of his or her right to respect for private and family life as guaranteed by Article 8 of the Convention. Respecting the confidentiality of health data is a vital principle in the legal systems of all the Contracting Parties to the Convention. It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general.'[111] The Court also acknowledged

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[109] Advisory no. 86/2001 of the Hellenic Data Protection Authority (HDPA), 19 June 2001, § 6.

[110] Ibid., Advisory no. 86/2001 of HDPA, §§ 5 & 7-8.; Directive 95/46/EC of the European Parliament and the Council of 24 October 1995 'on the protection of individuals with regard to the processing of personal data and on the free movement of such data'; Ibidem supra note 66, Law 3386/2005 on 'Entry, Residence and Social Integration of Third□Country Nationals in the Greek Territory'. The requirement to report, placed on public officials, was repealed by Law 3386/2005, Article 87(2).

[111] *Z. v. Finland* (Application no. 22009/93), ECtHR 25 February 1997, § 95; See, *inter alia*,

that without such protection, those in need of medical assistance may be deterred from seeking such assistance, thereby endangering not only their own health and but also, in the case of transmissible diseases, the health of the society.[112]

Finally, *quality* is another significant factor in the delivery of health care. It requires that health care is scientifically and medically appropriate and of a good standard. The requirement of quality also extends to the manner in which people are treated by the medical staff and as such cultural acceptability, as earlier elaborated, is an essential element of the quality standard.[113] On the basis of the professional/legal code -Codes of Health and Nursing Deontology (Law 3418/2005 and PD 216/2001, respectively)- the medical profession has legally committed itself to providing good quality health care (see section 6.2.2., *'(v) Members of the Medical Profession'*). Additionally, as mentioned previously, in the context of the CoE, the ECSR has paid attention in its 'conclusions' for Greece to indicators, such as life expectancy, rates of mortality and waiting lists which also raise matters of quality of health care and can serve as indicators of a well-functioning healthcare system in a given country.[114] Accordingly, the health status of the population in Greece was at a relatively good rate until 2008 which may reflect the State's commitment to quality health care. However, a resurgence of infant mortality rates was reported concerning the consecutive years 2009, 2010 and 2011.[115] Such an increase may indicate a decline of the quality of health care related to the Troika's structural adjustment programme (i.e. implementation of a number of austerity measures in the area of health) based on which the Greek State is obliged to restrict public health expenditure. Such disturbing figures in relation to infant mortality rates, which constitute also matter of availability of health care services (see section 6.4.1) raise concern about the availability and quality of pre-natal health care services for pregnant women under the 'AAAQ'. At the same time it must be conceded that infant mortality rates can be affected not only by barriers in access

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L.L. v. France (Application no. 7508/02), ECtHR 10 October 2006, § 44; *I. v. Finland* (Application no. 20511/03), ECtHR 17 July 2008, § 38; *Armoniene v. Lithuania* (Application no. 36919/02), ECtHR 25 November 2008, § 40.

112 *Z. v. Finland* (Application no. 22009/93), ECtHR 25 February 1997, § 95.

113 Ibidem supra note 5, GC No. 14, § 12(d); Ibidem supra note 4, UN Doc. A/HRC/7/11, § 54.

114 ESC, ECSR, Conclusions XIX-2 (2009) Greece, Council of Europe, January 2010; Ibidem supra note 44, Council of Europe, Recommendation No. R (99) 21, §§ 3 and 12.

115 Hellenic Statistical Authority, Statistics 2013, Athens: ELSTAT, 2013; See, also, WHO Regional Office for Europe, *European Health for All Database 2013*. <http://www.euro.who.int/en/data-and-evidence/databases/european-health-for-all-database-hfa-db>

to timely and effective health care in pregnancy and early life, but also by worsening socio-economic circumstances and immigration from poor countries, which are also of decisive importance for an individual's health status.[116] Thereto, the Greek State must ensure the best possible state of health for the population and as a result, every step should be taken to secure the quality of health care in Greece, involving the enhancement of socio-economic determinants of health, which constitute human rights concerns (see Part I, section 3.2).

In the meantime, there is a critical concern that due to the State's effort to decrease health care expenditure the ESY will not provide health care that is appropriate (of good quality) for its recipients (see Part I, section 4.2). In fact, the lack of funding has been reported as the main obstacle to higher quality of health care in Greece in a 2012 Eurobarometer qualitative survey.[117] Moreover, the Greek public health sector is characterized by corruption, as will be analysed in section 6.5.2, which hinders the quality of health care. In addition, long waiting lists in the ESY, which are medically unacceptable due to the patient's condition and need, are considered to be a large risk for corruption (perhaps one of the main forms of corruption) given the informal payments to bypass these lists and gain priority in access (section 6.5.2).[118] As noted earlier, long waiting lists is a major quality problem which several patients experience in the ESY. Indeed, a Eurobarometer survey shows that patients may need to wait up to 6 hours in emergency in Greece.[119] Thereby, the Greek State must adopt a national policy on the management of waiting times and waiting lists, pursuant to which access to medical treatment should primarily be based on transparent criteria, agreed at national level and consider the risk of deterioration in clinical as well as quality of life terms (see Part I, section 4.2.1).[120] Nevertheless, it should be noted that the non-existence of a national policy on the management of waiting lists and waiting times in the ESY makes available information incomplete. But most importantly, such a development

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116 N. Seeman, 'Canada's Missing News—Part II: Lower Infant Mortality Rankings' *Fraser Forum* 2003 (March), pp. 20-21; E. Nolte, A. Brand, I. Koupilová & M. McKee, 'Neonatal and postneonatal mortality in Germany since unification' *Journal of Epidemiology and Community Health* 2000, 54, pp. 84–90.

117 Eurobarometer Qualitative Study, *Patient Involvement*, Brussels: European Commission May 2012, p. 18.

118 Ibid., p. 23.

119 Ibid., p. 22.

120 Ibidem supra note 44, Council of Europe, Recommendation No. R(99) 21, §§ 5,7,12 and 13; See, (Revised) ESC, ECSR, Conclusions XV-2 (2001) - the United Kingdom, volume 2, Council of Europe 2001, p. 601, for an analogous approach.

cannot be considered to meet the requirement of State's responsibility to guarantee the availability and quality of health facilities, goods and services, and as such it creates tension with the right to health framework.

6.4.4 CONCERNS AND STEPS FOR THE FUTURE

The preceding analysis revealed that the Greek health care system and its ensuing policy measures were not designed and developed in light of the right to health framework. Nonetheless, using the international framework of 'AAAQ' under the right to health within the context of health care as an assessment tool we completed an analysis of the performance of the ESY. Accordingly, the inclusion of these key human rights principles, arising from the right to health, in the ESY is minimal. At the same time, like for most European countries, given the increasing health care costs coupled with the implementation of austerity measures generated by the economic crisis from 2010 onwards, it appears particularly important that the Greek State addresses the concerns raised as to the availability, accessibility and quality of health care. Indeed, these principles are under serious threat, in that there is a risk that the Troika's structural adjustment programme will create more problems in access to health care within the ESY in conjunction with the rising health inequalities owed to the worsening socio-economic circumstances (i.e., mainly resulting from the economic crisis and the implementation of the austerity measures), which, in turn, will lead to a (potential) violation of the right to health.[121]

More specifically, the current picture of the ESY appears to be most problematic and raises some issues of great concern with regard to the realization of the 'AAAQ' under the right to health. As already mentioned, primarily due to the State's effort to curtail public health expenditure, the general population, especially vulnerable or marginalized sections of the society, ultimately pays the price by having limited access to health care (emergency care) or losing access to health care, including preventive care (children vaccinations); by facing higher risks of HIV and other communicable diseases; and overall by putting their well-being in danger. When looking at the merging of hospitals and rehabilitation units, combined with the critical understaffing of the health system, it can be discerned that there is great concern in light of the availability and physical accessibility of health care services in Greece. Additionally, the levy of increased user fees and the high prices in medicines makes health care economically inaccessible, especially for the deprived

[121] Such concerns in relation to the severe impact of the financial crisis on the Greek health system have been expressed by the CESCR in its 2015 report to Greece (supra note 57, § 35).

and those most in need for care, such as people with chronic diseases, pregnant women, and children. As such, the increasing payments for health care raise concern in light of the principle of economic accessibility of health care services. Another point of concern is that the policies of 'Troika' put a strong pressure on the scope and quality of basic health care, namely to care which every individual should have access and which is financed by mainly the state budget (tax system) and by social insurance funds. For instance, this becomes obvious by looking at the long waiting times for hospital treatment, which render the performance of ESY poor.

Thus, as analysed in preceding sections, the Greek State takes a number of austerity measures with serious consequences for the realization of the right to health (care). Notably, the implementation of such measures combined with the rising concerns implicates a violation of its right to health obligations, unless the Greek State can justify that every effort has been made to use all available resources for realizing the right to health (care). In other words, a set back in the level of protection of the right to health due to a lack of funds requires a heavy burden of proof on the part of the Greek State (see Part I, sections 3.4 and 4.2.1). Thereto, it must be conceded that the lack of resources cannot be used as an excuse by the Greek State for not securing the core content of the right to health (see Part I, section 3.4), namely the basic health needs of the population, as this should be seen as a (potential) violation of the right to health.

At the same time, beyond revealing the shortcomings of ESY, human rights norms offer guidance on how a health system in general, the ESY in particular, should function in order to meet the right to health standards. As the ESY struggles to meet increasing health care demands with low financial resources, human rights standards offer a consistent basis to guide policy development, health care redesign and resourcing decisions for ESY. Most importantly, key principles under the right to health -the 'AAAQ'- must be embedded explicitly within national law and policy-making for the provision of health care. The practical means by which the Greek State will meet the 'AAAQ' requirements and, ultimately, realize the highest attainable standard of health of the general population within the functioning of the ESY will require not only financial resources, but also a range of resources as well as the means of international co-operation given its poor economic situation (see Part I, sections 4.2 and 4.4). Put simply, beyond financial resources the Greek State must utilize other kinds of resources relevant for the realization of the right to health (care) such as human, organizational, technological resources (see Part I, section 4.2).[122] In addition, another important issue is the appropriate allocation

[122] See, also, UN CRC Committee, Report on the Forty-Sixth Session, UN Doc. CRC/C/46/3,

and prioritization of the existing (even scarce) resources, as an inappropriate and inefficient allocation (i.e. misallocation and/or mismanagement) can serve as an indication that the Greek State does not comply with its right to health duties 'to the maximum extent of its available resources'.[123] Nonetheless, this cannot be done at the expense of other state obligations relating to other core areas, such as education (see Part I, section 4.2.3). The Greek State must implement existing processes and adopt, wherever necessary, new institutional structures (i.e., accountability and monitoring mechanisms) towards the transparent and effective utilization and allocation of the resources at its disposal (see Part I, section 4.2).[124] For instance, the Greek State must take (institutional and administrative) measures to combat the widespread corruption in the public health sector which has, as aforementioned, a negative impact on the level of available resources and on the realization of the right to health (care) (see also section 6.5.2).

Unless the Greek State introduces such measures, resource scarcity (i.e., incapacity) cannot be used as a pretext for not abiding by its right to health obligations. In other words, the Greek State must demonstrate a genuine commitment to secure the right to health (care), namely to increase/allocate the resources required to this end through the adoption of appropriate policies within the context of its fiscal matters and also by means of international co-operation.[125] Additionally, the process of identification, planning and implementation of such policies should be evolving in order to integrate and respond at the general population's health needs, and to ensure that the provision of health care meets the 'AAAQ' requirements under the right to health at all times. All in all, the Greek State must demonstrate willingness to comply with its right to health obligations (Part I, section 4.2).

Last but not least, in July 2013, it appeared that the Greek State sought to meet its obligations under the right to health (care) within the framework of international co-operation with the WHO (see Part I, section 4.4). The Greek State signed an agreement with this international organization for support in the planning of a health care reform for the years 2013-2015, with a view to improving individual

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22 April 2008, Ch VII, § 65 (Day of General Discussion entitled 'Resources for the Rights of the Child- Responsibility of States', 5 October 2007).

123 Article 2 § 1 ICESCR (Annex 2).

124 Ibidem supra note 122, §§ 73-75.

125 See, UN CESCR, General Comment No. 2: *International technical assistance measures (art. 22 of the Covenant)*, 2 February 1990, UN Doc E/1990/23, § 9. The CESCR adopts the term 'adjustment with a human face' to describe the State's efforts to protect ESC rights in terms of its fiscal matters; Ibidem supra note 33, GC No. 3, § 13.

and population-level health outcomes.[126] Particularly, the goal of this agreement, namely ensuring better health outcomes for the population in Greece would be achieved through a comprehensive health-system reform in line with the new European policy for health and well-being, Health 2020. The ultimate aim of the international co-operation is the design of a sustainable and equitable health system, within which access to high-quality care and financial protection can be ensured and with primary health care to be the cornerstone of care and prevention. This health-system reform initiative of the Greek Ministry of Health is also supported by the European Commission Task Force for Greece and the Federal Ministry of Health of Germany. Meanwhile, such a promotion of co-operation may facilitate the development of a comprehensive health infrastructure accompanied with a more efficient use of the existing (scarce) resources, as already mentioned. Note that this state action is in accordance with Article 2 ICESCR which refers to the international co-operation for the realization of the ESC rights at the national level, including the right to health (see Part I, section 4.4). Finally, within the framework of international co-operation the Greek State must insist in its negotiations with the 'Troika' that the terms of its financial assistance are compatible, *inter alia*, with its right to health obligations (i.e., ensure the progressive realization of the right to health) (see Part I, sections 3.4 and 4.4).

6.5. CHALLENGES WITHIN THE HEALTH SYSTEM IN GREECE

It is generally maintained that the landscape of the health system in Greece is characterized primarily by two operational challenges, which are central to its functioning and signal dangers for the realization of the right to health (care), as will be subsequently analyzed (see Part I, section 3.7).[127] Note that the analysis of the two challenges, namely the privatization and the corruption, will be directed solely to one dimension of the right to health, namely the field of health care.

6.5.1. PRIVATIZATION

From a right to health perspective, a critical concern is that the privatization of health care can be detrimental to the equitable availability and accessibility of

[126] WHO Regional Office for Europe, *WHO, Greece sign agreement on support programme for health reform*, WHO/Europe 2013. <http://www.euro.who.int/en/where-we-work/member-states/greece/ sections/news/2013/07/who,-greece-sign-agreement-on-support-programme-for-health-reform> (last accessed April 2, 2014).

[127] See, e.g. with respect to the NHS corruption in Greece, a study of the European Commission (note 12), pp. 54 & 243.

health care, especially for the poor and other vulnerable groups, if poorly conceived and monitored by the State (see Part I, section 3.7.1).[128] Experiences from the past are indicative of the impact that privatization in the provision of health care has on the health of the general population in Greece. More specifically, prior to 1983, health care in Greece was mainly delivered by private actors.[129] Note by way of background that 45 percent of hospital beds were in private clinics, whereas at the same period in France this figure was estimated around 25 percent and in Spain 20 percent. Additionally, the private health sector remained unregulated by the Greek State which was at the expense of the public sector. In fact, the proliferation of the unregulated private health sector led, *inter alia*, to high out-of-pocket payments for health care, which placed excessive financial burdens on the poorest segments of the population, as well as increased disparity in the availability of health care between remote, rural and urban areas in Greece. Health care was commercialized, as access to health care was dependent on the individual's ability to pay. As a consequence, this development affected negatively the general population's health conditions, which was reflected in increasing mortality and morbidity, especially with regard to infant mortality.[130] Apparently, such alarming development was not in conformity with (international and European) human rights law as well as with the Constitution of Greece (sections 3.7.1 and 5.2.1). Meanwhile, it must be conceded that the privatization in the health sector in principle is not in contradiction with the effective enjoyment of the right to health (care) by every individual, as will be subsequently elaborated; the privatization that is not regulated by the State poses a threat to the objectives of the right to health (care) and, finally, to its enjoyment by every individual.

In light of the above disturbing developments, there was a growing demand for a health care reform and, ultimately, this demand led in 1983 to the establishment

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128 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover. UN GA, 67th Sess., Agenda Item 70(b),* UN Doc. A/67/302, 13 August 2012, § 3.

129 S.A. Alexiadou, E.A. Alexiadou & A. Chamalidou, 'The Historical Development of Hospitals in Greece' *Administrative Review* 2005, April-May-June, pp. 23-28.

130 Introductory Report of draft Law on the National Health System addressed to the Hellenic Parliament, pp. 86, 88 & 94; A.D. Alexiadis, *Introduction to Health Law*, Thessaloniki: Dimopoulou Publishing 1999, pp. 75 & seq.; See, also, concerning the issue of commercialization of health care, M. Mackintosh & M. Koivusalo, 'Health Systems and Commercialization: In Search of Good Sense' in: M. Mackintosh & M. Koivusalo, *Commercialization of Health Care: Global and Local Dynamics and Policy Responses,* Hampshire: Palgrave 2005, pp. 3-21.

of a national health system (Law 1397/1983 – founding law of ESY), as elaborately discussed in section 6.2. At the same time, the activities of private health care providers were banned under Article 5 of Law 1397/1983. As a result, during that period efforts were made to either close or absorb the pre-existing private hospitals into the public sector. In 1992 alterations to the system were made as the legislature acknowledged the potential role of private actors in health care. Therefore, Law 2071/1992 under Article 11 § 1 removed the then existing restriction on the establishment of private initiative and allowed the provision of primary, secondary and tertiary health care also by private actors.[131] Even so, there was an ambiguity in Law 2071/1992 as regards to the adoption of monitoring (accountability) mechanisms for regulating the behavior (i.e., position and activities within the system) of private health care providers. In turn, the functional requirements of private actors, namely the operation, staffing and modernization of private clinics, were specified by a number of Presidential Decrees (PD 247/1991, PD 517/1991, PD 235/2000, PD 84/2001 and PD 198/2007).[132] Overall, since the 1990s there has been an increase in the establishment of private diagnostic health centers as well as specialist health care is provided by private actors who are either contracted by social insurance funds or paid directly by patients. Additionally, rehabilitation care and nursing care for elderly and persons with disabilities are mainly provided by private actors.[133] As such, private initiative in health care tends to develop a health sector which has the potential to respond to the health needs of its recipients and to cover existing gaps -deficiencies- within the public health sector in Greece.

Along with the body of legislation, in 2001 a national supervisory body (SEYYP) was created to hold both public and private actors in the health care sector to account in case of failing to realize the right to health (care), as identified in section 6.2.2. As regards to private health care providers, the Body of Inspectors for Health and Welfare Services (SEYYP) primarily aims to monitor the decisions and actions of these providers, namely to look at whether these actors provide care

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131 Ibidem supra note 26, Law 2071/1992.

132 PD 247/1991, *Official Government Gazette* – ΦΕΚ issue Α′ 93/21-06-1991; PD 517/1991, *Official Government Gazette* – ΦΕΚ issue Α′ 202/24-12-1991; PD 235/2000, *Official Government Gazette* – ΦΕΚ issue Α′ 199/14-09-2000; PD 84/2001, *Official Government Gazette* – ΦΕΚ issue Α′ 70/10-04-2001; PD 198/2007, *Official Government Gazette* – ΦΕΚ issue Α′ 225/14-09-2007.

133 See, ESC, ECSR, Conclusions XX-2 (2013) Greece, November 2014, p. 14; 23rd National Report on the Implementation of ESC and 8th National Report, The Government of Greece, pp. 24-25; See, also, European Observatory on Health Systems and Policies, 'Greece - Health System Review', *Health Systems in Transition* 2010, Volume 12, No. 7, pp. 1-180.

that is sufficiently accessible (affordable) and of appropriate quality for its recipients.[134] Thereto, the establishment of this monitoring mechanism reflects the Greek State's intention to acknowledge its responsibility to regulate and supervise the private health sector and to finally meet the state 'obligation to protect', a State's duty stemming from the right to health (Part I, section 3.3).

Since 2010, Greece, after its agreement with the Troika by means of the Memorandum of Understanding (MoU), is undergoing more intensively privatization processes in the context of health care provision. State roles and responsibilities within the context of health care are increasingly transferred to private actors, as the Greek State uses private actors in the delivery of health care.[135] For instance, the Greek State purchases health care, by contracting out health care delivery to private health care providers: medical doctors, diagnostic centers and private hospitals. Meanwhile, Law 3370/2005 under Articles 32, 33 and 34 promotes the co-operation between public hospitals and private law entities, which operate as non-profit making institutions.[136] Accordingly, public hospitals can co-operate with such private institutions as to the treatment of patients in intensive care units of the private institutions. Additionally, doctors can obtain their medical specialization in private institutions after the issuing of a ministerial decision under which the appropriateness of the relevant institution will be judged. Note also that the partnership between public and private health sector introduced by Law 3370/2005 is in line with the (Revised) ESC which provides in Article 11 the co-operation between the State and public or private organizations towards the realization of the right to health.[137] In fact, a ministerial decision, issued in 2011, provides that inpatient care facilities of the public sector, namely ESY hospitals, can be used by private insurance funds.[138] Particularly, a number of hospital beds and other specialist care are disposed by the public health sector to private insurance funds.

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134 Ibidem supra note 18.

135 Articles 17-33 of Law 3918/2011, 'Structural Changes in the Health System and Other Provisions' *Official Government Gazette* – ΦΕΚ issue Α′ 31/02-03-2011, partially amended by Law 4238/2014, Article 8.

136 Law 3370/2005 'Organization and Functioning of Public Health Services and other provisions', *Official Government Gazette* - ΦΕΚ issue Α′ 176/11-07-2005.

137 European Social Charter, 18 October 1961, entered into force 26 February 1965, ETS 35; (Revised) European Social Charter, 3 May 1996, entered into force 1 July 1999, ETS 163; See Annex 2.

138 Ministerial Decision Υ4a/oik.93320 'Approval of Contracting an Agreement between ESY Hospitals and Private Insurance Companies' *Official Government Gazette* – ΦΕΚ issue Β′ 1842/19-08-2011.

In light of the preceding, it can be observed that under certain circumstances (i.e., primarily under a concrete regulatory framework) privatization is possible to create a window of opportunity for significant positive changes in the provision of health care. In fact, a further argument as to the proliferation of privatization in the provision of health care is that privatization provides an opportunity to cover inefficiencies in public health services and, ultimately, realize national health goals.[139] Indeed, regulated privatization can contribute to the enhancement of health care provision through the application of new health technologies as well as through the creation of competition for more effective, available and higher quality services for all members of the population.[140] As a consequence, the privatization has the potential to enhance timely access to quality services as well as to reduce waiting times for hospital treatment in the NHS (see section 6.4.1).

At the same time, as elaborated in Part I, human rights standards do not regulate whether a State should use a public system, a private system, or a mixture of these two systems (see section 3.7.1).[141] However, each system must abide by the four essential elements of the right to health framework (i.e., the 'AAAQ' requirements) (see section 3.7.1) as well as the Greek State must meet the state 'obligation to protect' (see sections 3.3 and 3.5).[142] This means, as indicated before, that the Greek State has an overall responsibility to oversee the engagement of private actors in the health sector and supervise the health care provision by these actors in the terms of achieving a regulated balance between public and private health sector and guaranteeing a right to health (care) for everyone (see section 5.2.2). This State's responsibility could extend to the imposition of explicit legal obligations on private actors by way of concrete legislative provisions that will ensure a range of safeguards for the effective enjoyment of the right to health (care) by all individuals and especially by marginalised and disadvantaged population groups.[143] All in all, it is important to stress that beyond any correlative responsibility of the private actors in the health sector, the Greek State must not excuse itself from its own primary and overall responsibility for realizing the right to health (care) within its jurisdiction (see section 3.7.1).

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139 E.A. Friedman, 'Building Rights-Based Health Systems: A Focus on the Health Workforce' in: A. Clapham & M. Robinson (eds), *Realizing the Right to Health,* Zurich: Rüffer & Rub 2009, pp. 421-435, p. 428.

140 S. Gruskin & D. Tarantola 'Health and Human Rights' in: S. Gruskin, M.A. Grodin, G.J. Annas & S.P. Marks (ed.), *Perspectives on Health and Human Rights*, New York and London: Routledge 2005, pp. 3-57, pp. 28-29.

141 Ibidem supra note 33, GC No. 3, § 8.

142 Ibidem supra note 5, GC No. 14, § 35.

143 Ibidem supra note 5, GC No. 14, §§ 8, 35, 43(a), 51.

6.5.2. CORRUPTION

Generally, it has been argued that health systems are prone to corruption (see Part I, section 3.7.2).[144] The health system in Greece is characterized by persistent corruption.[145] The level of corruption in the system remains disturbingly high. It is maintained that corruption can be detected at all levels of the ESY, affecting primarily two essential principles, arising from the right to health, namely the accessibility and the quality of health care, as will be subsequently elaborated.[146] An elucidating report on health sector corruption commissioned by the European Commission indicates that corruption within public hospital sector in Greece mainly occurs in health care delivery through informal payments and in procurement processes.[147] This report of the European Commission reveals not only the existence of corruption in the Greek national health system, but also provides a concrete idea about the magnitude of the effect.

Accordingly, a major and visible type of corruption in public hospitals involves informal payments to the members of the medical profession (i.e., state officials), even though they bear a legal/professional duty to make decisions to the best interests of the patients (see also section 6.2.2., *'(v) Members of the Medical Profession'*).[148] More specifically, corruption takes place at the point of health care delivery, where members of the medical profession (mainly surgeons) demand informal payments from their patients. Indeed, the reasons for the patients in engaging in such processes are, *inter alia*, to gain priority in access to health care through bypassing long waiting lists (i.e. reduce time spent on such lists) at overstretched public hospitals (see section 6.4.1), to obtain access to better quality health care and more attention (i.e., preferential treatment) by the medical profession (see section 6.4.3). In fact, since the establishment of the ESY, incidents involving ESY doctors demanding from patients and receiving under-the-table (illegally)

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144 See, e.g., W.D. Savedoff, & K. Hussmann, 'Why are health systems prone to corruption?', in: Transparency International, *Global Corruption Report 2006, Special Focus- Corruption and Health*, London: Pluto Press, pp. 4-13.

145 Ibidem supra note 12, European Commission 2013, pp. 54, 60 and 243.

146 Ibid., p. 29 and 243.

147 Ibid., p. 9.

148 Special Eurobarometer 397, *Corruption Report*, Brussels: European Commission February 2014, pp. 85-95; The Special Eurobarometer 397/ Wave EB79.1 survey on 'Corruption' covers the population of the respective nationalities of the EU Member States, resident in each of the EU Member States. Fieldwork in February-March 2013, published in February 2014; See, also, Law 3418/2005 'Code of Medical Deontology' (note 104); PD 216/2001 'Code of Nursing Deontology' (note 106).

payments have been reported. It is referred to commonly in Greek as *fakelaki* (i.e., small envelope). Indeed, from the side of the members of the medical profession, there is a growing interest in maintaining such unethical transactions-practices (i.e., influence the entry of patients to public hospitals through bypassing waiting lists) in view of demanding from patients additional illicit payments.[149] Nonetheless, this is not to say that all the members of the medical profession are engaged in such illicit and unethical practices.

Beyond the members of the medical profession, another significant sector within the ESY vulnerable to corruption is procurement in health care, where corruption appears to be widespread.[150] In addition, decentralization of procurement processes combined with the lack of strong regulatory mechanisms has increased the risk of corruption within the ESY over the years. Particularly, corruption most frequently occurs in the procurement of medical equipment and of pharmaceuticals. Supply companies exert pressure to public health officials in order to influence regulations and secure favorable public procurement contracts.[151] A 2012 Special Eurobarometer report on corruption revealed that 78 percent of the respondents - the general public- in Greece perceived corruption in the public health sector to be systematic.[152] This survey manifests distrust in the society as a whole with respect to public institutions, including public health care, as a consequence of the several incidents of corruption in Greece.

Meanwhile, such cases of corruption within the Greek national health system implicate violations of the right to health (care) especially with regard to vulnerable groups, as they create barriers for these groups to access health care (see Part I, section 3.7.2). More specifically, poor people, due to their weak economic status (financial capacity), are often denied the care that the State is under the obligation to provide. This means that these people are deprived of using health care and life-saving treatment, as they cannot afford the informal payments (under-the-table

149 Ibid.; Ibidem supra note 12, pp. 60 and 153 (reported incidents of corruption in health care delivery); European Commission, *Annex - Greece to EU Anti-Corruption Report*, COM (2014) 38 final, Brussels: European Commission 2014, p. 12.

150 Ibidem supra note 12, p. 71.

151 Ibid., p. 244.

152 Special Eurobarometer 374, *Corruption Report*, Brussels: European Commission, February 2012, p. 12; The Special Eurobarometer 374/ Wave EB76.1 survey on 'Corruption' covers the population of the respective nationalities of the EU Member States, resident in each of the EU Member States. Fieldwork in September 2011, published in February 2012. Notably, in the 2013 Special Eurobarometer 397 report on corruption (note 148), 99 percent of the respondents in Greece considered corruption to be a widespread national problem.

payments), charged for health care that should be provided free of charge or at lower price. Therefore, corruption constitutes a threat to the affordability of health care within the ESY. In addition, corruption at the level of health care provision may lead to less favorable treatment of patients, who have not engaged in unethical practices (i.e., to respond to under-the-table payment demands), and thus, to the provision of substandard health care on the part of the medical profession. Indeed, it is argued that corruption prevents the enjoyment of the right to health (care) especially with respect to the vulnerable population groups (see Part I, section 3.7.2).[153] At the same time, corruption in procurement processes increases health care costs, while it undermines quality of health care services and goods (e.g. as to the quality of drugs and the medical equipment within the ESY) and ultimately impairs the functioning of the ESY at the expense of the patients.[154] As such, procurement corruption hinders the realization of the right to health (care). The aforementioned issues raise concerns in light of the 'accessibility', 'acceptability' and 'quality' core requirements as set out in the right to health framework (see Part I, section 3.5).

In light of the preceding analysis, tackling corruption constitutes both an enduring concern and a challenging issue in light of the right to health, but with ample opportunities for engagement by the Greek State. Thereby, one significant action is to establish and implement firmly the national and international frameworks against corruption. Greece, already, has anti-corruption laws and policies in place. Most notably, in May 2008 Greece ratified the United Nations Convention against Corruption, which was incorporated into domestic law by Law 3666/2008.[155] However, such initiative of itself is not enough to combat corruption and needs to be embraced fully by the Greek State. Unfortunately, in Greece legislative efforts are often rendered ineffective by uneven or weak enforcement and implementation. The Greek State needs to pay even more attention to law enforcement with the ultimate aim of reducing opportunities for corruption. Indeed,

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153 Ibidem supra note 29, UN Doc. E/CN.4/2003/58, § 98.

154 See, also, W.D. Savedoff & K. Hussmann, 'Why are health systems prone to corruption?', in Transparency International, *Global Corruption Report 2006, Special Focus - Corruption and Health*, London: Pluto Press, pp. 4-13.

155 Law 3666/2008, 'Ratification of the UN Convention against Corruption and replacement of relative provisions of the Criminal Law', *Official Government Gazette* - ΦΕΚ issue Α′ 105/10-6-2008; Of note, Greece has ratified several other conventions on corruption. For instance, in May 2007 the Council of Europe's Criminal Law Convention on Corruption and its additional protocol were ratified with Law 3560/2007, *Official Government Gazette* - ΦΕΚ issue Α′ 103/14-5-2007.

the CRC Committee in its report for Greece expressed its concern about 'the persistence of corruption in public institutions' and called upon Greece 'to increase anti-corruption efforts'.[156]

In order to effectively combat and prevent corruption in the ESY Greece needs to build strong safety nets by putting an explicit emphasis on rigorous supervisory mechanisms (i.e., transparency, monitoring and accountability mechanisms) and by providing legal means of redress accessible to all (see Part I, section 3.7.2).[157] For instance, transparency within the ESY should be promoted and enhanced through publication of waiting lists - waiting times for hospital treatment, so as the management of waiting lists will be based on transparent criteria and not on the individual's ability to pay.[158] The window of opportunity for taking decisive action has rarely been more favorable. Notably, the economic crisis in Greece has offered several opportunities to enhance accountability and transparency within the ESY. In response to a wave of corruption scandals involving ESY sector and pursuant to the economic adjustment programme, the Greek Ministry of Health promoted an enhanced procurement mechanism and the centralization of healthcare procurement. A special Commission, the Procurement Coordination Commission, was established under the auspices of the Greek Ministry of Health, aiming at introducing increased monitoring and transparency in the process of procurement within ESY.[159] Additionally, financial accountability has been imposed through the introduction and implementation of an Electronic Prescription System (e-prescribing) which monitors the prescriptions of drugs and as such results gradually in the reduction of corruption related to pharmaceuticals.[160] It appears that the aforementioned monitoring and accountability mechanisms provide evidence that, to some extent, genuine efforts have been made by the part of the Greek State to set up institutional changes-policies for regulating the behaviour of the State and the non-State actors with the ultimate aim of combating corruption within health care.

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156 Ibidem supra note 30, UN CRC Committee, §§ 17 and 18(f).

157 Ibidem supra note 148, Special Eurobarometer 397, p. 65. Note that 87 percent of the respondents in Greece suggested that high level corruption cases are not sufficiently pursued in Greece.

158 See, for instance, A. First, 'Hospital waiting lists open for scrutiny in Croatia', in: Transparency International, *Global Corruption Report 2006, Special Focus- Corruption and Health*, London: Pluto Press, pp. 55-57.

159 Article 6 of Law 3918/2011, 'Structural Changes in the Health System and Other Provisions', *Official Government Gazette* - ΦΕΚ issue Α′ 31/02-03-2011.

160 Ibidem supra note 12, European Commission, p. 246.

Meanwhile, when it comes to the notion of participation (see Part I, section 3.5) civil society can play a crucial role in fighting and rejecting corruption in the public health sector. Particularly, civil society can help the Greek State to raise awareness about corruption by means of campaigns and strategies.[161] Indeed, a social pressure for continued political commitment against corruption should be strongly maintained. All in all, along with the imposition of monitoring and accountability mechanisms, the possibilities for participation of citizens and enterprises in the formulation of anti-corruption measures should be promoted by the Greek State by way of formal participatory structures accessible to all.

6.6. CONCLUSIONS

Given the rising costs of health care, resource scarcity and increasing health inequalities in Greece, the extent of the Greek State's compliance with its right to health duties must be at all times subject to scrutiny with a view to ensuring the advancement of individual and population health. At the same time it must be, however, conceded that the level of compliance with international health standards is insufficient. There is an apparent contrast between the international standards that Greece has ratified and what is being ultimately implemented by the Greek State within healthcare settings. Indeed, this becomes evident especially if one considers that the national health system in Greece and its ensuing policy measures were not designed in light of the right to health framework (see sections 6.2 and 6.4).

Meanwhile, the most pressing problem and concern as to the realization of the right to health (care) is the implementation of a number of austerity measures in the public health sector. Indeed, when the performance of the national health system was evaluated against the 'AAAQ' requirements, a number of shortcomings in the provision of health care were revealed. It became evident that primarily from 2010 onwards, measures, such as the charge of increased user fees for publicly funded health care and the mergers of healthcare facilities, adopted in the framework of the MoU, have a detrimental impact on the enjoyment of the right to health (care) in Greece. The infant mortality rate as well as health disparities based on low socio-economic status have increased in the country over the course of the last 5 years (i.e. during the economic crisis) and constitute serious points of concern under the 'AAAQ'. Thereto, it must be conceded that such developments clearly

[161] For instance, a civil society reporting website entitled *Edosa fakelaki* (i.e., I gave a small envelope) whereby *fakelaki* refers to a bribe, was created in Greece to raise awareness on the issue of corruption in the public sector, including the health sector - <http://www.edosafakelaki.org>.

reflect the State's failure to comply with its right to health obligations, in that they cause a limitation on the enjoyment of the right to health (care) by individuals, especially by people belonging to vulnerable groups. Unless the Greek State takes (legislative and policy) measures in light of its available (limited) resources to remedy such alarming developments, such as by enacting legislation to prioritize the most urgent health needs of vulnerable groups, this failure will amount to a violation of the right to health (care) of these groups.

Given the economic situation in Greece, the progressive nature of the right to health (care) should not be regarded by the Greek State as a means to excuse its failure to abide by its obligations and based on the assertion of lack of economic growth and of insufficient national resources to adopt retrogressive measures that will undermine the realization of this right, especially concerning vulnerable populations (see Part I, section 4.2.3).[162] Rather, it demands that the Greek State within its (limited) scope of capacity (e.g., by way of optimum prioritization of health in its national budget) to set concrete health priorities (i.e., needs of vulnerable individuals or groups), whilst avoiding misallocation/mismanagement and corruption. As such, in light of the progressive nature of the right to health (care) the Greek State must endeavor to strengthen its health infrastructure by placing emphasis on primary health care, namely the primary step in the health care process and an integral part of the core content of this right (see Part I, section 3.4).

Last but not least, seen privatization and corruption in health care delivery from the perspective of the right to health, the Greek State retains the primary and ultimate responsibility to effectively realize this right. The Greek State is required to pay considerable attention to accountability and monitoring mechanisms for addressing possible failures to realize the right to health (care) of every individual. For that reason the Greek State must ensure in its national law implementation measures (see Part I, section 3.7): (1) the comprehensive regulation and supervision of the behaviour of both public (i.e., ESY) and private health care providers; (2) the review and adjustment of legislation and monitoring mechanisms when they do not achieve the expected results, namely to hold (public/private) health actors to account for possible failures to realize the right to health (care); (3) the establishment of mechanisms for individuals' complaints concerning failure or malpractice by (public/private) actors in the health sector and (4) the promotion of accessible to all participatory mechanisms whose implications so far are not duly considered within the adoption of national law and policies in the area of health, particularly as regards to efforts to combat health sector corruption.

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[162] Ibidem supra note 5, GC No. 14, §§ 31-32.

Looking to the future, the Greek State has to move from adopting a plethora of laws and policies irrespective of the right to health to taking concrete action in actually integrating and implementing right to health standards in the functioning of its national health system. This helps Greece to comply with its right to health obligations and, thereby, to ensure long-term sustainability of a robust public health system grounded on the essential principles of 'AAAQ'.