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Out of pocket payments and social health insurance for private hospital care: Evidence from Greece

Nikolaos Grigorakis [a], Christos Floros [b,*], Haritini Tsangari [a], Evangelos Tsoukatos [b]

[a] University of Nicosia, Business School, Cyprus
[b] T.E.I of Crete, School of Management & Economics, Greece

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ABSTRACT

The Greek state has reduced their funding on health as part of broader efforts to limit the large fiscal deficits and rising debt ratios to GDP. Benefits cuts and limitations of Social Health Insurance (SHI) reimbursements result in substantial Out of Pocket (OOP) payments in the Greek population. In this paper, we examine social health insurance's risk pooling mechanisms and the catastrophic impact that OOP payments may have on insured's income and well-being. Using data collected from a cross sectional survey in Greece, we find that the OOP payments for inpatient care in private hospitals have a positive relationship with SHI funding. Moreover, we show that the SHI funding is inadequate to total inpatient financing. We argue that the Greek health policy makers have to give serious consideration to the perspective of a SHI system which should be supplemented by the Private Health Insurance (PHI) sector.

1. Introduction

1.1. Out of pocket payments in Greek health care system

The financial crisis that the globe is currently experiencing is extremely painful as regards funding of existing health care systems [1]. Especially in Greece, the national health care system is on the focus of structural public reforms and severe funding cuts in the frames of the Programme of economic reforms currently implemented [2].

Greece, in order to obviate a potential fiscal default in 2010, agreed to a bailout rescue from the European Commission (EC), European Central Bank (ECB) and International Monetary Fund (IMF) with the precondition to proceed in significant cuts of public sector expenses, including health financing [3]. Greek policymakers concentrated only on achieving fiscal adjustments disregarding the fact that these harsh austerity measures would result in growth of OOP spending especially as a consequence of inequitable climate of health financing [4,5]. The external creditors of Greece required a decline of public health financing to less under 6% of GDP in 2012, while the Greek government managed to reach 6.22% [6–8]. Policy responses in public health funding encompassed huge cuts in health service benefits and shifting costs to health consumers either by applying higher formal cost sharing or by adopting policy instruments that lead patients to seek health care in the private sector [9].

According to the OECD Health Data, total Current Health Expenditures (CHE) "is the sum of total personal and total collective services but not including investment (gross

* Corresponding author.
E-mail addresses: nigrigor@yahoo.com (N. Grigorakis), cfloros@staff.teicrete.gr (C. Floros), tsangari.h@unic.ac.cy (H. Tsangari), tsoukat@staff.teicrete.gr (E. Tsoukatos).

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capital formation in health)" [6,7: 2]. The Greek health system is diachronically characterized by considerable OOP payments, which in 2013 approached 30.7% of CHE considerably higher than the OECD countries' average 19.5%; in this respect, Greece ranks in the 4th position, after Mexico, Korea and Chile [6,7]. OOP payments for the same year reached 26.39% of Total Health Expenditure (THE) [10]. The difference between current and total health expenditure is that the latter also includes capital formation (investments). For the same year, Greece's public health funding approached 65.5% of CHE; one of the lowest in the E.U. (28) [11]. Amongst OECD countries, Greece ranks 28th out of 34, with the leading positions to be classified by Hungary, Israel, Korea, Mexico, U.S.A. and Chile [6,7]. This, over the years, results in a blooming health care "black" economy mainly in the form of "under the table" payments from health users mainly to public providers (e.g. surgeons) in order for the users to skip the queues to overcrowded public hospitals [12,13]. Thus, "under the table" OOP payments account for more than 20% of total health care private expenses and have always been an important problem for Greek health system financing [14,15]. The Greek healthcare system is among the most "privatized" between E.U. countries [16–18], while public policy in health expenditure is a tool to achieve fiscal goals [19].

The fiscal pressure of the Memorandum of Understandings (MoUs) on Greek public hospitals' budgets resulted in significant downsizing in both human and medical materials resources, worsened even more hospitals' chronic problems (long waiting queues for operations, low quality standards of hospitalization stay, remarkable volume of side and informal payments) and prevented hospitals' efficiency in providing qualitative care [20,21]. Despite that the use of inpatient health care in private hospitals is currently for high-income individuals and/or PHI coverage due to the higher prices compared to the public sector [17], the persistent weaknesses and deficiencies of public hospitals may inevitably lead insured regardless of income to private hospital care [13,22] (EOPYY's Press Release published on the 09.22.2014).

According to a similar study published by Siskou et al. [13], 26.10% of Greek households' aggregate OOP hospital expenditure concerned physicians' fees in private hospitals and 28.6% of this spending was represented by extra OOP expenses in private hospitals. Further, the Greek private hospital expenditure in 2013 reached 1.757 billion Euros or 10.52% of total CHE, whilst OOP payments' funding approached 57.50% of total private hospital expenditure [6,7].

1.2. A short overview of the Greek health care system

The health system in Greece is financed across two main axes, public and private. The public axis includes government subsidies and compulsory SHI financing. The private health funding comprises OOP payments, donations - charities and PHI financing, the latter to negligible levels over time [18].

Regarding health care services' supply, the system was working as a Beveridge model [23], through N.H.S public hospitals and affiliated private health providers with SHI carriers.

On the demand side of health care services, the system was operating as a Bismarck model through a broad range of SHI funds for the previous years [8].

Since the beginning of 2012 almost all insurance carriers are under the umbrella of a unique SHI institution, which now covers over 90% of the insured population [24,25]. The creation of the National Organization for the Provision of Health Services (EOPYY), as a unified SHI fund, was among the Country's major reforms [26].

EOPYY, nowadays, purchases for its insured members primary and secondary health care services, from both public and private health providers through contractual mechanisms and payment systems [27]. However, coverage and benefits limitations often result in extra OOP spending [8,28].

Although, the first two years after the crisis, the PHI financing to CHE in OECD countries recorded downward trends, the period 2011–2013 increased by 3.2%, as an offset to formal cost sharing and moderate state health coverage [6,7]. Nevertheless, the PHI funding as a share of CHE in Greece is minimal share (3% in 2012 and 2013) [6,7]. The Greek state had never considered the substantial OOP payments and the NHS weaknesses as major concerns, preferring to pass direct private spending on households' budget rather than promoting the PHI sector [28,29]. Several factors explain the minor share of PHI funding in Greece, including the lack of confidence to PHI, the lack of insurance awareness, people's belief that they are fully covered by SHI, the limited income of individuals, the high level of unemployment rate, the absence of suitable products to fill the gaps of social security and several other social and cultural factors [30]. The Greek population prefers to pay "under the table" a doctor in order to ensure faster access and better quality to public health sector rather than a third party as a PHI for-profit company [18,31].

1.3. Objectives of the study

The current study aims at investigating the extent and distribution of OOP payments of insured in private hospitals affiliated to the new SHI fund, evaluating OOP payments' catastrophic impact on insured family budget as well as assessing the factors affecting OOP spending. On evidence from the Greek SHI system, the study addresses the following research questions:

(i) How well does the Greek SHI protect insured members against financial burden or catastrophe due to OOP payments to private health hospitals?
(ii) Do individuals face catastrophic health costs relative to their income?

Scheil-Adlung and Bonan [32] report that existing literature mainly focuses on the financial catastrophe that health care OOP payments bring to households in developing and low income countries, with insufficient or almost nonexistent social health systems (see, among others, [33–40]). Only a few studies examine the financial burden of health OOP payments in developed countries, for the years before