

EWHNET
European Women's Health Network



Women`s Health Network:

**State of Affairs, Concepts, Approaches, Organizations
in the Women`s Health Movement**

**Country report
Greece**

September 2000

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1. The Movement for Women's Health in Greece since the 1970s

In the 1970s, women's organisations and groups got activated in the matters of abortion and contraception. Information on issues of contraception was non-existent, with abortions being the only way to resolve an unwanted pregnancy. As the state turned a blind eye to the problem, women had their abortions in private clinics and surgeries, a fact that often resulted in them facing post-abortion implications and health repercussions.

The Women's Movement had a highly dynamic presence in the fight for the sensitisation of the state, by organising protest marches and speeches throughout the entire country, producing informative material, releasing proclamations (handbills), bringing pressure upon the government, etc. In addition, various organisations took active part in the international campaign for a free and safe abortion.

In the early 1980s pressure became more massive and more intense, and recompense results came in 1986, when the law allowing abortion - even in public hospitals - was passed and abortion expenses started being covered by insurance funds. Information about contraception, thus, practically lay in the hands of the people participating in the Movement. Nonetheless, governments performed very poorly on this issue despite their promises to disseminate information on contraception.

Apart from the struggle for the legalisation of abortions, some groups also endeavoured to inform women on their body functions and health problems. Therefore, these groups spread information on PAP tests and organised teams for self-examinations, while the Women's Liberating Movement issued brochures that contained information on the ways women would get to know their body, maintain its health and familiarise with it.

At the same time, the Federation of Greek Women continued to campaign in favour of hygiene in work areas, a request dating back from late 1970s. Moreover, in mid 1980s and on the aftermath of the Nairobi Conference for the Decade of Women, the organisation of Non-Aligned Women's Movement initiated an informative campaign on Women's Health Movement.

In 1987, at an international conference for women's health in Costa Rica, May 28th was established as the Day of Action for Women's Health. Consecutively, the organisation of Non-Aligned Women's Movement (N.A.W.M.) succeeded in this date being adopted by the Greek Women's Movement, for the purpose for which the date was instituted. Thus, N.A.W.M., being a member of an international network for women's health, has a leading role at the organisation of campaigns that take place on May 28th in Greece, as in other countries. Such campaigns are focused on the following issues, among other:

- Maternal mortality
- Maternal morbidity
- Adolescent pregnancy
- Free and legal abortion throughout the world
- Girl-child health
- Reproductive rights
- Health services
- Easy access to health services

In addition, these campaigns demand the following:

- Increase in public expenditure for health.
- Organisation of information campaign for contraception.
- Establishment of units of preventive medicine, specialising in breast and PAP tests.
- Establishment of a centre for women's mental and physical health.
- Dissemination of information on the effects of new reproductive technologies on women's health.

Moreover, N.A.W.M., as a member of Finrrage (network against new reproductive technologies), set up a special campaign for in Vitro fertility and for the implications such methods had on women's health. Various analyses and articles concerning women's health were published in newspapers, and special editions were issued with "Telesilla" magazine. Last but certainly not least, N.A.W.M. presented the issue about women's health at the Beijing Conference in 1995. Indisputably, N.A.W.M. has been up to this point the most active organisation for women's health in Greece.

On the other hand, the Federation of Greek Women initiated in 1988 a campaign - still active - aiming to the spread of information on the issue "Women and AIDS". This organisation is activated in the entire Greek state and distributes informative material.

Furthermore, during the period 1987-1996 the Research Centre of Women's Affairs (R.C.W.A.), in cooperation with N.A.W.M., campaigned in the whole of Greece for the effects of smoking on women's health, as there is a tremendous increase in the number of Greek women smokers. This increase is mainly due to three main reasons: firstly, because women pay little attention to their health, secondly, because they feel more independent, and thirdly, because tobacco multinational corporations focus a large part of their campaigns on women. R.W.C.A. also conducts research on minor tranquillisers in Greece, and then spreads the information gained concerning this matter. What's more, R.C.W.A. participates in the campaigns for May 28th and in those for the effects of violence on the mental health of women. Finally, with the cooperation of British organisations, R.C.W.A. conducts research on 3,000 women in Greece and the United Kingdom, regarding the issue "Women and Smoking".

The Institute of Equality conducts research on low-income women smokers (1999) and in the same time gives information on smoking in general. It participates in the research and campaign against Female Genital Mutilation (F.G.M.) and also detects the health problems faced by women immigrants in Greece, as the number of abortions in our country has increased due to the immigrant influx.

Moreover, in the 1990's an annex of the "World Family Planning" organisation conveyed information on contraception.

Finally, in the 1990's, the Association of Greek Housewives got engaged in the issues of the health of the third age, osteoporosis, menopause, sexuality of the third age etc.

The Movement for Women's Health is nowadays directed towards the policies for women's health, requesting changes in all policies and practices that violate reproductive and other women's rights (N.A.W.M.). The Movement is also involved in the protection of women immigrant's rights and their right to fully access health services, as well as in the dissemination of information.

More information on each of the groups that take action in the Movement for Women's Health in Greece is contained in the Appendix. However, what should be mentioned is that the Research Centre of Women's Affairs cooperated with the Institute of Equality on this report.

Our basic and focal demand is to amend and ameliorate health systems, taking also into account the needs of women.

2. Gender and health¹

2.1 The gender perspective in health

For biological as well as for social and financial reasons, women face health problems either differently or in a different way than men. The fact that they live longer does not justify the higher percentages of chronic diseases and disabilities from which women suffer, as they have in general a more negative perception of their health. Financial dependence, violence experiences, prejudices they have been confronted with during their childhood, lack of autonomy regarding their sexuality and their natural ability of bearing children, all are negative factors for their health. What's more, as biomedical knowledge usually stems from men and is based on male patterns, it ignores the effect of sex differences on the base of diagnosis, therapy and ultimately, health itself. Nevertheless, female morbidity and mortality patterns are different. Moreover, the changes in women's way of life render them susceptible towards diseases that until recently were thought to be infectious only for men.

Women use health services, either as patients themselves or as escorts of patients (i.e. of children or of elderly members of the family) more frequently than men. As a rule, there are implications that when health matters arise within a family, the responsibility of coping with them shall be undertaken by women, for the allocation of family care is basically sexist. Women, therefore, have been charged with the care of the children and the elderly, being them who are in contact with the services of the health system and the family health instruction. The above constitute women's dimension of health. The goal, thus, is to incorporate the dimension of gender within health policy, leading the latter to deal in a special way with the problems and the relationship of women with the health field.

2.2 National system of health - statutory framework

Up to this day, the Greek state has consigned to the integrated and decentralized National System of Health-ESY (Law 1397/83) the confrontation of health problems of the citizens without gender-based discrimination, hence making no distinction for women. The state undertakes the responsibility to equally provide every citizen with health services, regardless their financial, social and professional status. What's more, the accession of Greece to the International Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) by virtue of Law 1342/83 strengthens the Greek government's commitment to provide health services to women without any discrimination.

2.3 Women and health professions

The health sector traditionally composes an area of occupation for women. However, while women quantitatively dominate the health system, its authorities and powers are man-centred. The low representation of women at managerial positions and at the decision-making centres restrains dramatically the influence women exercise upon the planning and development of health policies.

¹ Some of the informations contained herein were taken from National Report of Greece, June 1999

2.4 Demographic trends

According to the data of the Greek National Statistical Service, the proportion of the elderly in the population rose from 15.2% in 1994 to 16.4% in 1997, while the proportion of children dropped from 17.3% to 16.0% respectively. Therefore, a birth-rate reduction is noted, as the average number of children per woman fell from 2.23 in 1980 to 1.39 in 1990 to 1.30 in 1996; consequently, demographic senility rose. 1996 was the first year in which deaths (100.740) exceeded births (100.718).

Another interesting indicator is life expectancy at birth, which is about 75 years for men and 80 for women. In comparison with other EU countries, Greek men have the second highest life expectancy, whereas Greek women have the sixth highest; the difference of five years between men and women is one of the lowest in the European Union (Eurostat 1997).

Furthermore, infant mortality drops continually from 17.9 % in 1980 to 9.7% in 1990 to 7.25% in 1996. Mortality rates, both maternal (0.00 in one thousand births of babies that survived birth in 1996) and infantile (0.34 in one thousand male babies aged from 1-4 years old and 0.24 in one thousand female babies of the same age in 1996) are very low and sanitary conditions during delivery are very good. The total of women in Greece give birth in fully equipped obstetrical clinics and with the help of specialised staff.

The distribution per sex of the annual rate of premature mortality in Greece is of particular interest. During the decade 1980-1990, this rate was 2.2% for men and 3.0 % for women, whereas in the five-year period between 1990 and 1995, fell to 0.4% and 2.7% respectively. This happened because Greece had already surpassed the transitional period, during which deaths from infectious diseases had diminished considerably due to the improvement of living standards. At the same time, the country had not yet got into the course of developed countries whose characteristics are the epidemics of ischemic cardiopathy and cancers. The low rate of premature mortality reduction of the Greek population is connected with the rise in these diseases (cardiopathies, cancers), in combination with non-effective intervention for other major health problems (road accidents, smoking, hepatitis, environmental pollution, etc). However, the difference at the distribution per sex of the index is due to the tendency of Greek women to have an 8-9 year difference from men (as it happens in the other European countries), contrasted to the 4-5 year difference that prevailed up to now.

This 4-5 year difference between men and women was one of the lowest in Europe and mainly due to socio-economic reasons, as the Greek female farmer population was exposed to health dangers, and countrywomen had no access to the health services, etc.

2.5 Reproductive health

The particular problems of women's health are handled in specialised services in the field of Prevention, Health Education and Care. Programmes are in place for free examination including breast examination, mammography, ultra-sound breast examination and PAP tests, which are conducted by gynaecologists, specially trained nurses and specialised cytological laboratories. In cooperation with cancer organisations and local government, population-testing programmes are implemented.

Mobile units conduct preventive examinations for cancer of the cervix, uterus and breast, making it possible for tests to be done on women in their own district. In this way, an effort is

being made to familiarise women from a variety of social strata and of different educational levels with the concept of prevention. In cooperation with the prefecture, local government authorities and women's organisations, information is provided on prevention issues and women are taught self-examination methods.

The women are informed in writing of the results of their tests. In event that the findings from the tests require additional testing or treatment, women are directed to health units. Preventive testing in Greece is based on women's voluntary visits to Public Hospitals, free of charge.

2.6 Family planning

Family planning constitutes an integral part of primary health care. The goal is for a family planning centre (FPC) to operate in every prefectorial hospital and for all Health Centres to provide family planning services in order to make possible the conscious choice of having children, to treat reproductive problems, to prevent sexually transmitted diseases, to reduce the effects of unwanted or premature pregnancies, to prevent gynaecological cancer (breast, cervix) and to provide sex education. The FPCs are open at regular hours every day, every week, and are staffed with personnel specially trained at two educational centres in Athens and Thessalonica.

2.7 Contraception - abortion

The distribution of contraceptive devices by the private sector does not allow the collection of statistical data about contraception in Greece. Condoms and coitus interruptus seem to be still the most widespread methods of contraception. The rise in use of condoms is also connected with AIDS and the relevant information campaign. It seems that the reduction in the number of abortions is connected with this fact, as well as, of course, with the legalisation of abortions (law 1609/86) and the development of family planning.

The reduction in the number of abortions also appears to be connected with the large influx of economic migrants and refugees in the last years. Most of the abortions in the gynaecological clinics of public hospitals concern this population group. This fact is, of course, owed to the level of nursing costs (expenses are covered by the insurance fund and, if the person is uninsured, by the indigence booklet), but also exhibits the problem of information and access insufficiency to contraceptive measures, faced by these population groups.

The impression that there is a high percentage of abortions among the adolescent population does not appear to reflect the truth. Gynaecological health problems of young girls concern more poor hygiene than abortions, and hence there is a need for information dissemination and sensitisation regarding this issue. Adolescent gynaecology, which has developed considerably in Greece in the recent years, has contributed substantially towards these ends.

Within the framework of the programme INTERREG II, a special project is under materialisation, aiming to look into the frequency of abortions and violence incidents, as well as to study the knowledge and the stances of women towards family planning issues.

2.8 Breast feeding

Emphasis has been placed on promoting and implementing breast feeding in Greece. A National Committee on Breast Feeding has been set up (1993) and the celebration of World Breast Feeding Week (1995) has been established, which in addition to the special theme

determined every year, features other activities such as lectures, educational seminars, conferences, media information, artistic events, etc. so as to raise consciousness and create a friendly and supportive climate for the promotion and protection of breast feeding.

2.9 Artificial insemination

The legislative framework for artificial insemination (AI) was laid down by Law 2071/92. It determines that AI can take place only in state hospitals or in well-organised gynaecological clinics. The same law provides for the issuing of a Presidential Decree to regulate relevant individual issues. What's more, in the effort to control sexually transmitted diseases (STDs), a venereal disease clinic has been set up to monitor women prostitutes who work in the Attica region. Similar checks are carried out by counterpart clinics in the prefectures.

2.10 AIDS and other diseases

The confrontation of AIDS composes an important goal of the national health policy. The Special Infection Control Centre (KEEL) is promoting action plans, which aim towards sexual education as well as towards primary and secondary care of those who suffer from AIDS / HIV.

According to KEEL data, the total number of AIDS cases that had been reported to Greece by 30 June 1998 was 1,811 persons: 26 children and 1,785 adolescents/adults. Of the 26 children, 14 (53.8%) were boys and 12 (46.2%) were girls; of the 1,785 adolescents/adults, 1,561 (87.5%) were men and 224 (12.5%) were women. Furthermore, by 31 December 1999 there was a slight rise in the total number of reported cases, amounting up to 2,015 persons - 32 children (1.6%) and 1,983 adolescents/adults (98.4%). Of the 32 children, 71.4% were boys and 28.6% were girls.

Among the cases in which the infection was transmitted through heterosexual contacts, the frequency of AIDS cases shows rising trends among men, while on the contrary it showed a downward trend among women in 1997, in comparison to 1996.

In 1994 emphasis was placed on informing women both as individuals and as candidate mothers, but also in their role as family caregivers.

As far as tuberculosis is concerned, there has been a rise in the number of reported cases in Greece. 654 men and 179 women were reported to have been infected in 1999. However, this recording is not complete, as:

- not all cases of tuberculosis are reported at the prefectures,
- some patients are examined by private doctors, and
- immigrants who are infected by tuberculosis tend to conceal the fact.

Another infection reported in rural areas is burcella melitensis. The disease is transmitted through animals, in such cases as when people come in contact with animals, drink unboiled milk or consume dairy products (i.e. cheese). 271 men and 138 women were reported to have been infected by burcella melitensis in 1999.

2.11 Immigrants - refugees

Within the operational framework of the National Centre of Epidemic Survey and Direct Intervention (EKEPAP), research, control and epidemic surveillance of the moving population (legal and illegal immigrants, refugees etc) take place.

In addition, special vaccination programmes are in progress, addressed principally to the vulnerable population groups. The Ministry supports financially multi-dimensional programmes (multi-dynamic centres, instruction, housing), which are materialised by non-governmental organisations, in order to integrate refugees in the Greek society.

2.12 Senior citizens

A number of facilities and benefits are provided for the elderly without gender discrimination. These are transportation facilities (Hellenic Railways-OSE), communications (Hellenic Telecommunications-OTE) and tourism (Greek National Tourist Organisation-EOT), as well as tax exemptions. The benefits include summer camps, housing assistance, allowances for the uninsured, and social housing for the aged.

2.13 Persons with special needs

State care for persons with special needs is materialised by the Ministry of Health and Welfare, regardless of gender; moreover, as Law 2646/98 determines for the "Development of the National System of Social Care and other regulations", every person residing legally in the Greek territory and being under a situation of need is entitled to receive social care from the agencies of the National System, which must be provided without discrimination, according to the particular personal, family, financial and social needs of each person.

State care is distinguished into:

- In-patient care that takes place within health institutions for chronic diseases, which are already being transformed to centres for rehabilitation and therapy.
- Outpatient care through the Ministry programmes.

The Ministry of Health and Welfare subsidises 104,869 persons (out of a total Greek population of 10.5 million), who are either destitute, uninsured and unemployed (apart from those who are blind and paraplegic), and whose percentage of disability amounts over 67%, or indirectly insured persons, who receive the difference between the provided benefit for their category and the one accruing from their insurance fund. There are also various insurance funds, which under specific conditions subsidise persons with special needs.

2.14 Mental health

In the area of mental health and in that of dependence on substances, pioneer programmes are being applied, which as all services and health provisions in our country address equally to both men and women.

According to the data of the Attica Psychiatric Hospital, the distribution per sex of those who suffer mentally and are being nursed in it is 60% men and 40% women.

Mental health problems among women appear to be characterised by the following (taken from the newspaper of Non-Aligned Women's Movement):

- Over-prescription of medication to women.
- Even though women's average life expectancy is consistently higher than that of men, the level of their health is lower.
- While smoking and the use of alcoholic beverages can be observed among younger women, the use of sedatives appears to be particularly widespread among older women.

- Regarding dependence-producing substances, there seems to be an alarmingly positive attitude toward them among young women, which may possibly be due both to lack of sufficient information, and frequently to misinformation among their peers, and the adoption of a specific attitude and way of life.
- 19% of women use tranquillisers and sleeping pills every day.
- 70% of the people taking tranquillisers are women.

In the field of substance dependence, of particular interest is a special therapy programme for women, which has been operating since March 1997 out of the Drug Therapy Unit at the Attica Psychiatric Hospital.

The factors that demonstrated the need for such a programme were the understanding and experience of the relatively small number of women drug abusers who sought help and the even smaller number in mixed treatment programmes, in conjunction with the truly great capacity they show, when they finally join the programme, to finish it and become reintegrated in the society.

The criteria for joining this drug therapy programme for women are:

1. The existence of young children who cannot be left for periods as long as the mixed programme requires.
2. Previous failures in mixed programmes.
3. Strong and traumatic experiences of sexual and other abuse, which make their coexistence with men particularly problematic.
4. Accompanying mental disturbance (depression, anorexia nervosa or bulimia, anxiety, phobia, etc.), which requires treatment with medication.

The programme has ten places, lasts for six months and entails living in a sheltered hostel. Treatment includes individual and group psychotherapy, psycho-educational activities of various kinds, intervention in the family, etc.

2.15 Prospects - limitations

Limitations and hurdles in the rapid and effective implementation of positive actions for women's health arise from problems in computerising services, in developing biomedical technologies and human resources, and in the lack of sufficient funding.

There is a need to stress the necessity for adopting actions that shall positively affect women. In general, such actions regard health prevention through first-grade (primary) health care and should include:

- The amelioration and exploitation of action possibilities through Health Centres. Remote regions should be covered by mobile diagnostic, sensitising and counselling units. The spectrum of the services rendered by such units should not only cover purely medical activities (i.e. PAP tests), but should also include health education activities (i.e. smoking, nutrition, exercise, etc.).
- The redefining and expansion of Centres for Family Planning. Care and information on sexual and reproductive behaviour is not limited only to the bearing of children and the prevention from sexually transmitted diseases (STDs), but also includes the improvement in the quality of life and in interpersonal relations. In Greece, where the birth rate is decreasing and deaths exceed births, there should be an explicit separation between contraceptive methods and factors that cause the decreases in the birth rate. The sexual education of the young and the spread of family planning principles shall not only reduce the number of abortions, but shall also maintain the fertility of the adolescent.
- The introduction of sexual health in school curricula, within a non-sexist frame, which shall assist boys and girls in behaving consciously and responsibly towards issues that may affect

their health. This shall also help them improve their interpersonal relationships on the basis of mutual respect and companionship.

- The conduct of research on mental health problems confronted by women and the evaluation of the impact of socio-economic disproportions between men and women in life conditions.
- The provision of care to victims of violence, which shall contribute to the restoration of their physical and mental health.
- The conduct of research on the profile of Greek women, based on the directives and the parameters set by World Health Organisation.

3. The health system in Greece

3.1 Introduction

The perception of health as a social good in Greece presented a considerable time lag relatively to other European Union countries. In Europe, reforms in health systems started being introduced on the very aftermath of the Second World War. An ideology of consent regarding the "good of health" was formed in Europe, where the public sector of health started to set up and expand continuously, regardless of the various different policies that each state pursued. Such conclusions can be easily derived from the fact that public expenditure for health grows steadily in Western European societies. Indeed, social sensibility moulds new rules about social justice and provides equal access to health services. This perception of equality concerning health is gradually consolidated and established as a constitutional right of the European citizen.

On the contrary, in Greece, the civil war (1946-1949) and the dictatorship (1967-1974) inhibited the formation of some specific health policy. The main problem arising in Greece was not as much the imbalanced development between public and private sectors, as their in-between relationship and function. It was thus a matter of a relationship that did not follow fixed regulations and rules, but was based on circumvention and uncontrolled service-supply and financial procedures. The dominant characteristic of that period were the acute inequalities between the centre and the periphery, regarding access to health services, as this can be expressed through the imbalanced allocation of hospital beds, doctor-force and financial resources.

As a result, Greece entered its reformative development in 1974. The political changeover stimulated a conscious need for profound health reforms. The most important attempts of this period towards this end took place in 1976 and shortly after that year, when the "Doxiadis scheme" was brought forward. Unfortunately, the latter was stifled by reactionary political oppositions that characterised the scheme as "marxist". Despite the scheme's failure, the pressure exercised by mass organisations (especially by doctor collective movements) and citizens themselves, strengthened the decision for the creation of a concrete national health system.

The establishment of the National Health System (ESY) became a state law in 1983 (Law 1397) and started to gradually materialise. Historically, it constituted the first concrete and complete scheme for the organisation of the system for health care services in Greece.

3.2 Development of health services in Greece

1st Period: 1836-1914

During this period, the lack of sufficient financial resources forced the different governments to pursue restrictive economic policies. The absence of a social security system led some categories of professions to the creation of their own self-administered and self-funded insurance units, which provided coverage for accidents and sickness. According to the census of 1861, only 7-8% of the economically active population enjoyed insurance coverage by some insurance organisation.

2nd Period: 1914-1936

This period is characterised by the great development of small and administratively autonomous insurance funds, which are financed mainly by contributions of employers and employees. The governments of this period made no efforts for the organisation and unification of these insurance funds. The inflow of 1,220,000 Greek refugees from Asia Minor obliged the governments to allocate some resources for the improvement of the health and living conditions of these persons, but not for the development of a complete and integrated health policy.

The rate of unemployment in urban areas amounted up to 28-30%, whereas the rate of inflation was steadily increasing, without an equivalent rise in wages. What's more, the economic crisis of the 1930's resulted in substantial masses of the population living below the poverty level. Hence, the limited financial and social programmes in a politically unstable environment led considerable population groups to the establishment of their own insurance organisations.

The main goal of these insurance funds was the payment of unemployment and medical benefits, as well as the coverage for retirement. The very first effort for the formation of a complete and integrated policy for health and insurance was made in the early 1930's. After several political confrontations, the Establishment of Social Insurances (IKA) was established by the Law 6298/1934. Nevertheless, large portions of the population still remained without any insurance coverage.

3rd Period: 1935-1982

The first important change was brought about by the application of the Law 6298/1934, according to which IKA was created, aiming to cover all workers and employees of the private sector in a compulsory way. At the beginning, IKA was only covering employees that worked in urban centres, and more specifically, those who worked in industries that occupied more than 70 persons. Subsequently, only 1/3 of the population enjoyed insurance coverage. IKA started to function 3 years later (1937), due to financial problems, and provided insurance for health and medical services on the one hand, and pension and unemployment benefits on the other.

The second most important landmark for social security was the Law 4169/61, which provided for the establishment of the Organisation of Agricultural Insurances (OGA), for the coverage of the agrarian population (almost 51% of the total population at that time).

In the following years and especially during the 1960's and the 1970's, a rapid economic development of 8% annually in fixed prices was noted. This economic development bore a range of enterprises and banks, which created their own insurance organisations. The latter were being financed mainly by the contributions of the employers and provided full insurance coverage of high quality. Nonetheless, not more than 3% of the total population had coverage by these privileged, "noble" insurance funds.

After the restoration of democracy to 1974, one of the work teams of the Centre of Planning and Economic Research (CPER) presented a study, proposing a reform similar to the above. This work team defined the main problems of the Greek health system as the following:

- The lack of harmonisation in the financing and the coverage between different insurance organisations, which impeded the application of whichever policy.
- The existence of major geographical inequalities in the supply of health services.
- The existence of an important gap in the production of services, at the expense of rural populations.
- The lack of policy for capital growth in hospitals.
- The lack of cooperation between the ministry of Health and other governmental activities affecting the health sector.

The committee of CPER suggested three alternative solutions for the organisation of the system:

- a) the creation of a unified National Health Service,
- b) the unification of the biggest insurance funds (IKA, OGA, and TEVE), together with every other insurance fund which would like to participate, and
- c) the coordination and cooperation between the already existing funds so as to satisfy the populations' needs for health.

The opposition to the reform that derived from medical and political cycles was notable. In 1980, the Minister of Health attempted to pass legislation, providing for the creation of an authority for government planning, which would coordinate the supply of health services. He also attempted to create a network of primary health cares. Nevertheless, vigorous turmoil was presented by doctors and political parties, both in the Parliament and between members of the governing party, and therefore the bill was never passed.

4th Period: 1983-today

The Law 1397/1983 established the National Health System (ESY) in Greece. This constituted by far the most important legislative reform concerning the Greek health system and coincided with the introduction of National Health Systems in most European countries.

This Law granted all citizens the right to access health services; it provided a more just geographical allocation of health services, and finally, it exercised effective controls on health costs. Nonetheless, cost containment was not included in the goals of ESY, at least during the first phase of its functions, firstly because estimations for Greek public expenditure on health were not accurate, and secondly because the main problem in the sector of the health care financing was supposed to be the redefinition of the equilibrium between public and private sectors and not the control of health costs.

Law 1397/1983 was completed in 1985. In 1992, its central points were revised, but all main principles were brought back to their unrevised form in 1994. A further amendment of the ESY law is nowadays being considered, but relative debates have not started yet.

The main principles of the ESY law are summarised in Article 1:

1. Governmental responsibility for the supply of services. This implies that the state would be the main supplier of services.
2. Equal allocation of health services.
3. Sufficient coverage of all needs for health services of each and every citizen, regardless of age, sex, or ability to pay.
4. Decentralisation of services and participation of the community in the decision-making process.
5. Emphasis in the development of first-degree care. This provided for the creation of a system based on Health centres and family doctors.
6. Improvements in the service supply quality and better coordination of the insurance organisations health supply.

The law was brought into force in 1983. Despite the fact that it provided almost for everything that concerned the structure of the new system and the working relations of doctors, there was only one article that dealt with the financing of the health services. Article 16 mentions that the financial relationship between ESY and insurance funds will be determined in due course and that insurance funds will have the ability to choose between the private and public health system.

According to the Government Newspaper Issue (FEK) of 1983 (issue 143, Athens, 07.10.1983), it is decided upon the ESY:

Health Peripheries

- The state is divided in health peripheries.
- With a presidential decree, passed after a proposal made by the Minister of Health and Welfare, and after consulting with the Central Council for Health (KE.S.Y.), the number of health peripheries, their boundaries and their seat are determined.

Peripheral Health Councils

- At the seat of each health periphery a Peripheral Health Council (PE.S.Y.) is established.
- All PE.S.Y. constitute organs which: a) are consultative regarding matters of planning, b) supervise and control the health service supply system in their periphery, and c) surveillance the functional performance of the system on a peripheral level and the application of health programmes, according to the national planning and the general coordination of KE.S.Y.
- All PE.S.Y., within the frame of the responsibilities mentioned in the above paragraph, may give expert opinions and make recommendations to KE.S.Y., either on their own initiative or after a relative question.
- The presidents of PE.S.Y. or their legal surrogates may participate in the plenary session of KE.S.Y., but may exercise their right to vote only for matters that concern their own periphery.
- Prefectorial councils may express their opinions to PE.S.Y., regarding matters of health service supply in their respective prefectures.

N.B.: However, in spite of the provisions made by the FEK, the PE.S.Y. system did not work, and thus no substantial decentralisation in services took place. Consequently, the administration of the health system remained to the exclusive responsibility of the state, and more specifically, to the responsibility of the Minister of Health. This turn in the course of the system is in opposition with the development of health systems in Western European countries, where the decentralisation of services regarding planning, supply and financing constitutes everyday practice.

3.3 Organisation of the Greek health system

3.3.1 General characteristics

The principal financiers of health services are the government and the organisations of social security. Most funds (and mostly IKA) are being financed by contributions of employers and employees. Funds like OGA are being financed by taxation in general.

Greece presents a high level of private expenditure for health, which amounts up to 30%. The majority of private expenditure is allocated in primary services for health care. Furthermore, Greece exhibits one of the highest per capita doctor indices in the OECD countries (one doctor for less than 300 people). Despite (or because of) the large number of doctors, the number of specialised nursing staffs is insufficient (2 nurses for every 3 doctors, 1994).

3.3.2 Relations between the population and the organisations of social security

There are thirty-nine different organisations of social security in Greece, providing coverage against illness to almost the entire Greek population. 3/5 of these organisations do not only provide coverage against illness, but also for pension, welfare and other benefits. Contributions to these security funds are compulsory for the entire working population and the dependent

members of their families, and are based on professional categories and not on income (see table 2.1 overleaf).

The most important Greek insurance organisations are:

- **IKA:**
This is the biggest insurance organisation in Greece and provides pension funds, health insurance and welfare benefits. Until 1982, the basic source of IKA's income were contributions made by employers and employees, but after 1982, the organisation started receiving generous subsidies from the national budget. IKA provides its services directly to its members. It employs doctors, who are being paid with salaries for primary medical and dental services, and is the owner of numerous hospitals, where secondary care is offered. People insured at IKA have the right to be nursed in public hospitals, which are then compensated for the services they provided, as in private clinics. Around late 1990, IKA was covering 38% of the total insured population or 47.5% of the population insured at funds controlled by the Ministry of Health, Welfare and Social Security.

TABLE 2.1
MOST IMPORTANT INSURANCE FUNDS

1. I.K.A	Establishment of Social Insurances (Urban population/ blue and white-collar workers)
2. O.G.A	Organisation of Agrarian Insurances (Agrarian Population)
3. T.E.V.E.	Traders, tradesmen, craftsmen and small tradesmen
4. T.A.E.	Traders-Shopkeepers
5. CIVIL SERVANTS	Workers of the public sector
6. O.T.E. (Organisation of Greek Telecommunications), D.E.I. (Public Power Complex-P.P.C.)	Staff of the telecommunications and electricity companies
7. BANKS	Bank employees

- **OGA:**
OGA covers the agrarian population and, initially, it provided only hospital care. Coverage for primary care services started in early 1970's, and it is nowadays offered, on the one hand by Health Centres, and on the other hand by a network of agrarian doctors who are obliged to work at rural areas for at least one year after their graduation from the Medical School. Pharmaceutical coverage of OGA began in 1982.
- **CIVIL SERVANTS:**
Autonomous coverage of health care for civil servants started in 1963. It is estimated that 600,000 civil servants (including the dependent members of their families) are insured under this category, whereas 500,000 (including the dependent members of their families) are insured by IKA. Health care covers visits to doctors, hospitalisation, dental care and medicines.
- **BANKS:**
Bank insurance funds offer the best health benefits. Their main income derives from contributions made by employers and employees. It is estimated that in 1990, all bank insurance funds were covering 1.1% of the total insured population.
- **TEVE:**
TEVE was founded in 1934, aiming to offer insurance coverage to tradesmen and craftsmen. Until 1980, when the range of services became broader, it covered a limited

spectrum of primary health services, such as diagnostic tests and visits to general practitioners. Nowadays, TEVE also covers hospital care and expenses for medicines.

IKA, OGA and TEVE cover more than 75% of the total insured population (1990) or 91.5% of the population insured at funds controlled by the Ministry of Health, Welfare and Social Security. Almost 10% of the total insured population is covered together by civil servants' insurance funds, insurance funds of legal entities subject to the Public Law, O.T.E., D.E.I. and bank funds. The rest of the population is covered by other, smaller funds.

It should be hereby noted that the number of persons insured by IKA increases every year, not only due to demographic changes or other changes related to increases in employment, but also due to mergers between IKA and numerous other smaller insurance funds. On the contrary, the number of people insured by OGA has fallen by 20% since 1989.

Most funds provide their members with benefits, which mainly concern losses of income due to illness, maternity benefits, benefits for special therapies and funeral expenses. Moreover, various funds make payments in the form of illness benefits, with the exception of e.g. OGA and TEVE. Maternity benefits are being paid by almost all insurance funds and this is the only benefit offered by OGA.

3.3.3 The financing of the social security

Apart from health, most of the social security organisations in Greece also cover a broad spectrum of insurance risks. As far as the greatest funds are concerned, their department for diseases (medical department) comprise one of the various departments in the same organisation of social security.

The main income source of the Greek social security organisations derives from the contributions of the employers and the employees, which consist 65% of the total income. A general ascertainment is that major inequalities exist between the social security funds, regarding the proportion of the contribution or contributions that accrue from different sources to the funds. Although the financial sources of IKA, TEVE and of the Bank Insurance Funds derive mainly from the contributions of the employers and the employees, the resources of other funds stem from general taxation (as in the case of OGA) or from social resources.

National budget subsidies, as a social security revenue, are constantly rising due to the increasing deficit of the insurance funds, especially in the department of pension funds. However, insurance funds had been demonstrating surpluses in the pension-fund departments until the early 1980's. Ever since, various factors (such as demographic factors, changes in employment, expansion of the population insurance and general rises of benefits, without an equivalent rise in the level of contributions), led to the accumulation of deficits faced by the major insurance funds, and especially by IKA. Therefore, the state was forced to rise the financing that derived from the national budget and whose beneficiaries are the insurance funds.

Almost the total of state subsidies was absorbed for the financing of pension funds. Health departments, on the other hand, remained in surplus because the government followed a policy of low fees for the producers (doctors and hospitals).

The contributions of employers and employees compose the most important source of income for the funds' health departments, representing altogether 77.5 % of the total income for the

year 1990. There are increasing trends in state subsidies, but these comprise a relatively smaller source of income for social security organisations. In other words, health funds show surpluses. This situation started changing after 1992, due to considerable rises in hospital/medical charges, paid by insurance organisations to public and private hospitals. This resulted in the creation of deficits in the health departments of social insurance organisations. Subsequently, it became more difficult for social security organisations to draw additional income, imposing thus an additional burden to the state; the latter, then, had to also start subsidising the departments of health, apart from those of pension funds. For example, OGA is almost entirely subsidised by general taxation, receiving a 35-milliard drs. state subsidy for medical care in 1992.

3.3.4 Relations between insurance funds and suppliers

Producers/suppliers of health services are financed by the state and by social security institutions in various ways. The Ministry of Health, through the national budget, covers the expenses of agrarian surgeries (community clinics) and health centres and the subsidies for public hospitals. It also provides insurance coverage to public servants and finances the health insurance of OGA. Social security organisations pay the salaries of the doctors and those of the rest of their staff, cover the expenses of the hospitals and polyclinics of their property and compensate private doctors and hospitals contracted with them, for the services which the latter provide to the organisations' insured persons.

Health expenses are divided on central and peripheral levels and are allocated on a historical basis. The prefectorial allocation of expenses of the national budget is estimated after the examination of the previous year allocation, while expenses are increased proportionately to the inflation rate.

3.3.5 Social security expenses

There is no available data for the peripheral division of social security expenses. Nonetheless, social security organisations' expenses can be grouped in general. The largest part of the expenses concerns expenditure for medicines: from 28.4% in 1985 to 37.7% in 1990. These expenses continue to rise as a percentage of the total expenses of the funds even after 1990. The second expenditure category in rank concerns hospital expenses, whereas expenses for primary care come in the third place.

Finally, expenses for primary health care include mainly payments to private suppliers, who are either part-time employed at IKA or contracted with other funds. They also include expenses for diagnostic and laboratory examinations, even though it is possible that some of these payments be related to hospital treatment.

3.3.6 Methods of payment to the suppliers

The suppliers of primary health services are paid by social security organisations with salaries (as in IKA, for instance) or by a fee for service, as in the majority of funds. Therefore, the financial resources allocated to primary health services by the social security system are led by induced demand for such services; moreover, doctors are encouraged in general to provide increased services to the insured persons. Indeed, doctors are motivated to produce more services in order to get a higher income (target income). Thus, as social security organisations do not control the quality and the quantity of the provided services, the low rate policy of the Ministry of Health is the only method for restraining the cost.

However, the above do not comprise an efficient method of calculation for various reasons. Doctors usually bill their patients with additional amounts when they get the opportunity to do

so, and the income that is thus earned comprises a part of side-economy activities at the level of primary health services. It is alleged that in some funds, such as that of civil servants, doctors prescribe more visits and services (such as tests and medication) than the ones they produce, therefore receiving higher incomes from the respective funds. In most cases, doctors persuade their patients to also visit them at their private surgeries. Subsequently, patients often visit on a private basis the doctors who are contracted with their insurance fund, in the hope of obtaining better services. It is, of course, needless to say that patients pay for these visits from their own, personal income (out of pocket).

The financing of health centres and agrarian doctors does not pose the above-mentioned moral hazard problems.

As far as hospital care is concerned, social security organisations compensate the hospitals on a two-fold basis; that is, on the basis of daily hospital charges that cover hospitalisation costs (such as bedroom occupation, food, cleaning, and other so-called "hotel" costs), on the one hand, and on the basis of fees for service, on the other hand, which cover the additional diagnostic and laboratory examinations provided to the insured persons. Hospital charges were traditionally far below the daily cost of hospitalisation and for this reason, the budgets of disease divisions in social security funds exhibited surpluses. In June 1992, however, hospital charges doubled and in February 1993 they tripled. As a result, hospital expenses of social security organisations rose dramatically in 1993. Estimated expenses of the major social security organisations for 1993 also ascertain this fact. What's more, the restraining policy for suppliers' compensations pursued by the Ministry of Health resulted in the public hospitals being more and more dependant on state subsidies.

4. Health service supply

4.1 Primary health services

What should be firstly stated is that there is a distinction between rural and urban health centres. The public sector is the dominant sector in rural areas and includes health centres and peripheral health centres (community clinics).

According to the Government Newspaper Issue (FEK) of 1983 it is decided:

Goal of health Centres (article 15)

- The goal of health centres is:
 - Provision of equivalent primary care to the total population of their area and to all temporary residents of that area.
 - Nursing and surveillance of patients at the stage of recovery or after their exit from the hospital.
 - Provision of first aid and nursing of patients, on special occasions, until their transportation to hospital.
 - Transportation of patients to health centres or hospitals, by ambulance or by any other means of transportation, on special occasions.
 - Dental care.
 - Exercise of preventive medical and dental care and instruction of people on health matters.
 - Socio-medical and epidemiological research.
 - Work medicine.
 - Provision of school hygiene services.
 - Information and instruction on family planning issues.
 - Instruction of doctors and of the rest health staffs.
 - Provision of social care services.
 - Provision of medicines to beneficiaries, should there be no pharmacy in the area.
- According to the decision of the Minister of Health and Care and after a consultatory response of KE.S.Y., further responsibilities can be assigned to health centres:
Health centres are staffed by general practitioners, doctors of some speciality and nursing staff. They are all full-time civil servants and receive their salaries from the state. The number of doctors occupied at a health centre depends on the population size of the area, which the health centre is responsible of. Even though health centres have managed to render their services more accessible by rural populations, they have not yet fulfilled in total the goals to the accomplishment of which they have been established, due to lack of staff and because of financial and organisational obstacles.

It is therefore true that most health centres are not adequately staffed. Only 48% of the organic work-positions for doctors are filled. Doctors appear rather reluctant to work in health centres, because of poor working and living conditions in rural areas, as well as because of limited prospects for promotion.

Health centres are connected to peripheral health centres (community clinics), which are responsible for a specific population group of around 5,000 people. They are staffed by agrarian doctors and in some cases, by nursing staffs. All medical school graduates are obliged to work on an annual basis at rural areas.

Services of primary health care in urban areas are provided by hospital outpatient's departments, by multi-surgeries run by organisations of social security, by private individual doctors contracted with social security funds and by specialised doctors who work in private surgeries. In addition, local authorities provide services of primary care either in surgeries or in old people's homes, but these services comprise a minimal fraction of the totally supplied primary health care.

4.2 Hospital care

Secondary care in Greece is offered by public hospitals, private hospitals of speculative nature and hospitals that belong to IKA, the Armed Forces, etc. There are also a number of private clinics of non-speculative nature, which are contracted with social security organisations and which provide services to the insured persons.

Doctors and nursing staffs working at public hospitals are employed full-time and are paid salaries; such doctors, however, are not allowed to operate private surgeries. This prohibition was introduced in 1983, when ESY was established. Before 1983, public hospital doctors were employed partially, and thus had the right to operate private surgeries. Nevertheless, this prohibition has been infringed in many cases, as nowadays a large number of ESY doctors operate "illegal" private surgeries.

One of the major problems presented in public hospitals concerns "unofficial", "under the table" payments to doctors by their patients; it is an established practice that doctors at public hospitals are paid unofficially, or in other words, are offered the "little envelope" for the services they provide. Such payments may be due to various reasons: either because doctors require such payments from their patients, or because patients wish themselves to make such payments, as a way to show their gratitude to the doctors. Therefore, "little envelopes" are given in the hope of receiving better treatment and in the belief that the doctor shall express greater interest and make stronger efforts while nursing the patient.

An important fact that concerns private health care during the 1980's concerns the expansion of private diagnostic centres. As the establishment of new clinics and hospitals was forbidden, the private sector turned towards the supply of high-tech diagnostic services. Private diagnostic centres increased considerably in number, though without controls in the quantity, quality and appropriateness of the services they offer. Supplied diagnostic services are often low quality, as the technology used is obsolete.

According to the Government Newspaper Issue (FEK) of 1983 it is decided:

Supervision of hospitals

All hospitals, of whichever legal form, are subordinated to the supervision of the Ministry of Health and Welfare, regardless of the authority they belong to. Supervision is exercised on the way that health services are supplied, on the way that medical, hospital, scientific and educational work is performed and on their operation in general.

Distinction of hospitals

Hospitals are divided in general and special ones. General are the ones which operate departments of hospitalisation in more than one specialities. Special are those which operate departments of main hospitalisation in one speciality.

General hospitals are divided in regional and prefectorial ones. Regional hospitals operate at the seat of every health region and cover the needs of the region, provide medical education for all or most of the medical specialities and they contribute to medical research. Prefectorial hospitals operate at every prefecture, they cover the needs mainly of the population of the prefecture, they provide medical education and they contribute to the promotion of medical research.

Hospitals of every health periphery are connected to each other in hospital, scientific and educational ways, under the coordination and supervision of the PE.S.Y. in charge, as specifically defined by decree of the Minister of Health and Welfare, which is issued after consulting with KE.S.Y.

Psychiatric Care

Psychiatric care is provided by:

- Mental health centres,
- psychiatric departments of general hospitals, and c) special psychiatric hospitals.

Psychiatric health centres are established by joint decision of the Ministers of Presidency of the Government, Finance and Health and Welfare, after having consulted with KE.S.Y., as decentralized units of special psychiatric hospitals or as a prefectorial general hospital in which a psychiatric branch is operating. Psychiatric health centres are in direct scientific, hospital, educational and functional connection with the hospital to which they are subordinated, and with the special psychiatric hospital of the health periphery.

The goal of a psychiatric health centre is psychosocial care, consultative intervention in the community and the enlightenment, the prevention, the therapy and the contribution to the rehabilitation and social incorporation of the patient. Psychiatric health centres may also include medico-pedagogic stations, as well as part-time hospitalisation units (daily or nightly).

Psychiatric branches of general hospitals provide short hospitalisation. Patients who are in need of a longer hospitalisation are sent to the special psychiatric hospital. Psychiatric branches of general hospitals are in scientific and hospital connection with the special psychiatric hospital of their health periphery. If there is no special psychiatric hospital operating in the periphery, then the clause of paragraph 4 of Article 8 of this law is enforced. Hospital foundations for mental diseases, which have been in operation during the publication of this law, shall be renamed "special psychiatric hospitals". The Minister of Health and Welfare, after consulting with KE.S.Y., shall decide on the way in which they will be reorganised, aiming towards rehabilitation.

The expenses for the operation of mental health centres are covered by the budget of the corresponding hospital.

Medical Publicity

Article 6 of the ESY law passed in 1994 prohibits medical publicity, as well as publicity for private surgeries, private multi-surgeries, diagnostic centres and private clinics. Indicatively, this prohibition includes each and every publication of advertising signs, notices, advertising leaflets, etc. in public places. The hanging up of such signs in the doctors' work-buildings is an exception.

5. Structure and purpose of Public Health services

Public health services of the Ministry of Health and Welfare [and] of the regions and prefectorial self-governments have as a purpose the prevention of diseases, the promotion of health, the support of social equivalence in matters of health and the planning, organization and development of public health services.

Public health departments [authorities], through the use of methodologies, ways and sciences related to public health, analyse the health situation of population groups, the factors (health factors or other) that influence their health, and organise interventionist actions for the control of these factors. More specifically, the objects of these departments [authorities] include:

- The control of risk factors, which form the model of morbidity and mortality of the population.
- The control of risk factors of food hygiene and of those in work areas, in places of team coexistence, in hospital institutions and in health authorities in general.
- The elaboration, promotion and application of programmes for prevention, education and promotion of health, giving priority to schools, local communities, places of team coexistence and high risk population groups, as well as the application of programmes for the reduction of risks.
- The supervision and coordination of the observation and the recording of infectious diseases and the recommendation for the introduction of measures for chronic, non-infectious diseases and for the confrontation of medico-social problems of patients of this category.
- The instruction on and the promotion of the population's stomatic health.
- The contribution to the prevention of accidents and professional diseases.
- The tracking of the particularities of each region's health problems, the estimation of priorities, the processing of relevant data and the information of the authorities in charge.
- The application of international standards for medicine of work and the promotion of health regulations in work areas.
- The organisation of programmes for continuous education of the health staff and of the cadres of public health.
- The editing and submission of reports regarding the health situation of the population of the country per periphery and regarding the activities of the total of the public and private health sectors.

Public health departments [authorities] cooperate with the authorities of welfare and social protection in such matters as:

- The research on the problems and the study of methods for social protection of the elderly, the children, the disabled [persons with special needs] and the persons suffering from chronic diseases; and the attendance of programmes for the protection of the elderly and of those suffering from chronic diseases.
- The evaluation of the necessity for [providing] care at care-units and the control and evaluation of units providing care.
- The elaboration and application of health programmes for population groups exhibiting racial, social and cultural particularities, which are facing high social risk.

Public health departments [authorities] form and produce cross-field cooperation with other departments and authorities, the action of which has direct or indirect influence on public health.

Services of School Health

A Direction of School Health is being established within the Ministry of Health and Welfare, composed of two departments: a) the Department of Programs and b) the Department of Statistics and Studies.

The main responsibilities of the Direction of School Health are: the instruction, observation and materialization of programmes for the provision of services for prevention, instruction and promotion of health and, in general, for the psycho-social support of the infantile population at kindergartens, primary schools, gymnasiums and lyceums; the supervision of the school environment so as to verify that public health regulations are kept; and the care for the registration and the filing of the data for the individual health situation of the pupils. Equivalent responsibilities are undertaken by peripheral School Health Offices, which also adjust the programmes of the Direction of School Health according to the particularities of each periphery.

6. Appendix

The Movement for Women's Health in Greece – involved organisations

An overview of the organisations that take part in the Feminist and Women's Movements and their actions and activities is listed below:

Non-Aligned Women's Movement (N.A.W.M.)

109 Asklipiou street, 11472 Athens, Greece

Tel.: +301 362 81 04

Fax: +301 361 92 87

E-mail: ginaika@otenet.gr

Contact Person: Mrs. Mata Kaloudaki

Actions and Activities:

1983: Creation of N.A.W.M.

1985: Study on prostitution and its effects on the health of women in prostitution.

1986: N.A.W.M. introduces the Movement for Health in Greece.

1987: Accession to the ISIS International Network for women's health. Campaigns – and subsequent success – throughout Greece in favour of 28th May being adopted as the International Action Day for Women's Health.

1988: Conduct of research and campaign regarding maternal mortality in Greece and internationally, as part of the relevant international campaign. Nowadays in Greece, the maternal mortality rate is almost zero. Research and spread of information regarding new reproductive technologies, in Vitro fertility and their effects on women's health.

1989: Campaign on maternal morbidity, which is mainly due to abortions (haemorrhages, psychological problems) and childbirths (rare phenomena of eclampsia, haemorrhages). Maternal morbidity is still present in Greece in some cases, although in recent years there have been rapid improvements. An increase in maternal morbidity is noted among women immigrants and especially illegitimate ones.

1990: Campaign for the amelioration of access to health services.

1991: Publication of bulletin on Adolescent Pregnancy (AP), as there has been an increase in the cases of AP in Greece. This has been mainly due to the lack of information on contraception and to the lack of sexual education in school curricula. Despite the establishment of a centre for AP in Athens, only a small number of adolescent girls resort to it.

1992: "Legal and Safe Abortions" campaign. Spread of information on safe contraception and on the need to render health service more accessible. Despite the fact that abortions in Greece are legal and covered by insurance funds, some women are treated in an unfriendly and hostile way by doctors and social workers in public hospitals.

1994: Participation in the Conference on Population Policies held in Cairo. Campaign on reproductive rights and on the right of choice.

1995: Participation in the Beijing Conference and presentation of the issue "Poverty and Health", in workshops.

1996: Research on the effects of prostitution on women's health (STDs, gynaecological problems, drug abuse, tranquillisers, mental health, etc.).

1997-2000: Globalisation and Women's Health. Intervention in communities of immigrants. Organisation of seminars on contraception and hygiene.

N.A.W.M. is a member of the following international networks:

- Finrrage
- ISIS International
- Global Network for Reproductive Rights

Since 1983, N.A.W.M. has been constantly publishing leaflets, brochures, newspapers, bulletins and posters, which contribute in, and comprise effective means for, the achievement of the goals set.

Federation of Greek Women

120 Ippokratous street, 11472 Athens, Greece
Tel.: +301 361 89 51
Fax: +301 362 94 60
Contact person: Mrs. Poupa Boudouroglou (President)

Actions and Activities:

- Information campaigns for the hygiene in work areas.
- Conduct of research on the effects of poor working conditions on the health of women.
- Studies on the following issues: Motherhood-Health-Safety-Motherhood leaves.
- Study on the subject “Woman and AIDS”. Spread of information. Prevention.
- Study on the subject: “Women and Drugs”. Analyses on the consequences of drugs on the health of women.
- Study on the subject: “Poverty and Health”.

The publications of the Federation of Greek Women include brochures and the “Modern Woman” (“Synhoni Gynaika”) magazine, which includes special articles dedicated to women’s health.

Research Centre of Women’s Affairs (R.C.W.A.)

109 Asklipiou street, 11472 Athens, Greece
Tel.: +301 362 81 04
Fax: +301 361 92 87
E-mail: ginaika@otenet.gr
Contact Person: Mrs. Mata Kaloudaki (Consultant Director)

Actions and Activities:

1992: Research on “Women and Smoking” and the effects of smoking on the health of women. Speeches and presentations in various parts of the country in cooperation with medical associations and environmental organizations. Participation in the EU project “Europe against Cancer”.

1993: Participation in the EU project “Europe against Cancer” and focus on the particular issues of women and smoking and of smoking in work areas. Research on reproductive health. Campaign against smoking.

1995: Participation in the EU project “Europe against Cancer” and conduct of research in Greece and the UK, as part of the project (distribution of 1,500 questionnaires in Greece and 1,500 in the UK; comparison of the results driven in both states; publication of articles in newspapers; press conference on the results of the study). Participation in the Beijing Conference and presentation of the issue “new Policies – Women’s Health”, in workshops. Study on minor tranquillisers in Greece and internationally. Cooperation with psychiatrists and the Mental Health Centre in Athens.

As part of its activities, the R.C.W.A. has been constantly publishing brochures, newspapers, posters and stickers.

Association of Greek Housewives

3 Korai street, 14561 Kifissia, Athens, Greece

Tel.: +301 801 05 96

Fax: +301 808 87 28 (attn: Mrs. Sakka)

Contact Person: Mrs. Galateia Sakka (President)

Actions and Activities:

Since 1978, the Association of Greek Housewives has devoted a substantial number of activities in the health of women.

1979: Research and information on childbirths and delivery and on the conditions in obstetrical clinics.

1980: Information on nutrition, food hygiene, family planning, mental health, breast and cervix cancer.

1981: Information on female disabilities – especially on mastectomies, hysterectomies and the removal of organs in general, which is a practice that doctors follow quite often – on the occasion of the International Year for the Disabled.

1984: Discussions about the effects of the work of women in the household on their mental health (confinement in the house, irritation, nervousness, etc.). Continuous cooperation with other organisations on such matters as abortion and contraception.

1993: Information campaign on care, health and sexuality of the Third Age, on the occasion of the International Year for the Third Age.

1998: Information on osteoporosis, as part of a study on “From Reproduction to Menopause”

The Association of Greek Housewives has exhibited special concern regarding information on accidents of women that take place in the household, which are quite frequent. One of the views in which the issue is approached is that of women being not covered by insurance funds when such accidents occur, because their contribution in the household is not recognised officially as a profession.

Institute of Equality

26-28 Parthenonos street, 11742 Athens, Greece

Tel.: +301 691 6481 & +301 326 34 61

Fax: +301 924 6523

E-mail: insteq@yahoo.com

Contact person: Mrs. Nadia Georgakopoulou (President)

Actions and Activities:

- Campaign against Female Genital Mutilation (F.M.G.). Conduct of research in Greece and dissemination of information towards organisations and groups of women. Research among African immigrant communities and hospital doctors. The phenomenon of F.M.G. is not reported frequently in Greece, because the majority of women immigrants comes from Eastern European and Balkan states.
- (1999) Participation in the EU project “Europe against Cancer” and focus on the particular issue of “Smoking and Low-Income Women”. Conduct of survey among 900 women smokers. Presentation of the issue in Dublin.
- (1999) Participation in the EU project “Equal Opportunities” and conduct of research in the sector of Health and Care, among workers, trainees and teachers.
- (1999) Information speeches to women immigrants regarding access to health services.

The Institute of Equality is member of the Global Network for Reproductive Rights and, as part of its policies, it has been issuing leaflets, bulletins, posters and stickers.

“Telessila” Greek Feminist Network

109 Asklipiou street, 11472 Athens, Greece

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Actions and Activities:

- Quarterly publication of the “Telesilla” magazine, constantly containing articles on women’s health.
- Cooperation with women’s groups and participation in 28th May activities for women’s health.

N.B. This report is focused on the fights led by Feminist and Women’s Movements, for women’s health. It describes their claims since 1974 and henceforth. 1974 was the year of the fall of the dictatorship in Greece, and the decades that followed were full of fights for women’s problems. Organisations that occasionally got engaged with health issues or with conferences and/ or programmes are not mentioned in this report, as these organisations do not comprise part of the Movement for Health, but solely undertook occasional activities on the basis of being financed for them. However, all members that took part in the groups mentioned herein participated in the Movement on a voluntary basis.