World Health Organization

European Region

Can people afford to pay for health care?

New evidence on financial protection in Greece

Michael Chletsos
Charalampos Economou

Greece

WHO Barcelona Office for Health Systems Financing

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Abstract

This review is part of a series of country-based studies generating new evidence on affordable access to health care (financial protection) in Europe and central Asia. Financial protection is central to universal health coverage and a core dimension of health system performance. The incidence of catastrophic health spending is higher in Greece than in many European Union countries. It is consistently heavily concentrated in households with low incomes, who mainly spend on outpatient medicines and outpatient care. Inpatient care and dental care are larger drivers of catastrophic health spending in richer households. Unmet need for health care, dental care and prescribed medicines is consistently above the European Union average, driven mainly by cost and marked by stark income inequality, particularly for prescribed medicines. The economic crisis – and budgetary cuts and other measures introduced in response to the crisis – exposed underlying weaknesses in health care coverage and its lack of resilience to shocks. Financial protection deteriorated, with catastrophic health spending and unmet need rising rapidly as rates of unemployment and poverty soared. Although financial protection improved on average after the economic crisis, financial hardship and unmet need in the poorest households are not much better now than during the crisis, reflecting continued underfunding of the health system and persistent gaps in coverage.

Keywords

AFFORDABLE ACCESS
COVERAGE POLICY
FINANCIAL PROTECTION
GREECE
HEALTH FINANCING
OUT-OF-POCKET PAYMENTS
POVERTY
UNIVERSAL HEALTH COVERAGE
USER CHARGES (CO-PAYMENTS)

About the series

This series of country-based reviews monitors financial protection in European health systems. Financial protection – ensuring access to health care is affordable for everyone – is central to universal health coverage and a core dimension of health system performance.

What is the policy issue? Out-of-pocket payments can create a financial barrier to access, resulting in unmet need, and lead to financial hardship for people using health care. People experience financial hardship when out-of-pocket payments – formal and informal payments made at the point of using any health-care good or service – are large in relation to a household's ability to pay. Out-of-pocket payments may not be a problem if they are small or paid by people who can afford them, but even small out-of-pocket payments can cause financial hardship for poor people and those who have to pay for long-term treatment such as medicines for chronic illness. Where health systems fail to provide adequate financial protection, people may not have enough money to pay for health care or to meet other basic needs. As a result, lack of financial protection can undermine health, deepen poverty and exacerbate inequalities. Because all health systems involve a degree of out-of-pocket payment, unmet need and financial hardship can occur in any country.

How do country reviews assess financial protection? Each review is based on analysis of common indicators used to monitor financial protection: the share of people foregoing health care due to cost (unmet need) and the share of households experiencing financial hardship caused by out-of-pocket payments (impoverishing and catastrophic health spending). These indicators are generated using household survey data.

Why is monitoring financial protection useful? The reviews identify the health system factors that strengthen and undermine financial protection; highlight implications for policy; and draw attention to areas that require further analysis. The overall aim of the series is to provide policy-makers and others with robust, context-specific and actionable evidence that they can use to move towards universal health coverage.

How are the reviews produced? Each review is produced by one or more country experts in collaboration with the WHO Barcelona Office for Health Systems Financing, part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe. To facilitate international comparison, the reviews follow a standard template, draw on similar sources of data and use the same equity-sensitive methods. Every review is subject to external peer review. Results are also shared with countries through a consultation process held jointly by WHO

headquarters and the WHO Regional Office for Europe. The country consultation includes regional and global financial protection indicators. The UHC watch website has more information on methods and indicators.

What is the basis for WHO's work on financial protection in Europe?
Affordable access to health care is a Sustainable Development Goal and one of the principles of the European Pillar of Social Rights. It is also at the heart of the WHO European Programme of Work, 2020–2025 – "United Action for Better Health" – the WHO Regional Office for Europe's strategic framework. Through the European Programme of Work, WHO supports national authorities to reduce financial hardship and unmet need for health services (including medicines) by identifying gaps in health coverage and redesigning coverage policy to address these gaps. The Tallinn Charter: Health Systems for Health and Wealth and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region include a commitment to work towards a Europe free of impoverishing out-of-pocket payments. Other regional and global resolutions call on WHO to provide Member States with tools and support for monitoring financial protection, including policy analysis and recommendations.

Comments and suggestions for improving the series are most welcome and can be sent to euhsf@who.int.

UHC watch

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A digital platform tracking progress on affordable access to health care in Europe and central Asia

#1

Indicator explorer for the latest numbers and charts

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#3

Country pages with data, policy options and resources

#4

Country-level and comparative analysis

#5

Examples of good practice

UHC watch
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Abbreviations

AMKA	social insurance number
COVID-19	coronavirus disease
DYPA	Public Employment Service
EHIS	European Health Interview Survey
ELSTAT	Hellenic Statistical Authority
EOPYY	National Organization for the Provision of Health Services
ESY	National Health Service
EU	European Union
EU-SILC	European Union Statistics on Income and Living Conditions
GDP	gross domestic product
KYPA	alien health care card
OECD	Organisation for Economic Co-operation and Development
PAAYPA	temporary insurance and health care number for foreigners
SHI	social health insurance
TOMY	community-based primary health care units
VHI	voluntary health insurance

Countries

ALB	Albania
ARM	Armenia
AUT	Austria
BEL	Belgium
BIH	Bosnia and Herzegovina
BUL	Bulgaria
CRO	Croatia
CYP	Cyprus
CZH	Czechia
DEN	Denmark
DEU	Germany
EST	Estonia
FIN	Finland
FRA	France
GEO	Georgia
GRE	Greece
HUN	Hungary
IRE	Ireland
ISR	Israel
ITA	Italy
LTU	Lithuania
LUX	Luxembourg
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MDA	Republic of Moldova
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POL	Poland
POR	Portugal
ROM	Romania
SPA	Spain
SRB	Serbia
SVK	Slovakia
SVN	Slovenia
SWE	Sweden
SWI	Switzerland
TJK	Tajikistan
TUR	Türkiye
UKR	Ukraine
UNK	United Kingdom

Executive summary

This review assesses the extent to which people in Greece face financial barriers to access or experience financial hardship (impoverishing or catastrophic health spending) when they use health care. It covers the period between 2008 and 2025, using data from household budget surveys carried out from 2008 to 2023 (the latest available year), data on unmet need for health care up to 2024 (the latest available year) and information on coverage policy (population coverage, service coverage and user charges) up to May 2025.

The review's main findings are as follows.

- In 2023 3% of households were impoverished or further impoverished after out-of-pocket payments; almost 10% of households experienced catastrophic health spending, up from around 7% in 2008.

- The incidence of catastrophic health spending is higher in Greece than in many European Union (EU) countries, but lower than in EU countries with a similarly heavy reliance on out-of-pocket payments.

- Catastrophic health spending is consistently heavily concentrated in the poorest consumption quintile, which accounted for nearly two thirds of the total in 2023. Incidence in the poorest quintile has risen sharply over time, from 23% in 2008 to 32% in 2023, and was higher in 2023 than in any other year in the study.

- In 2023 catastrophic health spending was mainly driven by outpatient medicines and outpatient care in the poorest quintile. Inpatient care and dental care are larger drivers of catastrophic health spending in the richer quintiles.

- Unmet need for health care, dental care and prescribed medicines is consistently above the EU average and largely driven by cost. Income inequality in unmet need is substantial, particularly for prescribed medicines.

Financial protection was relatively weak in 2008, before the economic crisis, but due to increases in public spending on health per person it looked as though the situation might be improving. Heavy reliance on out-of-pocket payments had been falling due to steady increases in public spending on health per person, which grew by about a third between 2004 and 2008.

The economic crisis exposed the complexity and fragmentation of health care coverage in Greece and its lack of resilience to shocks. Financial hardship and unmet need increased markedly following large and sustained cuts to public spending on health; coverage restrictions through new or increased co-payments and caps on the volume of outpatient care; and underlying weaknesses in coverage policy. These policy responses had a particularly negative effect on households with low incomes and led to a strong shift in household spending towards outpatient medicines and inpatient care.

Financial protection improved on average after the economic crisis but not for people with low incomes. Financial hardship and unmet need are not much better for the poorest quintile now than they were during the economic crisis. This is due to:

- continued underfunding of the health system – public spending on health has risen since the economic crisis but, as a share of gross domestic product, it remains well below the EU average, reflecting the very low priority given to health in allocating the government budget; and

- persistent gaps in all three dimensions of coverage policy, which have a disproportionately negative impact on people with low incomes and exacerbate inequalities in access to health care.

Building on steps already taken, the Government can consider the following options for action to address key gaps in coverage and reduce financial hardship and unmet need, particularly for households with low incomes.

Reduce inequality in access to health care by extending benefits from the National Organization for the Provision of Health Services (EOPYY) to all residents. People not covered by the EOPYY rely on public facilities and face greater barriers to access due to longer waiting times and shortages of staff and equipment. In addition, many taxpayers are not entitled to EOPYY benefits even though they contribute to the financing of the EOPYY (e.g. by paying the taxes that make up the government budget and accounted for 34% of EOPYY revenue in 2022); this includes (but is not limited to) people who have paid contributions to the EOPYY (or its predecessors) while working but are no longer eligible for EOPYY benefits due to long-term unemployment.

These challenges can be addressed by changing the basis for entitlement to EOPYY benefits from payment of contributions to residence, as in

Czechia or France; the basis for entitlement to social health insurance (SHI) benefits in Czechia has always been residence and France formally changed the basis for entitlement to social health insurance (SHI) benefits from payment of mandatory contributions to residence in 2000. Changing the basis for entitlement would not require any fundamental change in the way the EOPYY is financed. Rather, it would mean that:

- all residents would be entitled to the same health care benefits; and
- non-payment of contributions would be treated in the same way as non-payment of other taxes (that is, through fines rather than by denying access to services).

Simplify and strengthen the design of co-payments, particularly for outpatient medicines and other forms of outpatient care. International evidence and experience show that this can be done by extending exemptions from all co-payments (including the avoidable co-payments caused by internal reference pricing) to more households with low incomes; introducing an income-based cap on all co-payments; replacing percentage co-payments with low, fixed co-payments; and applying protection mechanisms automatically, with the help of digital tools, to simplify access and maximize take up.

Continue efforts to:

- improve financial protection for people who need outpatient medicines and other forms of outpatient care by strengthening protection from co-payments; ensuring appropriate prescribing and dispensing; encouraging greater use of generics; and lowering medicine prices;
- expand access to publicly financed non-emergency dental care, going beyond the limited services provided at present – particularly for people with low incomes, who currently experience very high levels of unmet need;
- monitor and address long waiting times and informal payments, ensuring that existing and new measures do not exacerbate inequalities in access to health care; and
- strengthen the purchasing and governance of publicly financed health care, so that public resources are better able to meet equity and efficiency goals.

These policy choices can be supported by increasing the priority given to health in allocating the government budget. Any additional public spending on health should be carefully used to reduce financial hardship and unmet need for households with low incomes. In itself, an increase in public spending on health is not a guarantee of better financial protection.

1. Introduction

This review assesses the extent to which people in Greece face financial barriers to access or experience financial hardship (impoverishing or catastrophic health spending) when they use health care. It covers the period between 2008 and 2025, using data from household budget surveys carried out from 2008 to 2023 (the latest available year), data on unmet need for health care up to 2024 (the latest available year) and information on coverage policy (population coverage, service coverage and user charges (co-payments)) up to May 2025 (UHC watch, 2025).

Research shows that financial hardship is more likely to occur when public spending on health is low relative to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; WHO Regional Office for Europe, 2019a, 2023). Increases in public spending or reductions in out-of-pocket payments are not in themselves guarantees of better financial protection, however. Policy choices are also important.

Greece has a complex and fragmented system of health coverage that operates through public facilities under the National Health Service (ESY) and public and contracted private facilities under a social health insurance (SHI) scheme run by the National Organization for the Provision of Health Services (EOPYY) (Economou et al., 2017).

After the 2008 global financial crisis Greece experienced a deep, multifaceted and prolonged economic crisis that led to a huge rise in unemployment and poverty rates. The crisis also exposed underlying weaknesses in health coverage policy in Greece. Because entitlement to SHI benefits was (and remains) linked to employment and payment of mandatory contributions, around 20% of the population lacked SHI coverage in 2014 (OECD, 2015).

To address the crisis the Government accepted a bailout from the European Union (EU), the European Central Bank and the International Monetary Fund and agreed to three economic adjustment programmes. Austerity measures directly affecting the health system included a large decrease in public spending on health – which nearly halved in per-person terms between 2009 and 2014 (WHO, 2025), leading to a significant reduction in the volume and quality of publicly financed health care. Curbs on health coverage (benefits, volume caps and higher user charges) further hindered affordable access to health care. Some of these policy changes were eventually reversed and the Government also took steps to protect people from access barriers, but key gaps in coverage remain.

Although the health system in Greece has always relied heavily on out-of-pocket payments, the out-of-pocket payment share of current spending on health rose considerably during the economic crisis from 28% in 2010 to a peak of 37% in 2014 (WHO, 2025). This share remains much higher in Greece (34% in 2022 – the latest available year of internationally comparable data for Greece) than the EU average (19%) and higher than any other EU country except Bulgaria (WHO, 2025). Public spending on health accounted for just under 5% of GDP in 2022, which was well below the EU average of 7% and lower than in other countries with a similar level of GDP per person (WHO, 2025).

Previous studies of financial hardship in Greece have used different measures of impoverishing and catastrophic health spending to this study, or focused on particular patient groups or been part of global studies that lack country-specific analysis (Xu et al., 2003; Xu et al., 2007; Scheil-Adlung & Bonan, 2013; WHO & World Bank, 2015; Grigorakis et al., 2016, 2017; Yfantopoulos, Chantzars & Ollandezos, 2016; Chantzaras & Yfantopoulos, 2018; Yerramilli, Fernández & Thomson, 2018).

The review is structured as follows. Section 2 sets out the analytical approach and sources of data used to measure financial protection. Section 3 provides a brief overview of coverage policy, drawing on information from UHC watch (2025). Sections 4 and 5 present the results of the statistical analysis, with a focus on out-of-pocket payments in Section 4 and financial protection (covering financial hardship and unmet need for health care) in Section 5. Section 6 provides a discussion of results of the financial protection analysis and identifies factors that strengthen and undermine financial protection. Section 7 highlights implications for policy.

2. Methods

This section summarizes the study's analytical approach and main data sources. More detailed information can be found on the Methods page of UHC watch (2025).

The analysis of financial protection in this study is based on an approach developed by the WHO Regional Office for Europe (Cylus, Thomson & Evetovits, 2018; WHO Regional Office for Europe, 2019a, 2023), building on established methods of measuring financial protection (Wagstaff & van Doorslaer, 2003; Xu et al., 2003).

2.1 Financial hardship linked to out-of-pocket payments

Financial hardship is measured using two main indicators: impoverishing and catastrophic health spending. Table 1 summarizes the key dimensions of each indicator.

Table 1. Key dimensions of impoverishing and catastrophic spending on health

Impoverishing health spending	
Definition	The share of households *impoverished* or *further impoverished* after *out-of-pocket payments*
Poverty line	A *basic needs line*, calculated as the average amount spent on food, housing (rent) and *utilities* (water, electricity and fuel used for cooking and heating) by households between the 25th and 35th percentiles of the household *consumption* distribution who report any spending on each item, respectively, adjusted for household size and composition using OECD equivalence scales; these households are selected based on the assumption that they are able to meet, but not necessarily exceed, *basic needs* for food, housing and utilities; this standard amount is also used to define a household's *capacity to pay for health care* (see below)
Poverty dimensions captured	The share of households further impoverished, impoverished and at *risk of impoverishment after out-of-pocket payments* and the share of households not at risk of impoverishment after out-of-pocket payments; a household is impoverished if its total consumption falls below the basic needs line after out-of-pocket payments; further impoverished if its total consumption is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total consumption after out-of-pocket payments comes within 120% of the basic needs line
Disaggregation	Results can be disaggregated into household *quintiles* by consumption and by other factors, where relevant
Data source	Microdata from national *household budget surveys*
Catastrophic health spending	
Definition	The share of households with out-of-pocket payments that are greater than 40% of household capacity to pay for health care
Numerator	Out-of-pocket payments
Denominator	A household's capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs; the standard amount is calculated as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, as described above; this standard amount is also used as a *poverty line* (basic needs line) to measure impoverishing health spending
Disaggregation	Results are disaggregated into household quintiles by consumption per person using OECD equivalence scales; disaggregation by place of residence (urban–rural), age of the head of the household, household composition and other factors is included where relevant
Data source	Microdata from national household budget surveys

Notes: see the Glossary provided by UHC watch (2025) for definitions of words in italics. OECD: Organisation for Economic Co-operation and Development.

Sources: WHO Regional Office for Europe (2019a, 2023).

Financial hardship indicators are generated by analysing data from household budget surveys. This study analyses anonymized microdata from the household budget surveys conducted annually by the Hellenic Statistical Authority (ELSTAT) between 2008 and 2023 (the latest available year). The data sample consisted of around 3500 households surveyed yearly from 2008 to 2014 and around 6000 households from 2015 to 2023.

Household budget surveys collect information on health spending (consumption) in a structured way, dividing it into six broad groups following the Classification of Individual Consumption According to Purpose: medicines, medical products, outpatient care, dental care, diagnostic tests and inpatient care (UHC watch, 2025). Spending on mental health care is not assigned a specific category and may therefore be reported in most of these groups.

Household budget surveys capture all out-of-pocket payments incurred by households – formal co-payments for covered health care; formal payments for the private purchase of health care; and informal payments for covered or privately purchased health care. However, it is not possible to distinguish informal payments from other out-of-pocket payments in the data.

All currency units in the study are presented in euros (€), with notes on inflation-adjusted spending where relevant.

2.2 Unmet need for health care

Unmet need for health care due to cost, distance and waiting time (health system factors) is measured using data from European or national surveys (Box 1).

Box 1. Unmet need for health care

Unmet need is defined as instances in which people need health care but do not receive the care they need because of access barriers. Self-reported data on unmet need should be interpreted with caution, especially across countries. However, analysis has found a positive relationship between unmet need and a subsequent deterioration in health (Gibson et al., 2019) and between unmet need and the out-of-pocket payment share of current spending on health (Chaupain-Guillot & Guillot, 2015), which suggests that unmet need can be a useful indicator of affordable access to health care.

Every year EU Member States collect data on unmet need for health care (medical examination or treatment) and dental care (dental examination or treatment) through the EU Statistics on Income and Living Conditions survey (EU-SILC) (Eurostat, 2025a). EU Member States also collect data on unmet need through the European Health Interview Survey (EHIS), carried out every 5–6 years (Eurostat, 2025b). The third wave of this survey was launched in 2019. EHIS provides information on unmet need among people reporting a need for health care and asks households about unmet need for prescribed medicines, in addition to health care and dental care. EU-SILC typically provides information on unmet need as a share of the population but in recent years it has started to provide this information among people reporting a need for health care (Ingleby & Guidi, 2024).

Financial protection analysis that does not account for unmet need could be misleading. A country may have a relatively low incidence of catastrophic health spending because many people face barriers to access and are unable to use the health care they need. Conversely, reforms that increase the use of health care can increase people's out-of-pocket payments – through, for example, user charges – if protective policies are not in place; in such instances, reforms might improve access to health care but at the same time increase financial hardship.

Source: WHO Regional Office for Europe (2023).

3. Coverage policy

This section describes the three main dimensions of publicly financed health coverage in Greece – population coverage, service coverage and user charges (co-payments); reviews the role played by voluntary health insurance (VHI); and describes changes in coverage policy over time (Table 2). It draws on information from UHC watch (2025).

3.1 Population coverage

The situation during the first years of the economic crisis (2010 to 2016)

Greece has a complex and fragmented system of health coverage, which operates through two main paths: the ESY and an SHI scheme operated by the EOPYY. Coverage policy has been subject to many changes since 2010 (Table 2); one of the most significant was the decision in 2011 to merge multiple SHI funds to create a new single purchasing agency – the EOPYY – and establish a national benefits package.

The ESY operates exclusively through public facilities, while the EOPYY makes use of public and contracted private facilities; both come under the responsibility of the Ministry of Health.

Prior to the economic crisis, most of the population was covered by the SHI scheme and entitlement to publicly financed health care was linked to employment and payment of contributions. Unemployed people were only temporarily entitled to publicly financed health care; anyone unemployed for more than a year lost their entitlement to SHI benefits.

The economic crisis and a refugee crisis from 2015 tested this policy to its limits. Unemployment rose drastically from 8% of the active population in 2008 to 27% in 2014 (ELSTAT, 2024), leaving around 20% of the population (over 2 million people) without access to SHI benefits because they were no longer eligible (due to being unemployed for over a year) or could not afford to pay SHI contributions (encompassing many self-employed people). Although unemployment has decreased since then, there are likely to be many people who still lack access to EOPYY benefits, including long-term unemployed people aged under 55 years or self-employed people who struggle to pay contributions.

In 2015 Greece became an entry point into the EU for over a million refugees fleeing conflicts in Afghanistan, Iraq and the Syrian Arab Republic (UNHCR, 2025); these groups of people were only entitled to emergency care and essential treatment for illnesses and serious mental health conditions.

Between 2013 and 2015 two attempts were made to address this challenge but with little success (see Box 2). In April 2016 the Government introduced legislation and designated funding to extend coverage to non-covered citizens and legal residents, self-employed people, people with low incomes, refugees and asylum seekers.

Table 2. Changes to coverage policy, 2010–2024

Notes: COVID-19 = coronavirus disease. TOMY = community-based primary health care units.

Source: authors, based on UHC watch (2025).

Year	Month	Policy change
2010	October	Introduction of an e-prescription system.
2011	January	User charges for outpatient visits in public facilities are increased from €3 to €5 per visit.
	January	User charges are increased for many outpatient prescribed medicines.
	January	An exemption from user charges for outpatient prescribed medicines is introduced for people with very low incomes.
	March	Multiple health insurance funds are merged to create a new single purchasing agency, the EOPYY, with a new national benefits package.
	September	A positive list of medicines is introduced by the new EOPYY.
2012	March	External reference pricing is introduced to set prices for medicines on the positive list.
	March	The e-prescription system for outpatient prescribed medicines is made compulsory to enable monitoring of prescribing and dispensing.
	June	Mandatory generic prescribing is introduced for outpatient prescribed medicines.
	November	User charges are introduced for inpatient care and diagnostic tests in EOPYY-contracted facilities.
	November	A negative list of medicines is introduced by the EOPYY.
2013	January	Tax incentives for VHI are abolished.
	September	Coverage of primary and outpatient specialist care is expanded through the Health Voucher Programme for citizens and legal residents who are not covered by the EOPYY.
	September	Coverage of primary care and limited outpatient specialist care is expanded through the Health Voucher Programme for citizens, legal residents (and their dependants) who are not covered by the EOPYY and who have an annual income of less than €12 000 for a single person or €25 000 for a couple.
	September	Internal reference pricing is introduced to set prices for medicines on the positive list.
2014	January	A user charge of €25 per hospital admission is introduced in public facilities.
	January	A user charge of €1 per outpatient prescription is introduced in public facilities.
	May	Volume caps are introduced for outpatient doctor visits, outpatient prescribed medicines and diagnostic tests covered by the EOPYY.
	June	Coverage of inpatient care and outpatient prescribed medicines is expanded for Greek citizens and legal residents (and their dependants) following joint ministerial decisions.
	June	The Health Voucher Programme for citizens, legal residents (and their dependants) who are not covered by the EOPYY ended.
2015	April	User charges for outpatient visits (€5) and hospital admissions (€25) in public facilities are abolished.
2016	February	A cap of €20 is introduced on the difference between the retail price and the internal reference price per outpatient prescribed medicine.
	April	Coverage is expanded for non-covered citizens and legal residents, self-employed people, people with low incomes, refugees and asylum seekers, who are now entitled to all publicly financed health care in public facilities.
	April	Exemption from €1 user charge per prescription in public facilities is introduced for welfare beneficiaries, non-covered people with low incomes and other people in vulnerable situations.
2017	January	An electronic platform is introduced to book appointments free of charge.
	August	A new primary care provider network is set up (TOMY).
2018	January	A committee in the National Organization for the Evaluation and Compensation of Medicinal Products for Human Use is established under the supervision of the Minister of Health to evaluate new medicines to be added to the positive list using health technology assessment.
2020	March	Paperless e-prescriptions are introduced, enabling people to receive regular prescriptions on mobile devices via text message or e-mail. Defined by the authorities as a response to COVID-19.

Table 2. (contd.)

Year	Month	Policy change
2022	May	A new model of public–private partnership is introduced in which people register with a general practitioner (referred to as a personal doctor) to strengthen continuity of care. The reform is supported by an expansion of TOMYs and the development of digital tools for enrolment and appointment booking.
	July	Referral of non-covered people can only be carried out by doctors in public facilities.
	December	Doctors in public hospitals working in new part-time positions or full-time positions are allowed to work in both public and private practice (dual practice).
	February	A new Dentist Pass Programme provides children aged 6–12 years with a €40 e-voucher covering a private dentist visit for an oral hygiene check, tooth fluoridation and cleaning.
2024	February	A Unified Digital List of Surgeries is set up, allowing waiting times to be centrally monitored in real time in all public hospitals.
	March	People on the Unified Digital List of Surgeries are allowed to bypass surgical waiting lists in public hospitals by paying a large co-payment (ranging from €300 to €2000 depending on the surgery's complexity) to have their surgery outside normal operating hours.
	May	User charges for diagnostic tests (€1) and for imaging tests (€3) are introduced in contracted private facilities.
	May	Private doctors are allowed to perform medical procedures in public hospitals (including outpatient care, surgery and diagnostic procedures) outside normal operating hours and are responsible for covering the hospital costs associated with performing these medical procedures.
	September	Bonuses ranging from €200 to €600 a month depending on specialty and location are granted to ESY physicians to attract and retain them in remote and underserved areas.
	November	People are allowed to choose a private doctor not contracted by the EOPYY as their primary care doctor and pay out of pocket for services. Doctors contracted by the EOPYY as primary care doctors are given the right to offer additional services privately to up to 500 additional people (added to their patient list) and to be paid directly by patients.
	November	Surgeries outside normal operating hours are covered by the EU's Recovery and Resilience Facility funds and people who have been on the waiting list for more than four months are given priority.

Box 2. Efforts to address the large gap in population coverage in the early years of the economic crisis

The Health Voucher Programme was launched in 2013 to provide people who had lost coverage due to being unemployed for over a year and their dependants with a voucher granting them access to free primary care and limited outpatient specialist visits in ESY-contracted facilities. The programme had several weaknesses: the voucher was only valid for four months and could not be renewed; it did not cover inpatient care; it only applied to people with an income of up to €12 000 for a single person or up to €25 000 for a couple – around 230 000 people, representing only a fraction of those who lacked coverage (over 2 million people); and it only managed to issue 23 000 vouchers in total, in part due to the administratively cumbersome process involved in claiming them. The programme ended in 2014.

Two joint ministerial decisions were issued in June 2014 to grant Greek citizens, legal residents and their dependants (who had lost coverage because of their inability to pay SHI contributions) free access to inpatient care in public facilities. This was possible with a referral from a primary care doctor or a public hospital outpatient department and confirmation from a special three-member medical committee (set up in each hospital to certify a person's need for hospitalization). Access to outpatient prescribed medicines was also granted (if prescribed by a primary care doctor or a doctor in a public hospital) but with co-payments. However, the stigmatizing process for access to inpatient care and heavy co-payments for outpatient prescribed medicines were a barrier to access for many people.

In April 2016 the Government introduced legislation (Law 4368/2016) and allocated funding to extend coverage to non-covered citizens and legal residents, self-employed people, people with low incomes, refugees and

Source: WHO Regional Office for Europe (2019b).

The current situation (2025)

In 2025 the basis for entitlement to publicly financed health care remains linked to payment of contributions to the SHI scheme run by the EOPYY. The Ministry of Health and the EOPYY define population coverage and Greek citizens and legal residents can access publicly financed health care via the following three routes.

First, the EOPYY covers employees and their dependants, self-employed people and pensioners who were covered by the EOPYY before they retired. Pensioners retain access to EOPYY benefits without paying contributions as their entitlement is based on having paid contributions while working. These people are entitled to the full range of EOPYY benefits.

Second, unemployed people who can provide evidence of having worked for at least 50 days in the year before becoming unemployed continue to

have access to EOPYY benefits for up to 12 months. Afterwards, the Public Employment Service (DYPA) provides coverage of the full range of EOPYY benefits to the following groups:

- people aged over 55 years who have worked for at least 3000 days are covered until they retire;
- people aged 30–55 years who have worked for a minimum number of days (600 days for people aged 30 years, increasing by 100 days a year up to 3000 days for people aged 54) are covered for a period of up to two years; and
- people aged under 30 years who have been registered as unemployed with the DYPA for at least two months are covered for up to six months.

Third, all other Greek or EU citizens who are legally resident – including long-term unemployed people who are not eligible for DYPA coverage, refugees and people living in refugee shelters and hotspots – are entitled only to health care provided in ESY facilities (hospitals and health centres); they are not entitled to access publicly financed health care through EOPYY-contracted private facilities. Although there are no data on the share of the population currently lacking EOPYY coverage, it is assumed to be significant given that 6.2% of the active population was registered as long-term unemployed in 2023 (Eurostat, 2025c) and that long-term unemployed people aged under 55 years are not entitled to EOPYY benefits.

People need a unique social insurance number (AMKA) to access publicly financed health care. Asylum seekers need a provisional social security number (temporary insurance and health care number for foreigners – PAAYPA) to be entitled to health care in ESY facilities and have the right to work for six months, although some exceptions apply – for instance, minors or people with a certified inability to work may access care without registering to receive a PAAYPA.

Undocumented migrants are not covered and are only entitled to emergency care and essential treatment for illnesses and serious mental health conditions in public facilities. However, some groups of undocumented migrants (e.g. pregnant women, children, people with disabilities and people with mental health conditions) are entitled to use ESY facilities free of charge if they hold an alien health care card (KYPA). While there are no official data on the number of individuals lacking comprehensive EOPYY or ESY coverage, Eurostat data indicate that 72 105 third country nationals were found to be illegally present in Greece in 2023 (Eurostat, 2025d).

Delays in the issuance of the provisional AMKA and the KYPA create administrative barriers and hinder access for asylum seekers and undocumented migrants. Most Roma people may also lack any form of coverage or face access barriers due to the lack of birth registration, identity cards or other documents, the lack of targeted information campaigns and negative attitudes from some health professionals. However, national data on population coverage are limited.

3.2 Service coverage

Before 2011 the multiple SHI funds defined their own benefits packages. When the EOPYY was set up in 2011, it defined a new national benefits package for people covered by the SHI scheme. The Ministry of Health defines benefits for people not covered by the EOPYY.

People covered by the EOPYY (directly or via the DYPA) can access publicly financed health care in public and private facilities contracted by the EOPYY. However, Greek or EU citizens and legal residents not covered by the EOPYY can only access publicly financed health care in public facilities and may experience barriers to access due to shortages of staff and equipment (e.g. computed tomography and magnetic resonance imaging scanners) and long waiting times.

To access publicly financed health care people need a unique identifier of their social insurance coverage (AMKA or PAAYPA) or a KYPA for undocumented migrants and are required to register with a personal doctor contracted by the EOPYY. People can choose their personal doctor once a year. Since 2024 people have been allowed to choose a private doctor not contracted by the EOPYY as their primary care doctor and to pay out of pocket for services. Access to covered specialist care requires a referral but non-covered people (including refugees) can only be referred to public facilities. Access to covered medicines and medical products requires an e-prescription.

Recent initiatives – including a project funded by the European Commission Directorate-General for Structural Reform Support and the *National strategy for quality of care and patient safety* – are strengthening the role of health technology assessment and encouraging the use of generic and biosimilar medicines to improve affordability and access (WHO Regional Office for Europe, 2024; Ministry of Health, 2025). For details of how publicly financed benefits are defined, see UHC watch (2025).

The main gap in the benefits package is for non-emergency dental care. The EOPYY does not contract private dentists, so dental care coverage is limited to services provided in ESY health centres: free dental care for children aged under 18 years and emergency dental treatment for people of all ages. ESY health centres often lack staff and capacity, which further limits access to publicly financed dental care. As a result, many people have to pay out of pocket. A Dentist Pass Programme introduced in 2022 provides children aged 6–12 years with a €40 e-voucher covering a private dentist visit for an oral hygiene check, tooth fluoridation and cleaning. The voucher is valid for six months and parents need to apply for it. To date over 200 000 children have benefited (Information Society, 2024). Other types of care that are not so well covered include optical care (covered with limits, such as one pair of glasses every four years) and palliative care.

Caps on the volume of covered health care provided by contracted doctors (doctor visits, outpatient prescribed medicines and diagnostic tests) have

been in place since 2011. These daily, weekly and monthly ceilings on the volume of publicly financed consultations (10 per day, 50 per week and 200 per month) have increased informal payments (see section 4.3).

Long waiting times have become a significant issue in Greece since the economic crisis. Cuts in public spending on health and limits on staff recruitment in public hospitals led to a delay in surgical procedures, while the introduction of volume caps on the activity of contracted doctors increased waiting times for outpatient visits (Economou et al., 2017). The situation worsened during the COVID-19 pandemic, when hospitals were instructed to suspend all elective surgeries in both public and private hospitals; only oncology and emergency services remained operational (European Observatory on Health Systems and Policies, 2021).

Due to a lack of systematic monitoring it is difficult to know how many people are waiting, for what and for how long. There are no waiting time guarantees or targets. Policies to reduce waiting times include a Surgery List to identify prioritization criteria in public hospitals (2016); a Unified Digital List of Surgeries introducing a single list for all public hospitals and allowing waiting times to be centrally monitored in real time (2024); allowing people to bypass surgical waiting lists in public hospitals if they pay a co-payment (ranging from €300 to €2000 depending on the surgery's complexity) to have their surgery outside normal operating hours (2024); covering surgeries outside normal operating hours using EU Recovery and Resilience Facility funds; and giving priority to people who have been on the waiting list for more than four months (Economou, 2024). Although patients who have been on the waiting list for more than four months are eligible for surgery free of charge since November 2024, this new policy is likely to exacerbate inequalities in access to care.

Informal payments are widespread (Economou et al., 2017), particularly for obstetric services in public hospitals (see section 4.3).

Other access issues include low levels of public spending on health, leading to staff shortages and affecting the quality of care in public facilities. Significant variation in the geographical distribution of doctors and public facilities also undermines equitable access (OECD, 2023).

3.3 User charges (co-payments)

The Ministry of Health and the EOPYY define user charges, which do not vary across the country.

User charges were increased for outpatient prescribed medicines, outpatient visits and hospital admissions in public facilities between 2011 and 2014, during the crisis (see Table 2 in section 3.1). As a result, the average amount people had to pay for outpatient prescribed medicines rose from 13% in 2012 to 18% in 2013 and the share of prescribed medication packages that did not require a co-payment fell from 13% to 8% (Economou et al., 2017).

Some of the new co-payments for outpatient and inpatient care were abolished in 2015 and the Government also introduced income-based exemptions and a cap of €20 on the difference between the retail price and the reference price per outpatient prescribed medicine (see Table 2).

User charges still apply to most types of outpatient care in the form of fixed co-payments, percentage co-payments and internal reference pricing (Table 3).

There are exemptions in place to protect some people from some co-payments (Table 3), and a cap on reference pricing, but there are very few exemptions targeting people with low incomes and there is no overall cap on co-payments.

Table 3. User charges (co-payments) for publicly financed health care, 2025

Note: NA: not applicable.

Source: UHC watch (2025).

Service area	Type and level of user charge	Exemptions	Cap on user charges paid
Outpatient visits	**Outpatient primary care visits:** none **Outpatient specialist visits:** • none in public facilities • private services in public hospitals: fixed co-payments per visit ranging from €16 to €72, depending on physician location and qualifications • booking appointments with a specialist is free if booked online (since 2017); €1.65 per minute for telephone booking (since 2014) **Outpatient emergency visits:** none	NA	NA
Dental care visits and treatment	Fixed co-payments vary by service	• Children aged under 18 years in public facilities • Emergency treatment for people of all ages in public facilities	No
Outpatient prescription medicines	Fixed co-payment: €1 per prescription Percentage co-payment: 25% Reference pricing: users pay the difference between the reference and the retail price up to a maximum of €20 per medicine	• Exemption from fixed co-payment for people with an annual income under €2400 per person or €3600 per household, social beneficiaries, non-covered people and other people in vulnerable situations, such as unemployed people and undocumented migrants • Exemption from percentage co-payment for people with an annual income of less than €2400 per person or €3600 per household • People living with HIV, transplant recipients and paraplegics • Reduced co-payments: people with chronic conditions pay 10% rather than 25%	No
Diagnostic tests	None in public facilities Percentage co-payment: 15% in contracted private facilities Fixed co-payment: €1 per diagnostic test and €3 per imaging test in contracted private facilities	In contracted private facilities: • exemptions for people with multiple sclerosis, Mediterranean anaemia, sickle cell disease, cystic fibrosis or type 1 diabetes; • exemptions for people with end-stage chronic renal failure who are undergoing renal replacement therapy, peritoneal dialysis or have undergone a transplant; • exemptions for amputees with a disability rate of over 66% who receive disability allowance and those with a certified disability rate of 80% or more; and • percentage co-payment (user charges) reduced to 5% for covered people who receive the pensioners' social solidarity allowance	No

Table 3. (contd.)

Service area	Type and level of user charge	Exemptions	Cap on user charges paid
Medical products	Percentage co-payment: 25%	• Paraplegic and quadriplegic patients • Amputees with a disability rate of over 66% who receive disability allowance • Patients with kidney conditions undergoing continuous renal function replacement therapy or who have undergone a kidney transplant • People with multiple sclerosis, Mediterranean anaemia, cystic fibrosis or type 1 diabetes • Patients with severe heart failure and mechanical cardiac support • People who have undergone a solid or liquid organ transplant • People living with HIV • People with chronic conditions, with certified disability rate of over 66%	No
Inpatient care	No routine user charges in public facilities but people on the Unified Digital List of Surgeries can pay a large co-payment (ranging from €300 to €2000 depending on the surgery's complexity) to bypass surgical waiting lists by having their surgery outside normal operating hours Percentage co-payment: 30% in contracted private facilities	No	No
Inpatient medicines	No	NA	NA

3.4 The role of VHI

VHI plays a minor supplementary role in the health system, providing people with faster access to treatment, greater choice of provider and treatment in private facilities, including facilities owned by insurance companies (Sagan & Thomson, 2016). It covers around 16% of the population (OECD, 2022) and accounted for 4.1% of current spending on health in 2022 (WHO, 2025).

VHI is regulated by the Department of Private Insurance Supervision of the Bank of Greece. It is generally sold by non-specialist commercial entities in combination with life insurance or private pension schemes and tends to be purchased by people in higher socioeconomic groups (Sagan & Thomson, 2016) – mainly employers for their employees, especially middle and senior managers in large private companies and banks.

The share of the population with VHI rose in the mid-2000s but fell during the economic crisis. Data from the Hellenic Association of Private Companies indicate that the share of cancelled VHI contracts increased from 13% in 2010 to 15% in 2012 (Economou et al., 2017). In 2011 the Government allowed private insurers to use up to 10% of beds in public

hospitals, a policy intended to give public hospitals an additional source of income during the crisis. Tax incentives encouraging people to buy VHI were abolished in 2013, resulting in lower take up (Sagan & Thomson, 2016).

Table 4 summarizes the main gaps in publicly financed coverage and indicates the role of VHI in filling these gaps.

Table 4. Gaps in publicly financed and VHI coverage

Source: UHC watch (2025).

Coverage dimension	Main gaps in publicly financed coverage	Are these gaps covered by VHI?
Population coverage	The basis for entitlement to benefits covered by the SHI scheme (the EOPYY) is employment and payment of mandatory contributions, which leaves some legal residents without SHI coverage, including long-term unemployed people under the age of 55 or self-employed people who struggle to pay contributions There are no publicly available data on the number of legal residents who lack EOPYY coverage Legal residents (and their dependants) who are not covered by the EOPYY are only entitled to health care provided in public facilities and tend to face longer waiting times for treatment and other access barriers Undocumented migrants only have access to emergency care and essential treatment for illnesses and serious mental health conditions and may face administrative barriers, such as delays in access to the relevant type of proof of entitlement to social insurance coverage (KYPA for undocumented migrants or the temporary PAAYPA) Most Roma may lack coverage or face barriers to access	No, due to financial barriers to VHI
Service coverage	Coverage of dental care is limited, particularly for adults who are only entitled to emergency dental care in public facilities Caps on service volumes limit access to outpatient visits, prescribed medicines and diagnostic tests Although waiting times are a major issue, there are no waiting time guarantees or targets Informal payments are widespread, particularly in public hospitals	Yes, but take up is low and concentrated among people with higher incomes
User charges (co-payments)	User charges are applied to most types of outpatient care and to inpatient care and diagnostic tests provided in private facilities contracted by the EOPYY The design of user charges for outpatient prescribed medicines is complex There are very few exemptions from co-payments targeting people with low incomes and there is no overall cap on co-payments	No

3.5 Summary

The economic crisis exposed underlying weaknesses in Greece's complex and fragmented coverage policy and many policy changes made in response to the crisis exacerbated gaps in coverage. Although some changes were later reversed and the Government took steps to address some barriers to access, key gaps in coverage remain.

Entitlement to the SHI scheme run by the EOPYY is linked to employment and payment of mandatory contributions. Although there are no publicly available data on the number of legal residents who lack EOPYY coverage, this leaves some residents without EOPYY coverage – including long-term unemployed people aged under 55 years or self-employed people who struggle to pay contributions. Undocumented migrants are only entitled to publicly financed emergency care and essential treatment for illnesses and serious mental health conditions.

The EOPYY benefits package established in 2011 created a national set of entitlements for people covered by the EOPYY. However, legal residents who are not covered by the EOPYY are reliant on health care provided in public facilities, where they are likely to face greater access barriers due to long waiting times, shortages of staff and equipment and an uneven distribution of staff across the country.

The main gap in the benefits package is for non-emergency dental care. Some dental care is covered but lack of public funding and the absence of contractual arrangements with private dentists lead many people to pay out of pocket for services.

Caps on service volumes limit access to outpatient care, including outpatient prescribed medicines, outpatient visits and diagnostic tests.

Waiting times have become a significant issue since the economic crisis and were exacerbated during the COVID-19 pandemic. Although some policies have been put in place to address them, there are no waiting time guarantees or targets in the Greek health system.

Informal payments are widespread, particularly in public hospitals.

User charges (co-payments) apply to most types of outpatient care, including in the form of percentage co-payments, with limited protection mechanisms. The design of user charges for outpatient prescribed medicines is complex. There are very few exemptions from co-payments for people with low incomes and there is no overall cap on co-payments.

VHI plays a minor supplementary role in the health system, providing around 16% of the population with faster access to treatment and accounting for 4.1% of current spending on health in 2022. Take up of VHI is concentrated among people with higher incomes.

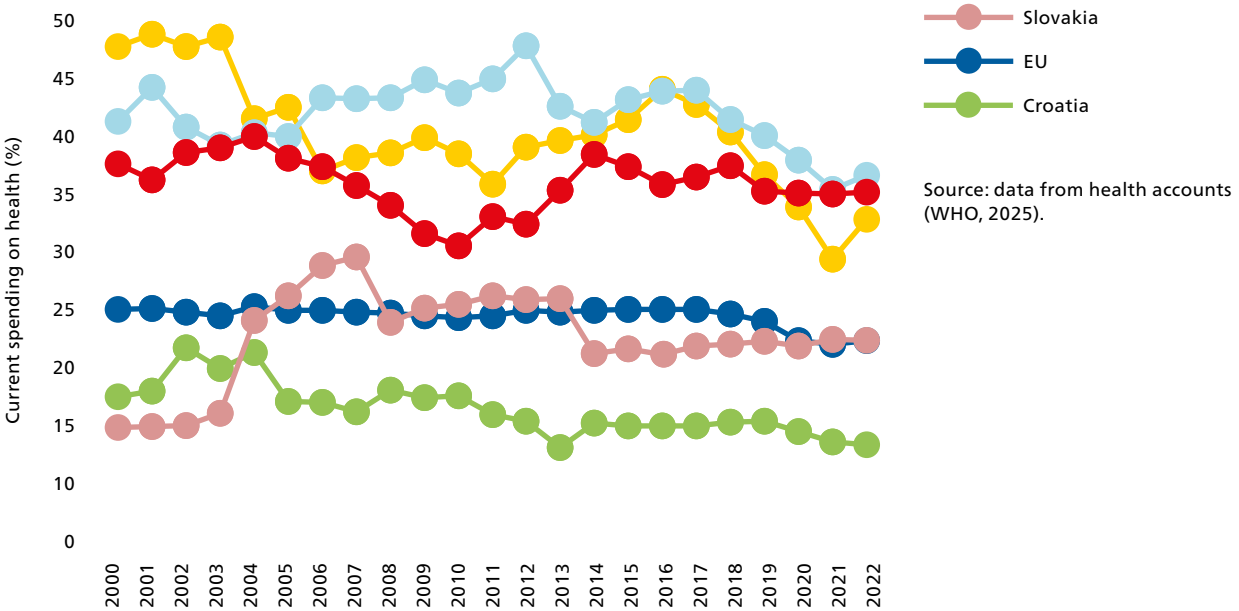
4. Household spending on health

The first part of this section uses data from national health accounts to present patterns in public and private spending on health. The second part uses household budget survey data to review out-of-pocket payments (the formal and informal payments made by people at the time of using any good or service delivered in the health system) and the third part considers the role of informal payments.

4.1 Public and private spending on health

Health accounts data show that out-of-pocket payments accounted for 34% of current spending on health in Greece in 2022 (the latest available year of internationally comparable data) – well above the EU average of 19% and higher than every other EU country except Bulgaria (Fig. 1). Reliance on out-of-pocket payments began to fall in the years before the economic crisis and continued to decrease in the early years of the crisis as households were hit hard by the economic shock and public spending on health plummeted. The out-of-pocket payment share of current spending on health rose sharply from 2011 onwards, reaching a peak of 37% in 2014 (Fig. 1). It has decreased since then.

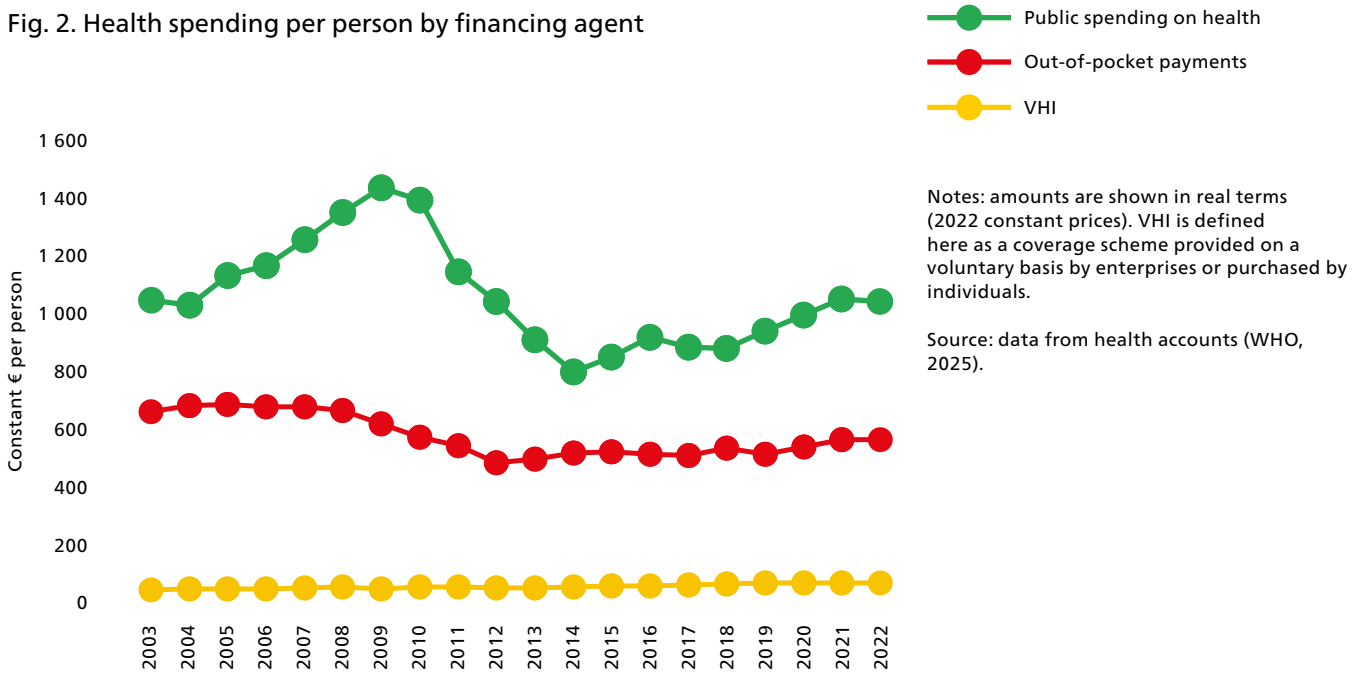
Fig. 1. Out-of-pocket payments as a share of current spending on health, Greece and EU countries with a similar or lower level of GDP per person



Source: data from health accounts (WHO, 2025).

These shifts are reflected in per-person spending on health. The recent decrease in reliance on out-of-pocket payments reflects increases in public spending on health per person between 2018 and 2022, mainly in response to the COVID-19 pandemic (Fig. 2). Public spending on health per person had been growing rapidly before the economic crisis but fell sharply after 2009, reaching its lowest point in 2014. Policy responses to the crisis led to sharp cuts in the health budget (of €7.5 billion) between 2010 and 2014, mostly concentrated in inpatient care (€3.1 billion), outpatient medicines (€2.2 billion) and outpatient care (€2 billion) (ELSTAT, 2018). Out-of-pocket payments per person also fell in the early years of the crisis and then rose slowly after 2012 and VHI spending per person is very low in Greece but has increased since 2014 (Fig. 2).

Fig. 2. Health spending per person by financing agent

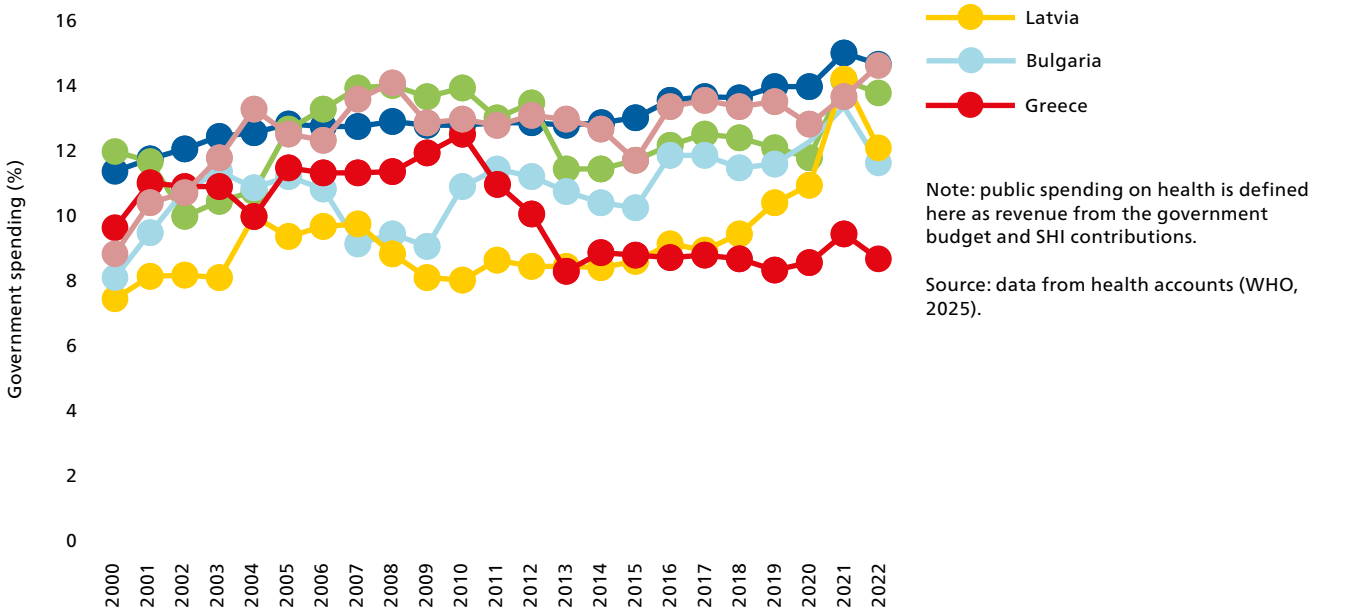


Notes: amounts are shown in real terms (2022 constant prices). VHI is defined here as a coverage scheme provided on a voluntary basis by enterprises or purchased by individuals.

Source: data from health accounts (WHO, 2025).

Public spending on health accounted for 9% of total government spending in Greece in 2022, the lowest in the EU (Fig. 3). This share fell dramatically from 2011 to 2013 and remains well below the EU average (15% in 2022), despite increases between 2019 and 2021. This reflects the relatively low priority given to health in allocating the government budget in Greece compared to other EU countries (Fig. 3).

Fig. 3. Public spending on health as a share of total government spending ("priority to health"), Greece and EU countries with a similar or lower level of GDP per person



Note: public spending on health is defined here as revenue from the government budget and SHI contributions.

Source: data from health accounts (WHO, 2025).

As a share of GDP, public spending on health accounted for just under 5% in 2022, well below the EU average of 7% and much lower than in countries with a similar level of GDP per person, such as Croatia and Slovakia (Fig. 4). This share fell substantially from a peak of 7% in 2010 to a low of 4% in 2019 but rose sharply in 2020 and 2021 due to the COVID-19 pandemic's effect on the economy, before falling again in 2022 (Fig. 5).

Fig. 4. Public spending on health as a share of GDP and GDP per person in the EU, 2022

Notes: Greece is shown in red. Public spending on health is defined here as revenue from the government budget and SHI contributions. The figure excludes Ireland and Luxembourg because they are outliers in terms of GDP per person and excludes Netherlands (Kingdom of the) because the country's data on public spending on health are not internationally comparable. The list of country codes used here can be found in the Abbreviations.

Source: data from health accounts (WHO, 2025).

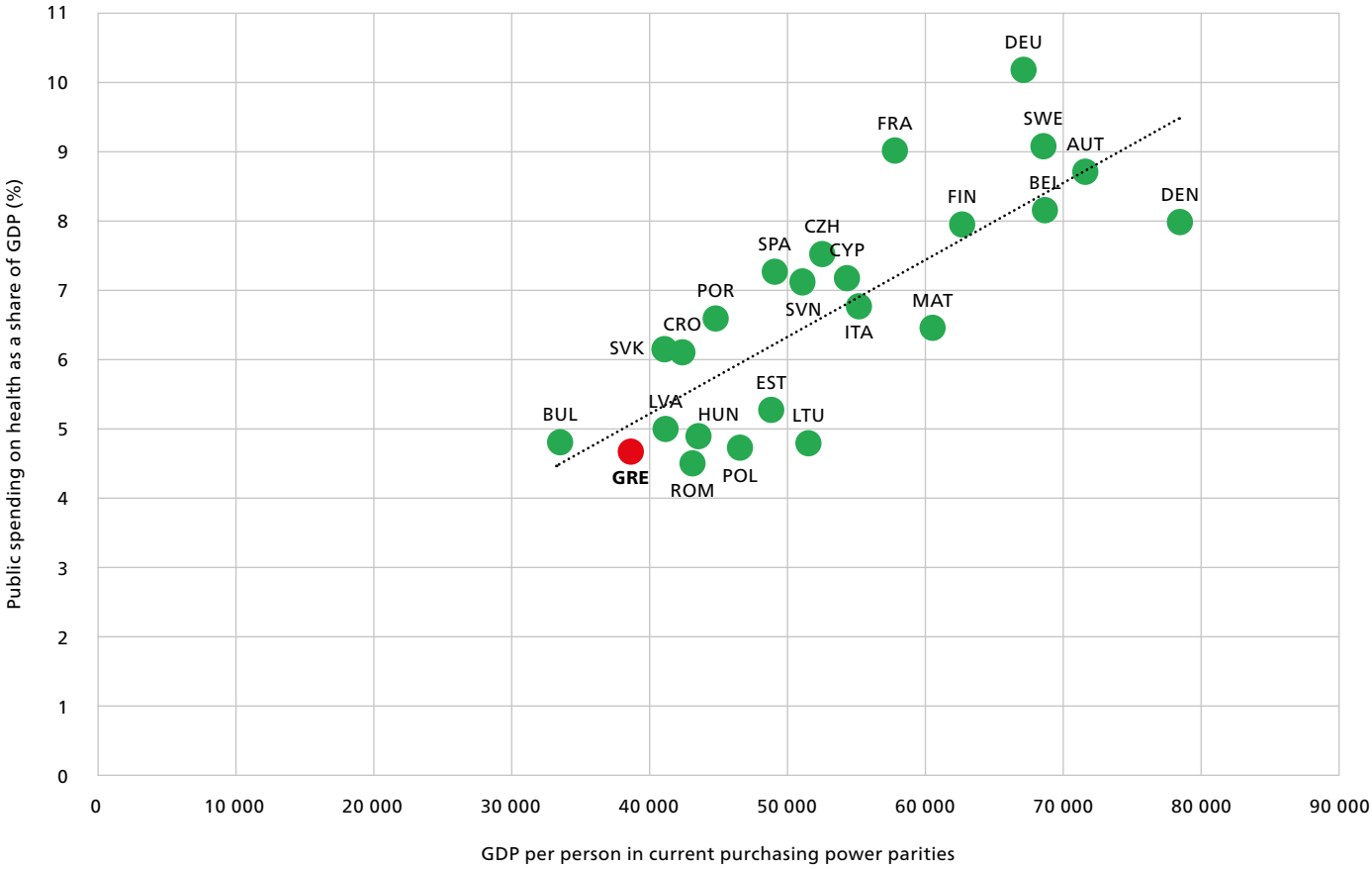
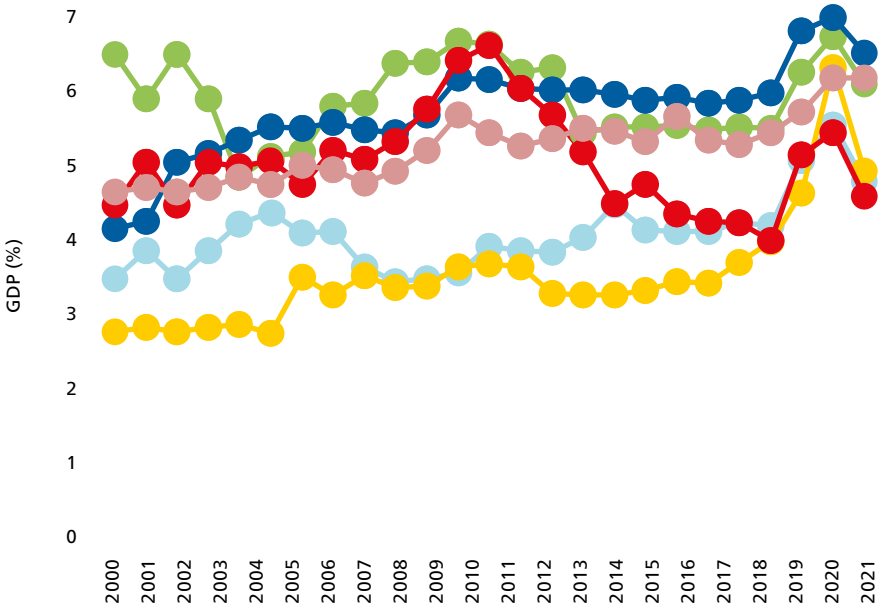


Fig. 5. Public spending on health as a share of GDP in Greece and EU countries with a similar or lower level of GDP per person

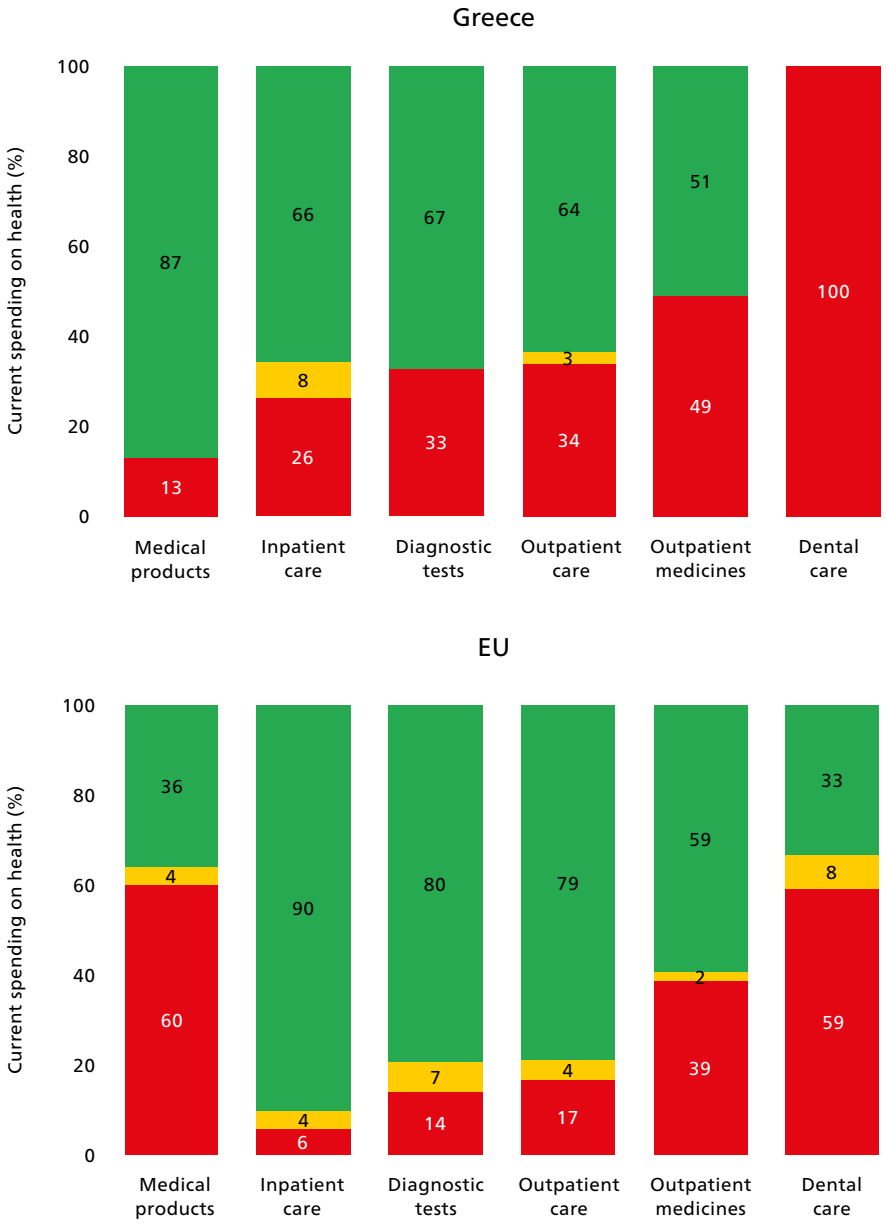


Note: public spending on health is defined here as revenue from the government budget and SHI contributions.

Source: data from health accounts (WHO, 2025).

Broken down by type of health care and financing agent, health accounts data show that dental care was entirely financed through out-of-pocket payments in Greece in 2022 (Fig. 6). Greece spends almost four times more than the EU average through out-of-pocket payments for inpatient care (26% compared to an EU average of 6%); double for diagnostic tests (33% versus 14%) and outpatient care (34% versus 17%) and considerably more for outpatient medicines (49% versus 39%). However, the out-of-pocket payment share in Greece is much lower than the EU average for medical products (13% in Greece versus an EU average of 60%). VHI played a very small role in financing health care in Greece in 2022 (in the outpatient and inpatient care sectors only) (Fig. 6).

Fig. 6. Breakdown of current spending on health by type of care and financing agent, Greece and the EU, 2022



Public spending on health

VHI

Out-of-pocket payments

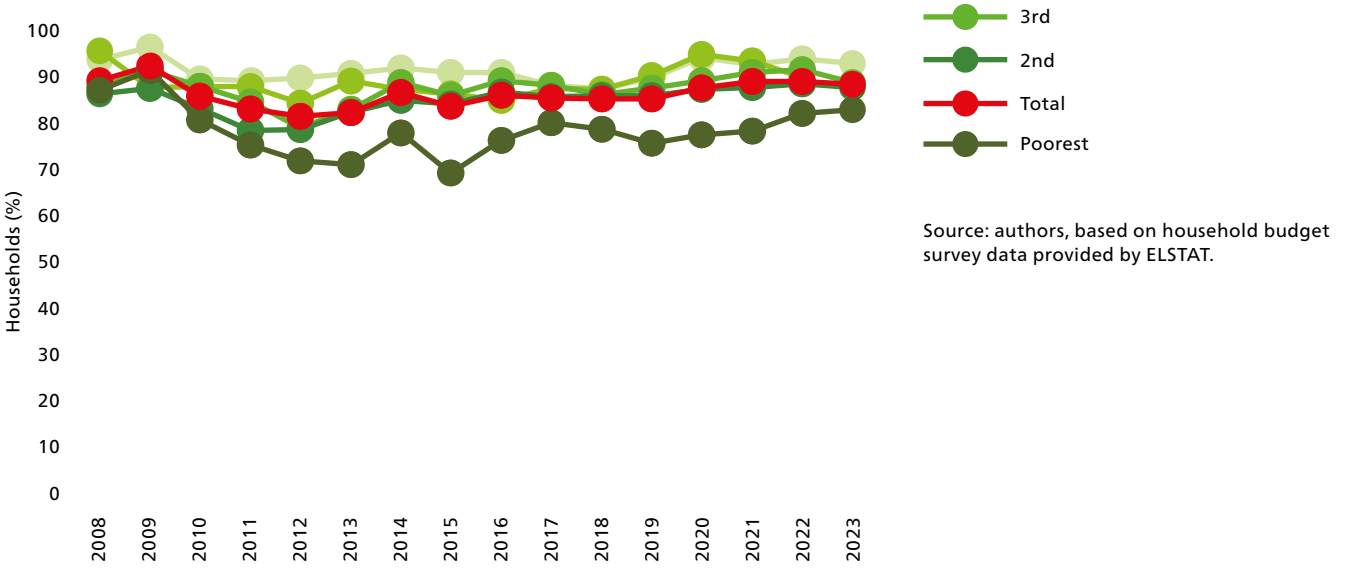
Notes: the EU average for outpatient care excludes Ireland, Italy and Portugal as these countries do not report dental care separately from other types of outpatient care. The EU average for diagnostic tests excludes Denmark, Ireland, Italy and Portugal as these countries do not report patient transport separately from ancillary services.

Source: data from health accounts (OECD, 2025).

4.2 Out-of-pocket payments

Household budget survey data show that 89% of households reported out-of-pocket payments in 2023 (Fig. 7). Households in the richest consumption quintile are consistently more likely to report out-of-pocket payments (93% in 2023) than households in the poorest quintile (83%), reflecting their greater ability to afford health care (Fig. 7). The share of households reporting out-of-pocket payments fell between 2008 and 2012, with the poorest quintile experiencing the sharpest drop, further widening the gap between the richest and poorest households. Because the household budget survey does not include questions on health care use or unmet need for health care, it is not possible to say whether poorer households are less likely to incur out-of-pocket payments due to access barriers or exemptions from co-payments.

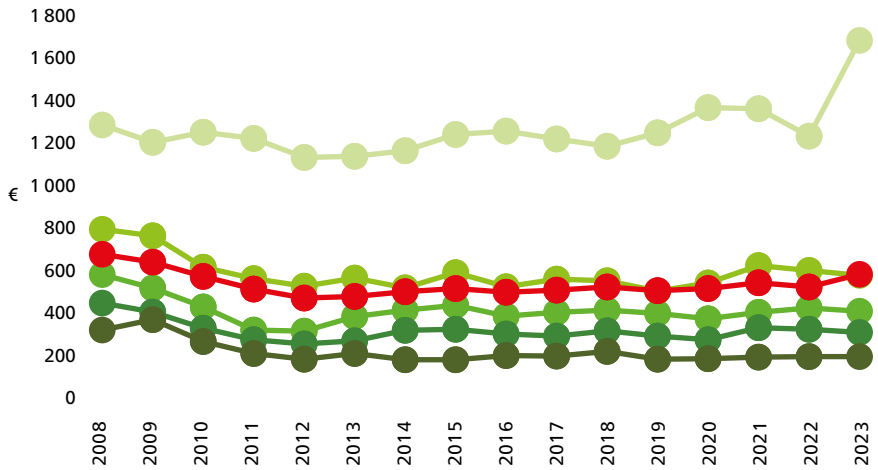
Fig. 7. Share of households with out-of-pocket payments by consumption quintile



Source: authors, based on household budget survey data provided by ELSTAT.

The average annual amount spent out of pocket per person was €580 in 2023, up from €515 in 2022 (Fig. 8). The average annual amount spent fell sharply between 2008 and 2012 in all quintiles. The richest quintile spent four times as much as the poorest quintile in 2008, rising to about seven times as much by 2022 and ten times as much by 2023 (Fig. 8).

Fig. 8. Annual out-of-pocket spending on health per person by consumption quintile

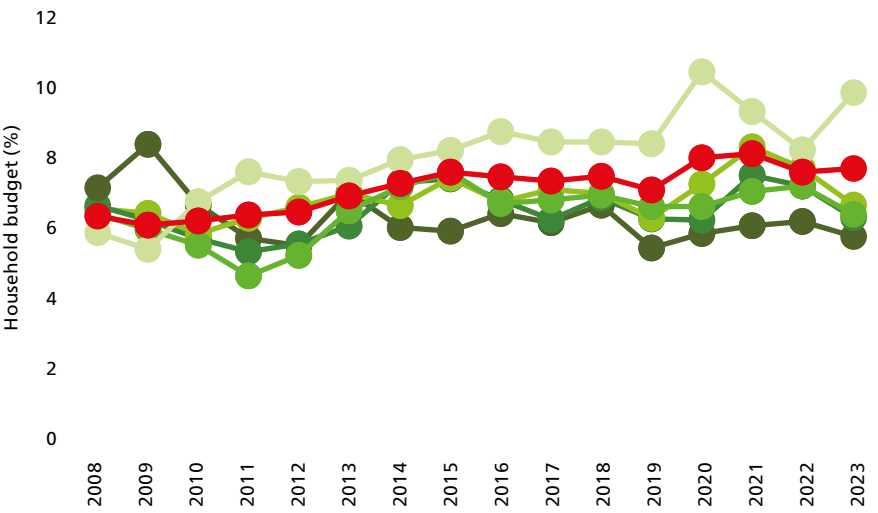


Note: amounts are shown in real terms (base year 2020).

Source: authors, based on household budget survey data provided by ELSTAT.

Out-of-pocket payments accounted for 7.7% of total household spending (the household budget) in 2023 (Fig. 9) – one of the highest shares in the EU (UHC watch, 2025). It was higher in the richest quintile (9.9%) than in the poorest quintile (5.7%). Over time this share increased in the two richest quintiles and fell in the three poorest quintiles, making the distribution more progressive in 2023 than in 2009. The sharp increase in 2019 and, more recently, in 2023 were mainly driven by the richest quintile.

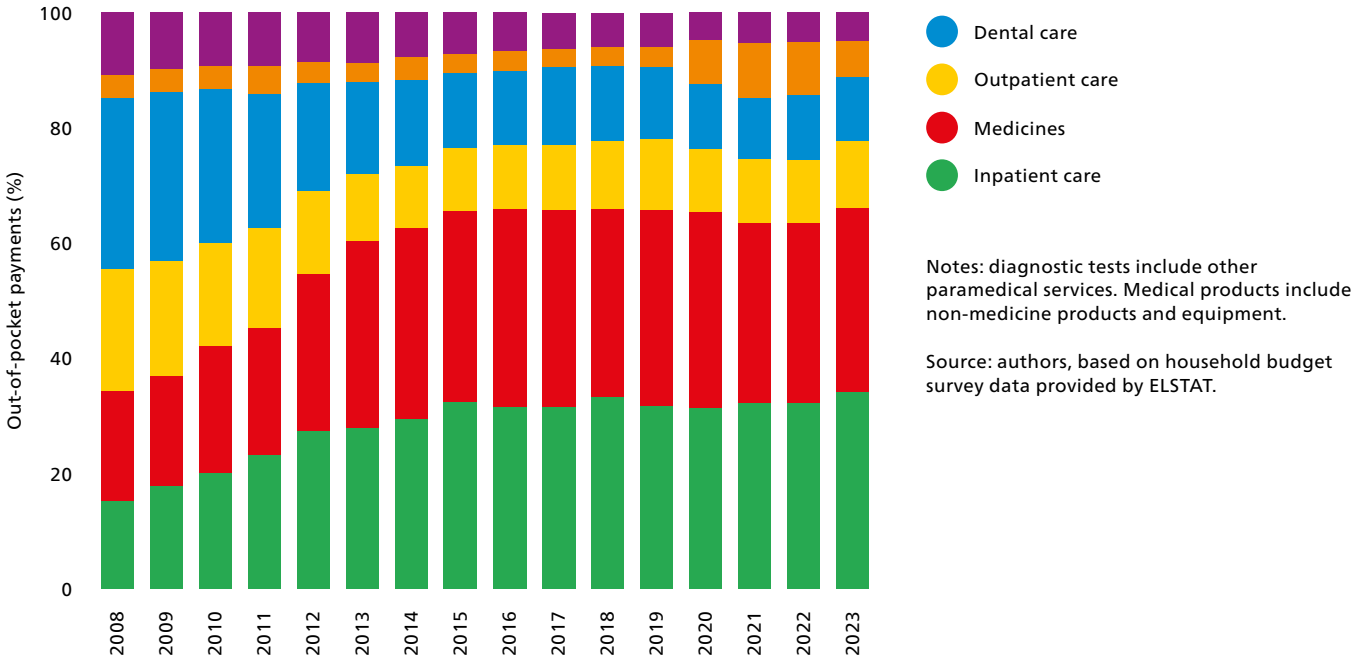
Fig. 9. Out-of-pocket payments for health care as a share of household spending (the household budget) by consumption quintile



Source: authors, based on household budget survey data provided by ELSTAT.

In 2023 out-of-pocket payments were mainly driven by spending on inpatient care (34%) and outpatient medicines (32%), followed by outpatient care (12%), dental care (11%), medical products (6%) and diagnostics (5%) (Fig. 10). Between 2008 and 2023 the outpatient medicines and inpatient care shares increased substantially, while the dental care and outpatient care shares fell (Fig. 11). The steep rise in the outpatient medicines share in 2012 and 2013 coincides with a large decrease in public spending on medicines between 2011 and 2014 as part of the policy response to the economic crisis (ELSTAT, 2018).

Fig. 10. Breakdown of out-of-pocket payments by type of care



Notes: diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment.

Source: authors, based on household budget survey data provided by ELSTAT.

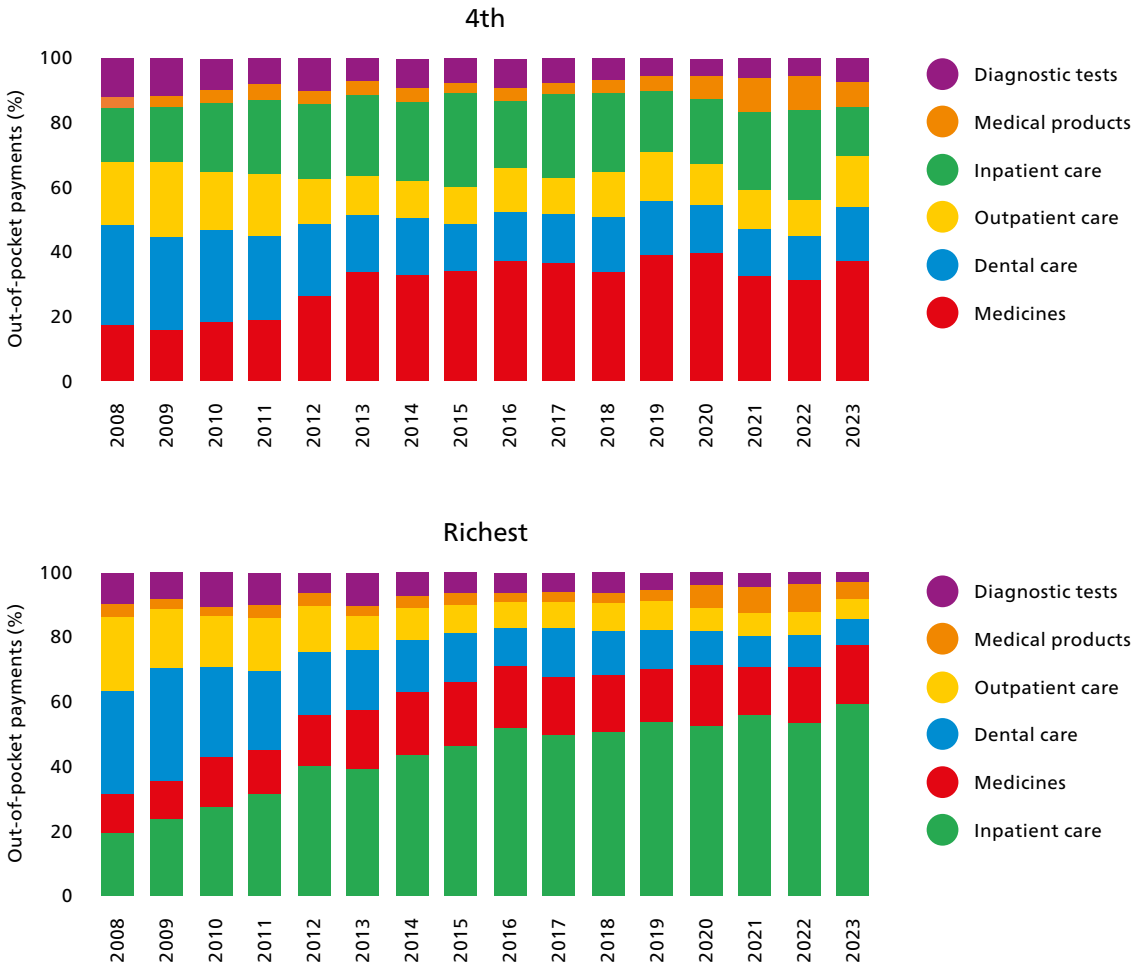
Outpatient medicines are consistently the largest single driver of out-of-pocket payments in the poorest consumption quintile and their share rose sharply from 43% in 2008 to 58% in 2023 (Fig. 11). Outpatient care is the second-largest driver in the poorest quintile. The share of out-of-pocket payments spent on inpatient care and, to a lesser extent, dental care was higher in richer quintiles. The share spent on dental care, outpatient care and diagnostics fell in all quintiles over time, while the share spent on inpatient care grew substantially in the richest quintile, where it more than doubled (Fig. 11).

Fig. 11. Breakdown of out-of-pocket payments by type of care and consumption quintile

Notes: diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment.

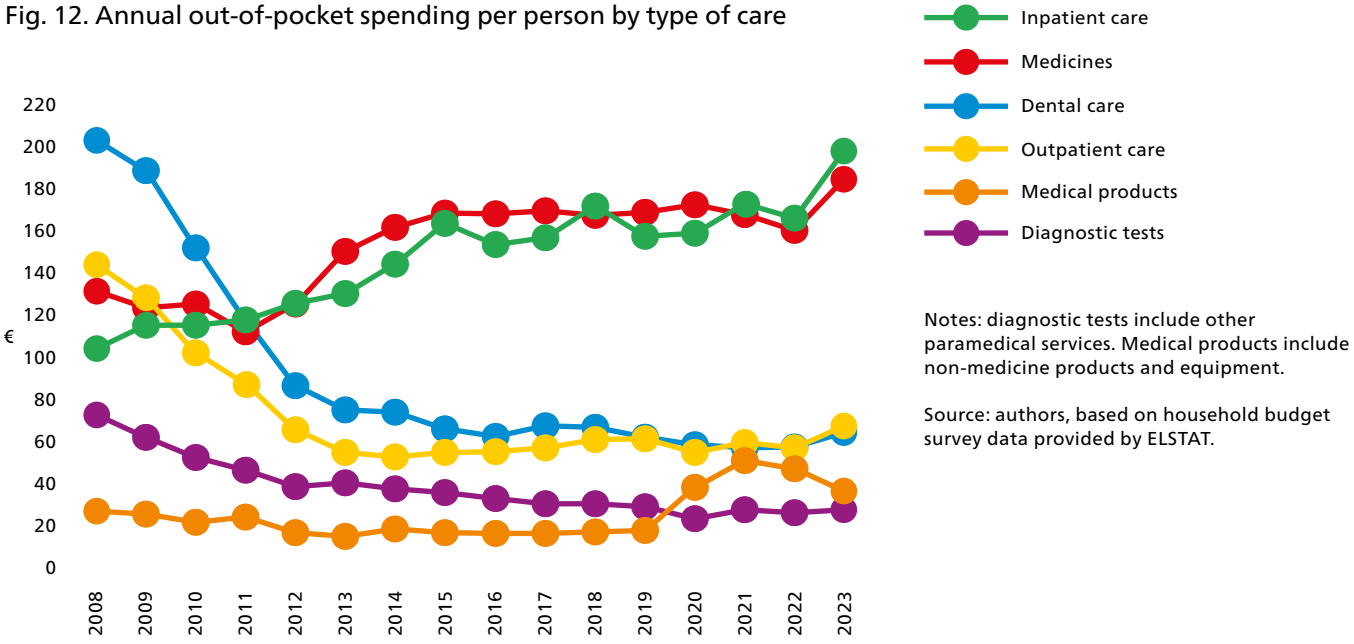
Source: authors, based on household budget survey data provided by ELSTAT.

Fig. 11. (contd.)


4th
Out-of-pocket payments (%)
100
80
60
40
20
0
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
Diagnostic tests
Medical products
Inpatient care
Outpatient care
Dental care
Medicines
Richest
Out-of-pocket payments (%)
100
80
60
40
20
0
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
Diagnostic tests
Medical products
Outpatient care
Dental care
Medicines
Inpatient care

Shifts in the drivers of out-of-pocket payments across quintiles reflect changes in the amount spent per person (Fig. 12). Per-person spending on outpatient medicines and inpatient care increased between 2008 and 2015 and per-person spending on medical products has increased since 2019, all mainly driven by higher spending in the richest quintile (Fig. 13), while per-person spending on dental care and outpatient care fell in all quintiles during the economic crisis.

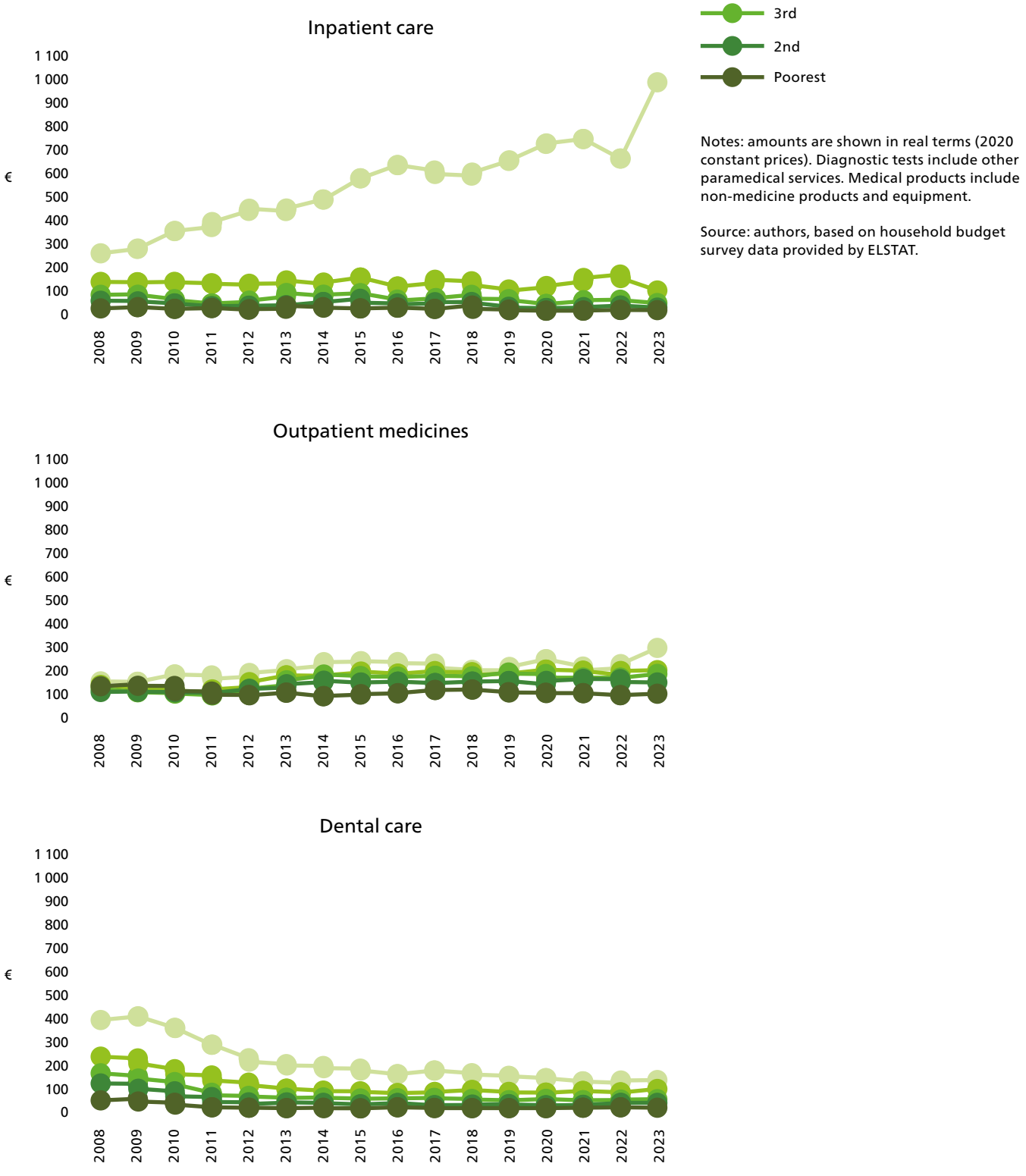
Fig. 12. Annual out-of-pocket spending per person by type of care



Notes: diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment.

Source: authors, based on household budget survey data provided by ELSTAT.

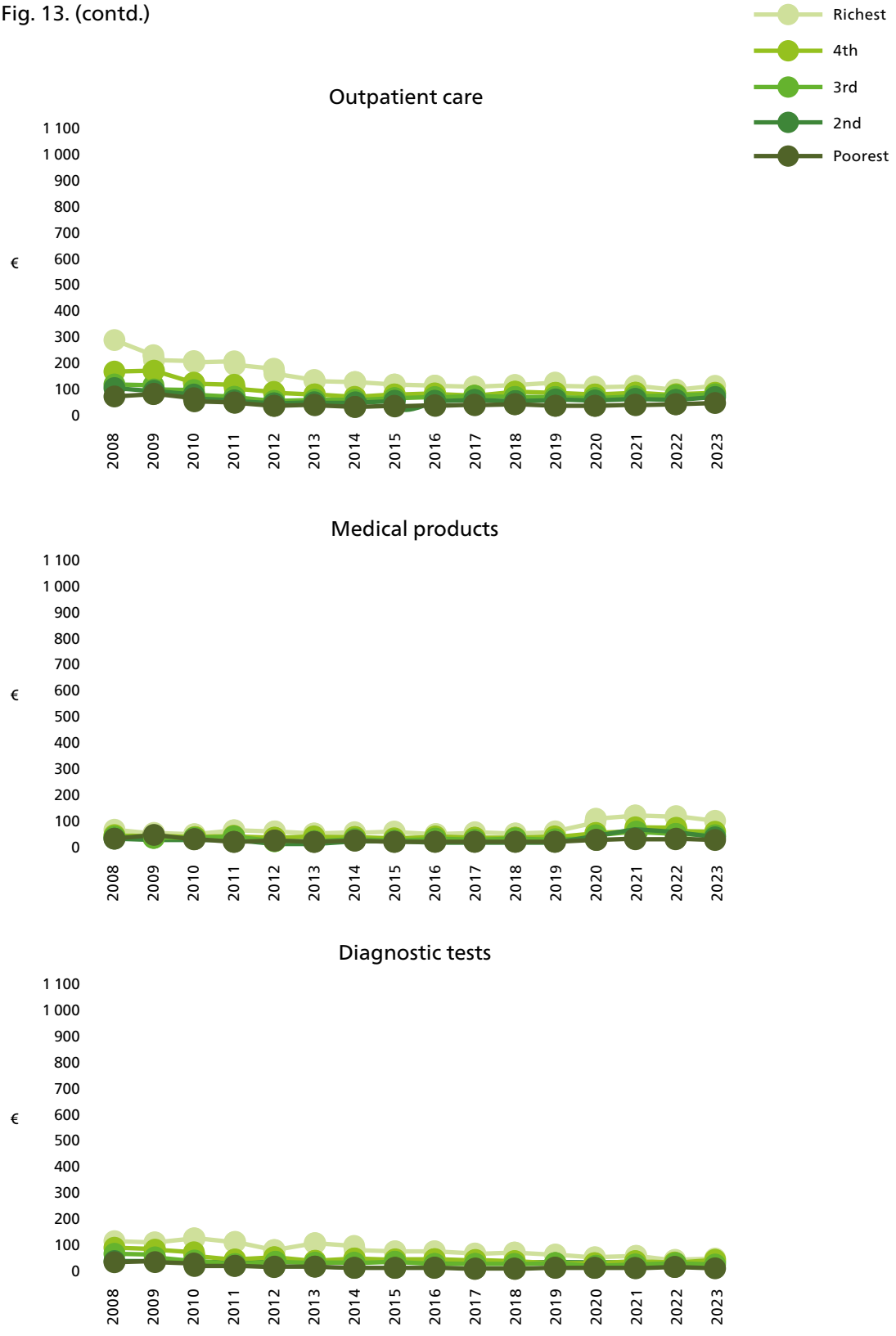
Fig. 13. Annual out-of-pocket spending per person by type of care and consumption quintile



Notes: amounts are shown in real terms (2020 constant prices). Diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment.

Source: authors, based on household budget survey data provided by ELSTAT.

Fig. 13. (contd.)


Richest
4th
3rd
2nd
Poorest
Outpatient care
Medical products
Diagnostic tests
€
1 100
1 000
900
800
700
600
500
400
300
200
100
0
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023

4.3 Informal payments

Informal payments are widespread in Greece, particularly for obstetric services in public hospitals (Kaitelidou et al., 2013; Economou et al., 2017; Giannouchos et al., 2020, 2021). According to a special Eurobarometer report on corruption, 10% of the Greek population reported informal payments in 2024 (down from 14% in 2023), well above the EU average of 3% (European Commission & Kantar, 2025). A 2012 survey found that informal payments occurred in 14–36% of visits to private clinics and 32% of visits to public hospitals; were made upon request, mainly to gain easier or faster access to services and, to a lesser degree, to ensure better quality of care; and were more likely to occur among people reporting their financial status as being bad (56%) than those reporting their financial status as average (48%) or good (32%), demonstrating the regressivity of informal payments (Souliotis et al., 2016).

Informal payments in Greece reflect a range of factors, including: low pay for health professionals; lack of transparency and information for service users; and inadequate and inappropriate planning and allocation of resources leading to long waiting times and unethical behaviour – encouraged by the absence of monitoring and supervision mechanisms (WHO Regional Office for Europe, 2018; 2019b). Since the introduction of volume caps for EOPYY-contracted doctors during the economic crisis, people have made informal payments to avoid having to look for doctors who have not yet reached visit or prescription volume caps (WHO Regional Office for Europe, 2018; 2019b).

There are policies in place to reduce informal payments. A law introduced in 2010 allows what are known as afternoon services in all public hospital outpatient departments: publicly employed doctors can offer private consultations and are paid directly by patients, with the fee shared between the hospital (40%) and the physician (60%). Although the strategy aims to reduce informal payments, it has also increased inequalities in access (Economou et al., 2017). The Surgery List introduced in 2016 to identify prioritization criteria for surgery has also reduced incentives for informal payments. In February 2024 the Unified Digital List of Surgeries was launched to enable central monitoring of waiting times in public hospitals (including the clinical characteristics of patients on the list). Informal payments are still not systematically monitored, however.

4.4 Summary

Data from health accounts show that out-of-pocket payments accounted for 34% of current spending on health in 2022, well above the EU average of 19% and higher than in all other EU countries except Bulgaria. This share had begun to fall in the years before the economic crisis but rose sharply from 2011 to reach a peak of 37% in 2014.

Public spending on health fell sharply during the economic crisis. Although it has grown on a per-person basis since 2014, it remains very low both as a share of total public spending (9% in 2022, the lowest share in the EU and far below the EU average of 15%) and as a share of GDP (5% in 2022, well below the EU average of 7% and lower than in countries with a similar level of GDP per person, such as Croatia and Slovakia).

Health accounts data show that out-of-pocket payments account for a much higher share of current spending on all types of health care in Greece than the EU average, except for out-of-pocket payments for medical products.

Household budget survey data indicate that 89% of households incurred out-of-pocket payments for health care in 2023, with richer households consistently more likely to report out-of-pocket payments than poorer households. Out-of-pocket payments accounted for 7.7% of total household spending (the household budget) in 2023 – one of the highest shares in the EU.

Out-of-pocket payments are mainly spent on inpatient care (34% in 2022) and outpatient medicines (32%), followed by outpatient care (12%), dental care (11%), medical products (6%) and diagnostic tests (5%). Spending by type of care has shifted over time; the outpatient medicines and inpatient care shares have increased while the dental care and outpatient care shares have fallen. Medicines are consistently the largest driver of out-of-pocket payments in the poorest consumption quintile. The shares spent on inpatient care and, to a lesser extent, dental care are higher in richer households.

Informal payments are widespread, particularly for obstetric services in public hospitals, and reflect low pay for health professionals, lack of transparency and inadequate and inappropriate allocation of resources. Although there are policies in place to reduce them, informal payments are not systematically monitored.

5. Financial protection

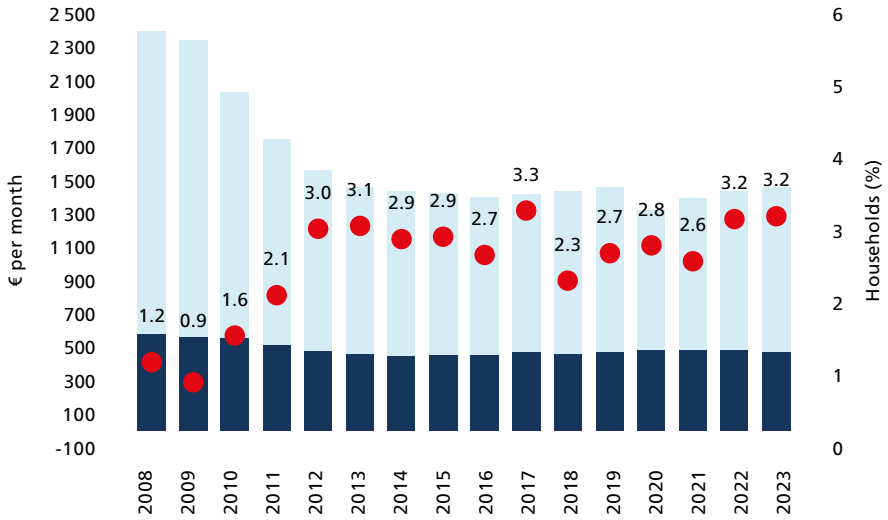
This section uses data from the Greek household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households who use health services. It looks at household capacity to pay for health care, the relationship between out-of-pocket payments for health care and poverty – impoverishing health spending – and estimates the incidence, distribution and drivers of catastrophic health spending. The section also draws on other survey data to assess unmet need for health care.

5.1 Household capacity to pay for health care

Household capacity to pay for health care is what is left of a household's budget after spending on basic needs. Basic needs are defined as the average cost of spending on food, housing and utilities (water, electricity and heating) among a relatively poor part of the Greek population (households between the 25th and 35th percentiles of the consumption distribution), adjusted for household size and composition (see Table 1 in section 2.1 for further definitions). In 2023 (the latest year of household budget survey data available) the monthly cost of meeting these basic needs (the basic needs line) was €477, down from €584 in 2008 (Fig. 14). This is below Greece's monthly national poverty line of €569 in 2023 (60% of median income) (Eurostat, 2025c).

Average household capacity to pay for health care almost halved over the course of the study period and during the economic crisis the share of households living below the basic needs line more than tripled, rising from 0.9% in 2009 to 3.1% in 2013 (Fig. 14).

Fig. 14. Changes in the cost of meeting basic needs, capacity to pay for health care and the share of households living below the basic needs line



Average household capacity to pay

Cost of meeting basic needs

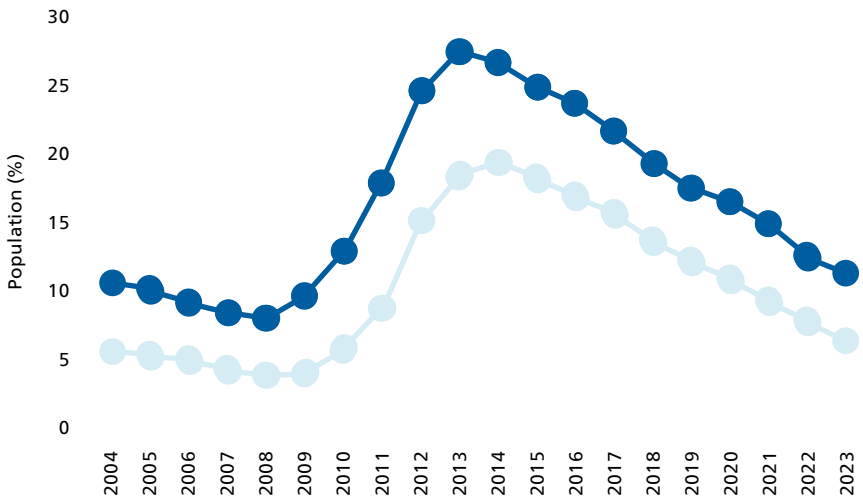
Share of households living below the basic needs line (%)

Notes: amounts are shown in real terms (base year 2020). Capacity to pay for health care is measured as a household's consumption minus a normative (standard) amount to cover basic needs, such as food, housing and utilities. The basic needs line and capacity to pay for health care are per household.

Source: authors, based on household budget survey data provided by ELSTAT.

In 2010 the Greek economy entered a deep structural and multifaceted crisis involving a large fiscal deficit and huge public debt (Meghir et al., 2017). This led to sharp increases in unemployment and long-term unemployment. Between 2008 and 2014 unemployment rates tripled and long-term unemployment rates quadrupled (Fig. 15).

Fig. 15. Share of the active population in employment or long-term unemployment



Unemployment (% of active population)

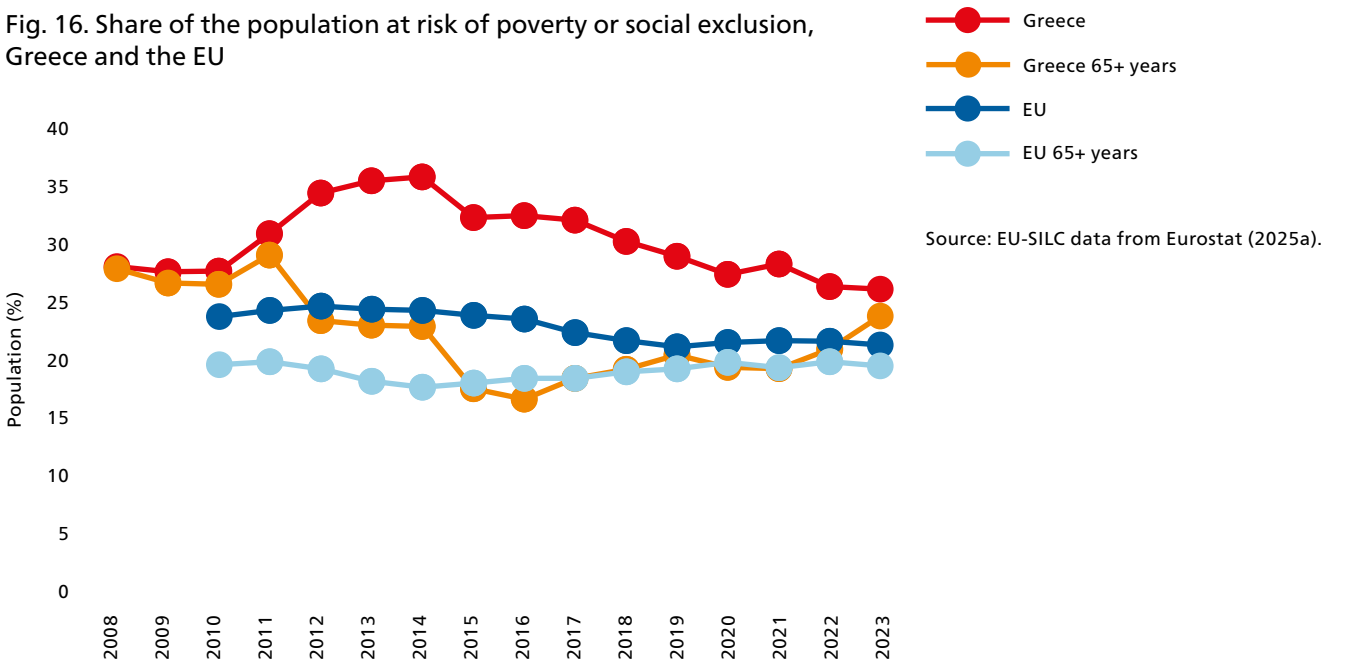
Long-term unemployment (% of active population)

Source: ELSTAT (2024).

It also led to a large increase in the share of the population at risk of poverty or social exclusion, from 28% in 2008 to 36% in 2014, far above the EU average of 25% in 2014. Although this share subsequently fell to 26% in 2023, it remained above the EU average of 21% (Fig. 16).

The share of people aged 65 years and over at risk of poverty or social exclusion fell during the economic crisis but began to increase again from 2017 and grew particularly sharply in 2022 and 2023 (Fig. 16). This earlier decline may reflect the fact that older people were less affected by unemployment than younger people. The more recent increase may be linked to rising living costs and inflation.

Fig. 16. Share of the population at risk of poverty or social exclusion, Greece and the EU



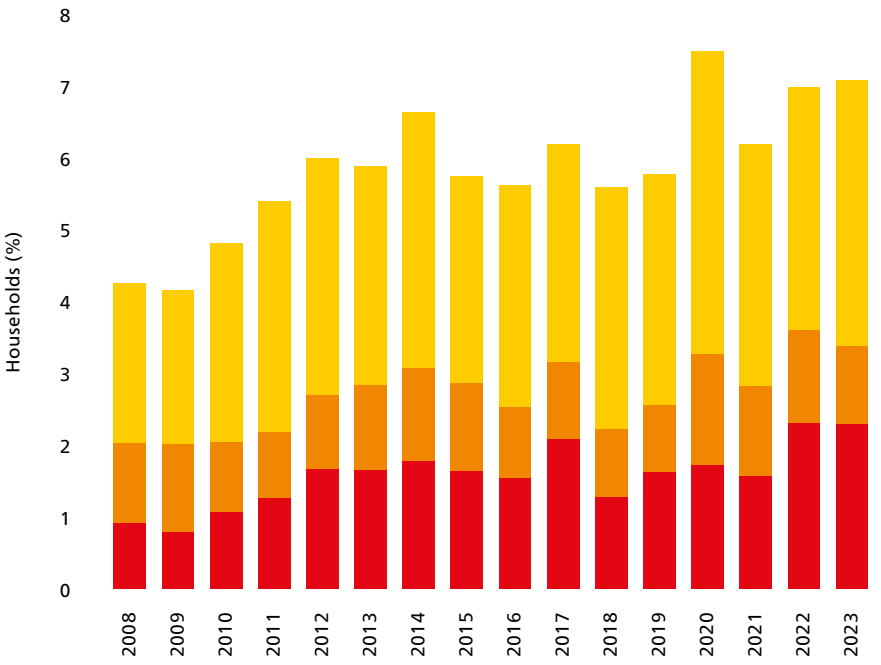
Source: EU-SILC data from Eurostat (2025a).

5.2 Financial hardship

How many households experience financial hardship?

Impoverishing health spending is defined in this study as out-of-pocket payments that push people into poverty or deepen their poverty. In 2023 over 3% of households were impoverished or further impoverished after out-of-pocket payments, higher than at the peak of the economic crisis in 2014 (Fig. 17). Increases in impoverishing health spending have mainly been driven by increases in the share of further impoverished households, especially during the economic crisis and since 2018.

Fig. 17. Share of households at risk of impoverishment after out-of-pocket payments



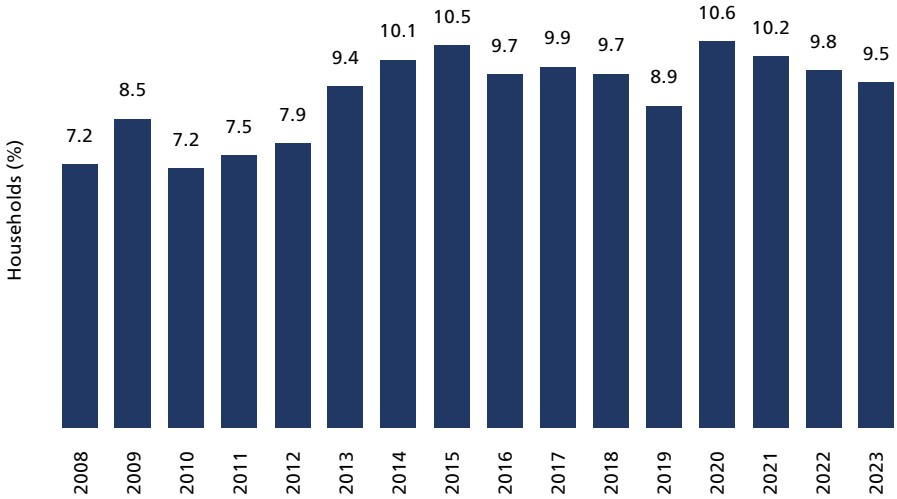
Notes: a household is impoverished if its total spending falls below the basic needs line after out-of-pocket payments; further impoverished if its total spending is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total spending after out-of-pocket payments comes within 120% of the basic needs line.

Source: authors, based on household budget survey data provided by ELSTAT.

Households with catastrophic health spending are defined in this study as those who spend more than 40% of their capacity to pay for health care out of pocket. In 2023 almost 10% of households experienced catastrophic health spending (Fig. 18). Catastrophic health spending increased markedly between 2010 and 2015, which partly reflects a decline in people's capacity to pay for health care during the economic crisis and an increase in the share of households living below the basic needs line (see Fig. 14). This severity of health spending decreased after the crisis before peaking again in 2020 and then falling after that.

Fig. 18. Share of households with catastrophic health spending

Source: authors, based on household budget survey data provided by ELSTAT.

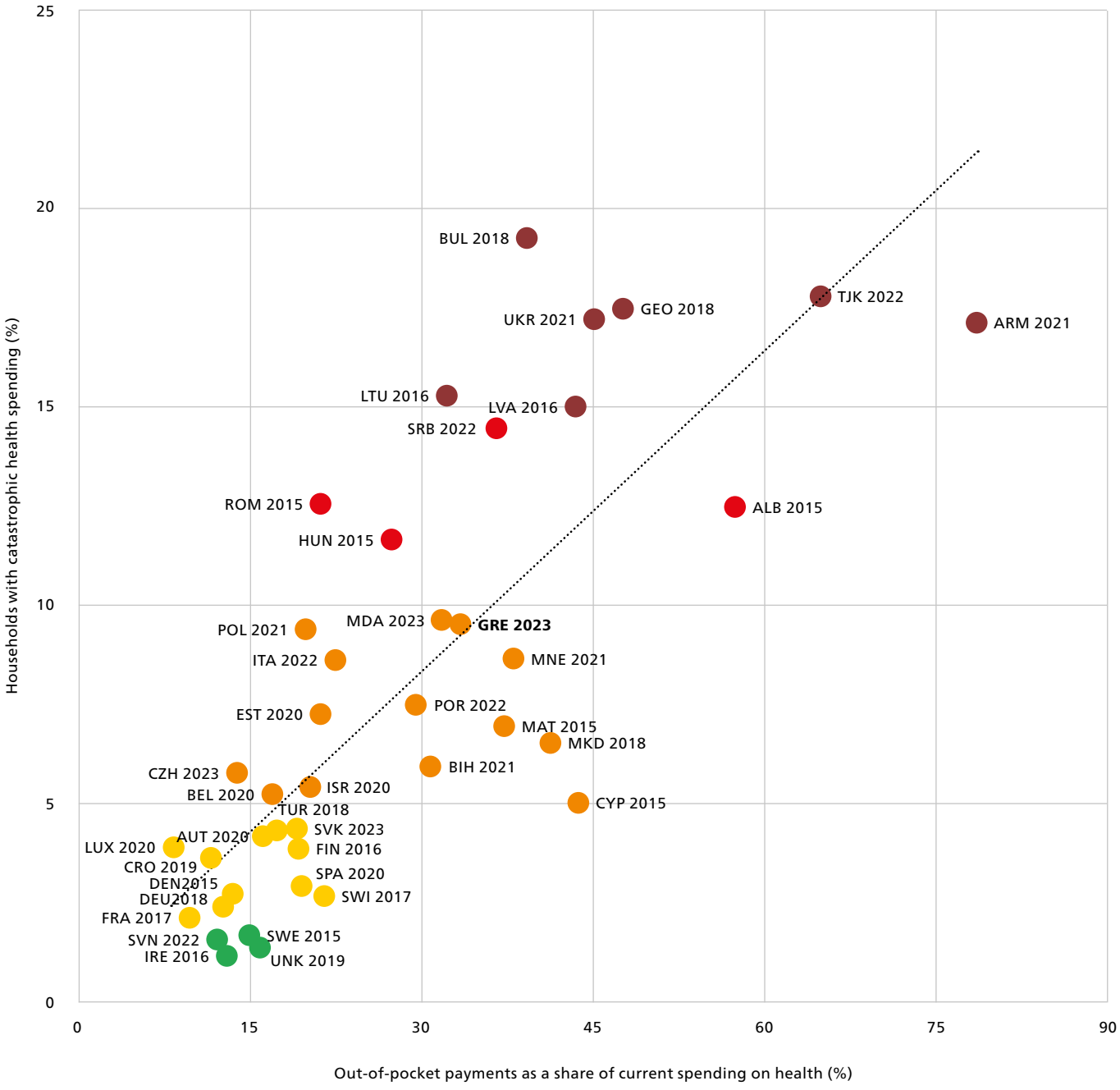


The incidence of catastrophic health spending is higher in Greece than in many EU countries, but lower than in EU countries with a similarly heavy reliance on out-of-pocket payments, such as Bulgaria, Latvia and Lithuania (Fig. 19).

Fig. 19. Households with catastrophic health spending and out-of-pocket payments as a share of current spending on health in the WHO European Region, latest available year

Notes: data on catastrophic health spending and out-of-pocket payments are from the same year. Dots are coloured by the incidence of catastrophic health spending: green under 2%, yellow under 5%, orange under 10%, red under 15%, dark red over 15%. The list of country codes used here can be found in the Abbreviations. Greece is highlighted in bold.

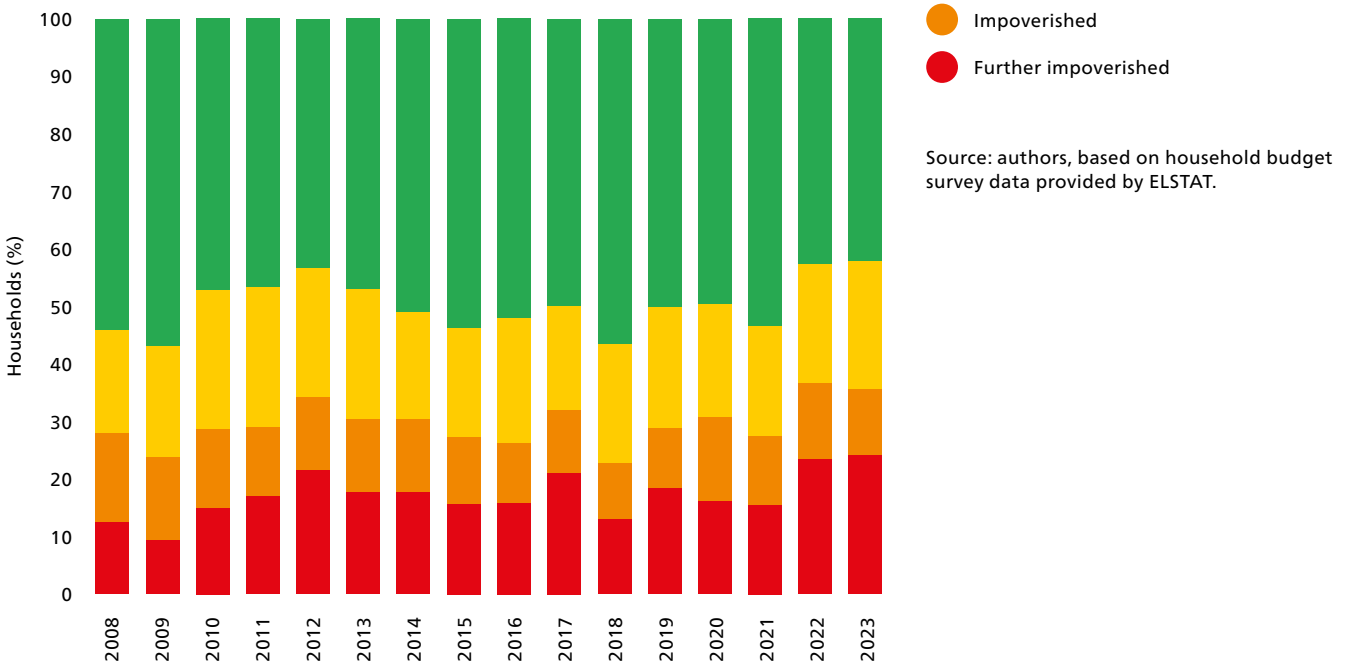
Sources: data on catastrophic health spending from UHC watch (2025) and data on out-of-pocket payments from WHO (2025).



Who experiences financial hardship?

More than half of households with catastrophic health spending were at risk of impoverishment, impoverished or further impoverished after out-of-pocket payments in 2023. In 2023 further impoverished households accounted for 24% of households with catastrophic health spending, up from 13% in 2008 and higher than a peak of 21% during the economic crisis (Fig. 20).

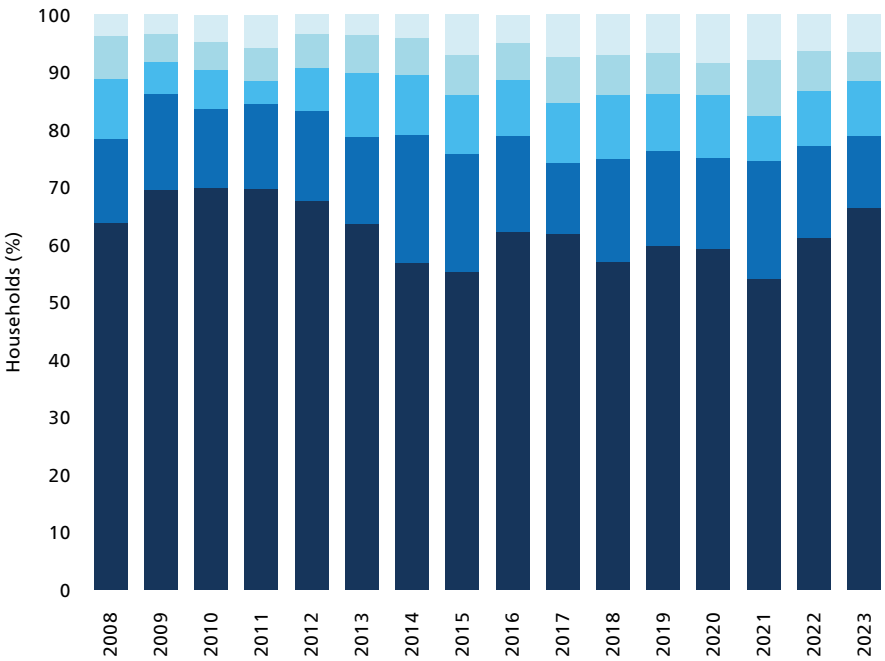
Fig. 20. Breakdown of households with catastrophic health spending by risk of impoverishment



Source: authors, based on household budget survey data provided by ELSTAT.

Catastrophic health spending is consistently heavily concentrated in the poorest consumption quintile, which accounted for nearly two thirds of the total in 2023 (Fig. 21). The share of the other quintiles experiencing catastrophic health spending rose as the economic crisis progressed (particularly the second and third quintiles).

Fig. 21. Breakdown of households with catastrophic health spending by consumption quintile



Source: authors, based on household budget survey data provided by ELSTAT.

A third of households in the poorest quintile experienced catastrophic health spending in 2023, compared to just under 10% on average and 3% in the richest quintile. Incidence in the poorest quintile has risen sharply over time from 23% in 2008 to 30% in 2017 before falling and then rising again in 2020 (Fig. 22). It was higher in 2023 than in any other year in the study.

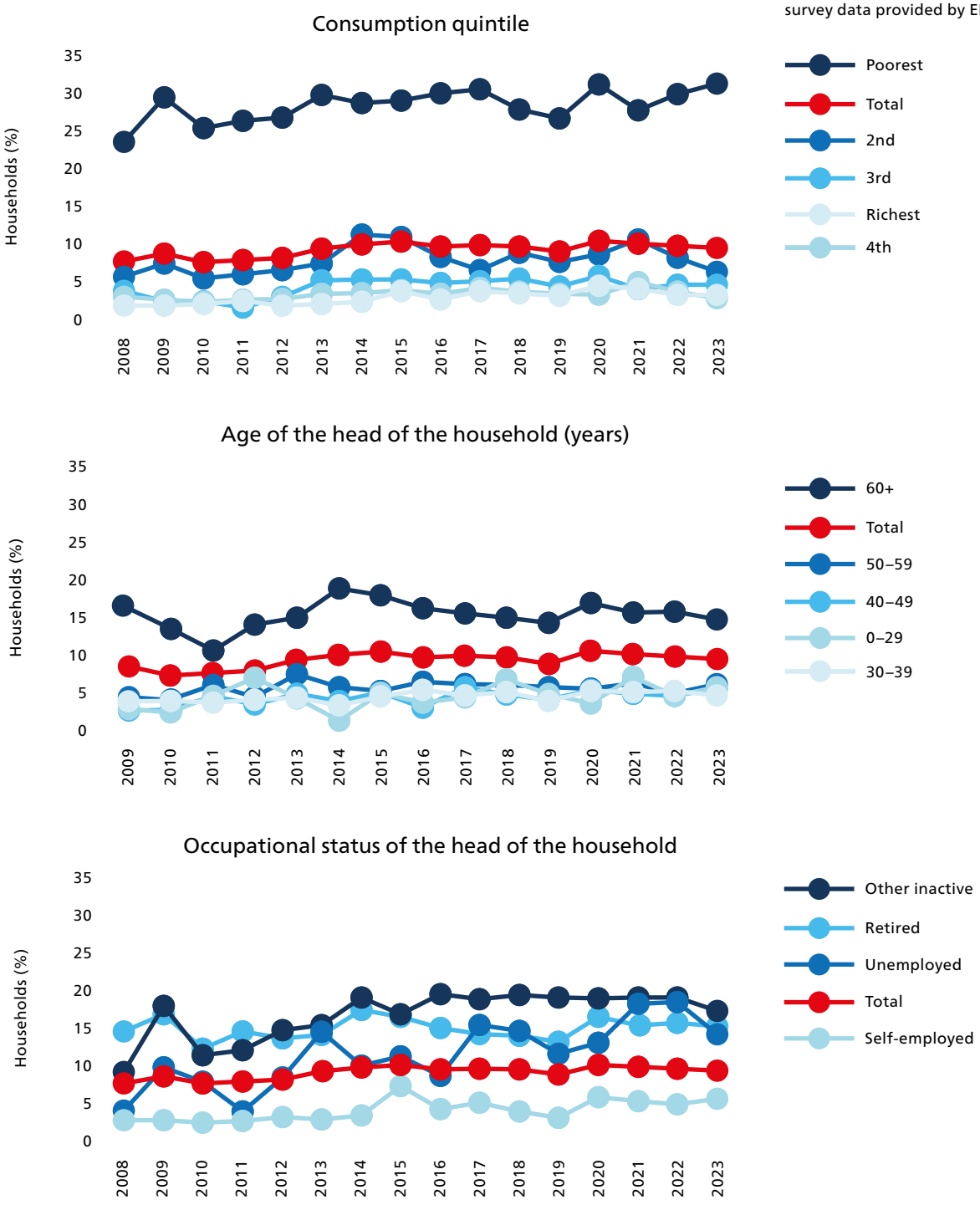
Catastrophic health spending is also much higher than average in households headed by people who are categorized as other inactive (17% in 2023), aged over 60 years (15%), retired (15%) or unemployed (14%) (Fig. 22). Many of these groups are likely to overlap with households in the poorest quintile.

Households headed by people aged over 60 years accounted for by far the largest share of households with catastrophic health spending in 2023 (80%) (data not shown). This may be due to higher levels of health care need and use in older people. It may also reflect growing rates of poverty in older people since 2021 (see Fig. 16 in section 5.1) and suggests that older people continue to be at high risk of financial hardship.

Fig. 22. Share of households with catastrophic health spending by consumption quintile, and age and occupational status of the head of the household

Notes: the term other inactive refers to people with domestic responsibilities, students, people in national service, economically inactive people or people unable to work. Self-employed includes farmers and agricultural workers.

Source: authors, based on household budget survey data provided by ELSTAT.

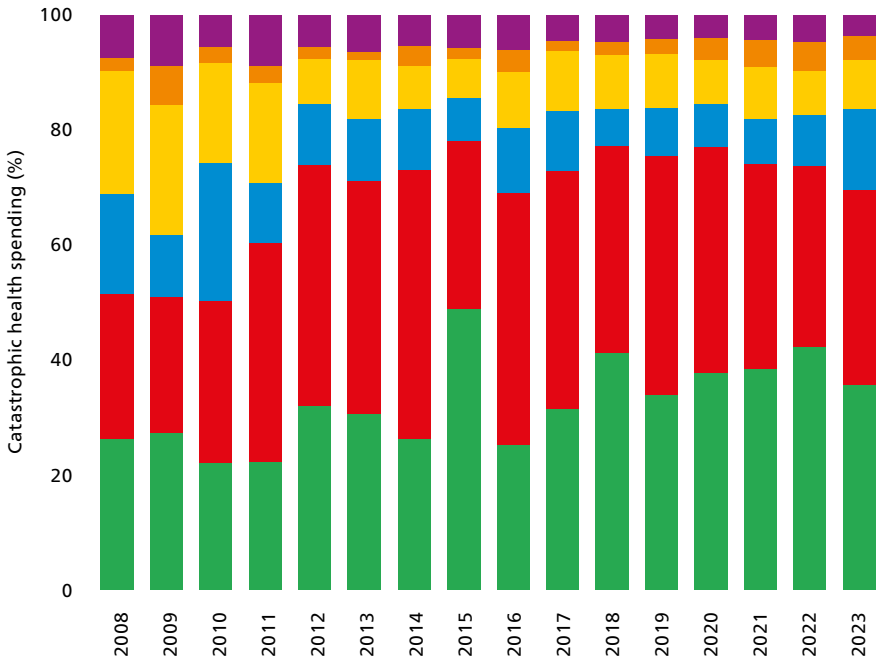


In 2023 households who were further impoverished spent 6% of their budget on health care; lower than the average share of the household budget spent on health (8%) and similar to the share in the poorest consumption quintile (6%) (see Fig. 9 in section 4.2). This reflects the fact that a relatively low share of a household's budget spent on health can lead to financial hardship for people with very low incomes.

Which health services are responsible for financial hardship?

In 2023 catastrophic health spending was mainly driven by inpatient care (36%) and outpatient medicines (34%). Between 2016 and 2018 the share spent on inpatient care increased and then fell in 2019 as medicines became the largest driver of catastrophic health spending overall. The share spent on inpatient care and outpatient medicines grew over time, while the share spent on outpatient care and dental care fell (Fig. 23).

Fig. 23. Breakdown of catastrophic health spending by type of health care



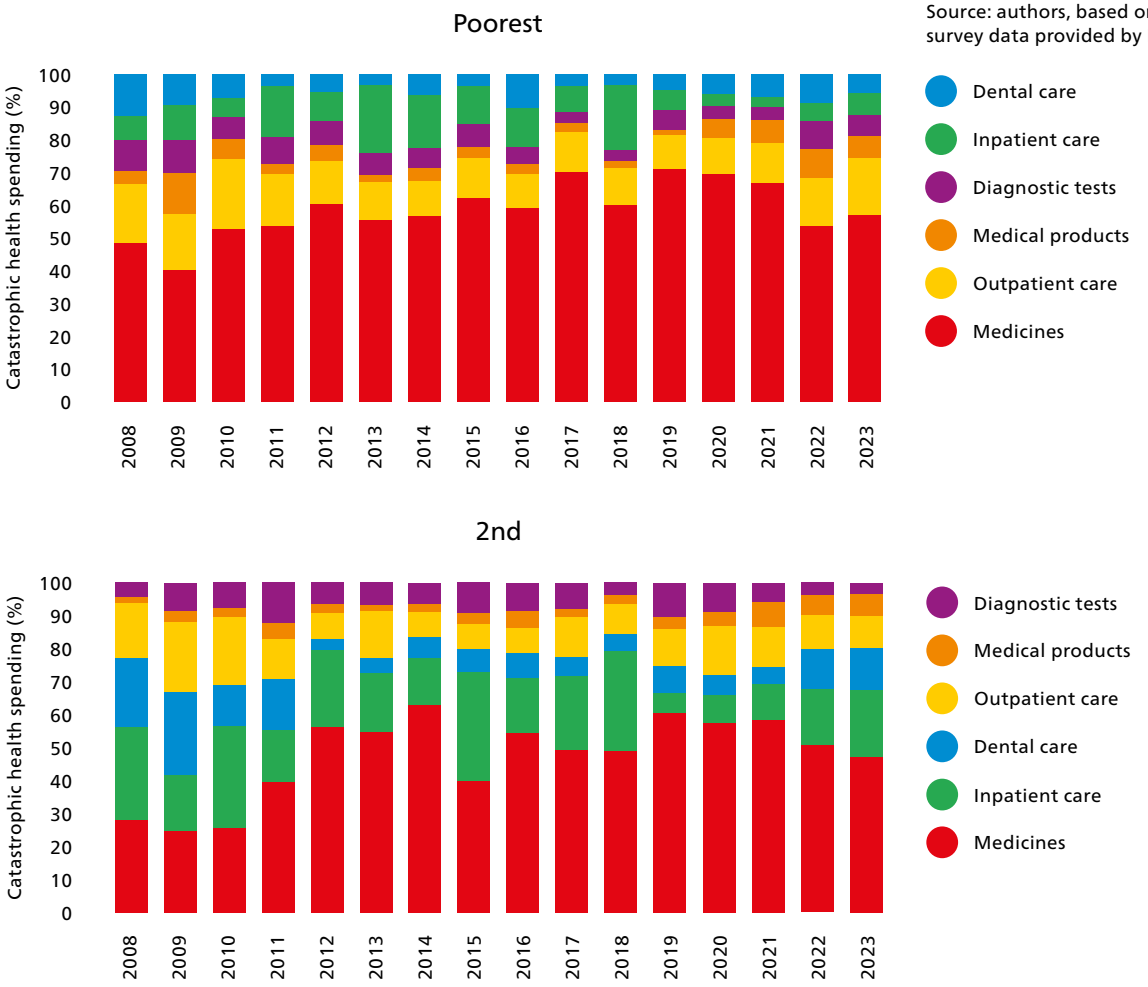
Notes: diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment.

Source: authors, based on household budget survey data provided by ELSTAT.

Broken down by consumption quintile, the pattern is different. In the poorest quintile, catastrophic health spending is consistently mainly driven by outpatient medicines (57% in 2023), followed by outpatient care (18%) and much smaller shares of roughly equal size spent on medical products, inpatient care, diagnostic tests and dental care (Fig. 24). Inpatient care and dental care are larger drivers of catastrophic health spending among people in the richest quintiles.

In 2014, as the economic crisis progressed, the outpatient medicines share of catastrophic health spending was higher than in 2008 in all consumption quintiles and the outpatient care share was lower, while the dental care share was much lower in the three poorer quintiles. In 2019 there was little change in the three poorer quintiles but inpatient care was a larger driver in the richest quintile, crowding out spending on dental care. In 2023 the dental care share was higher in the three middle quintiles (Fig. 24).

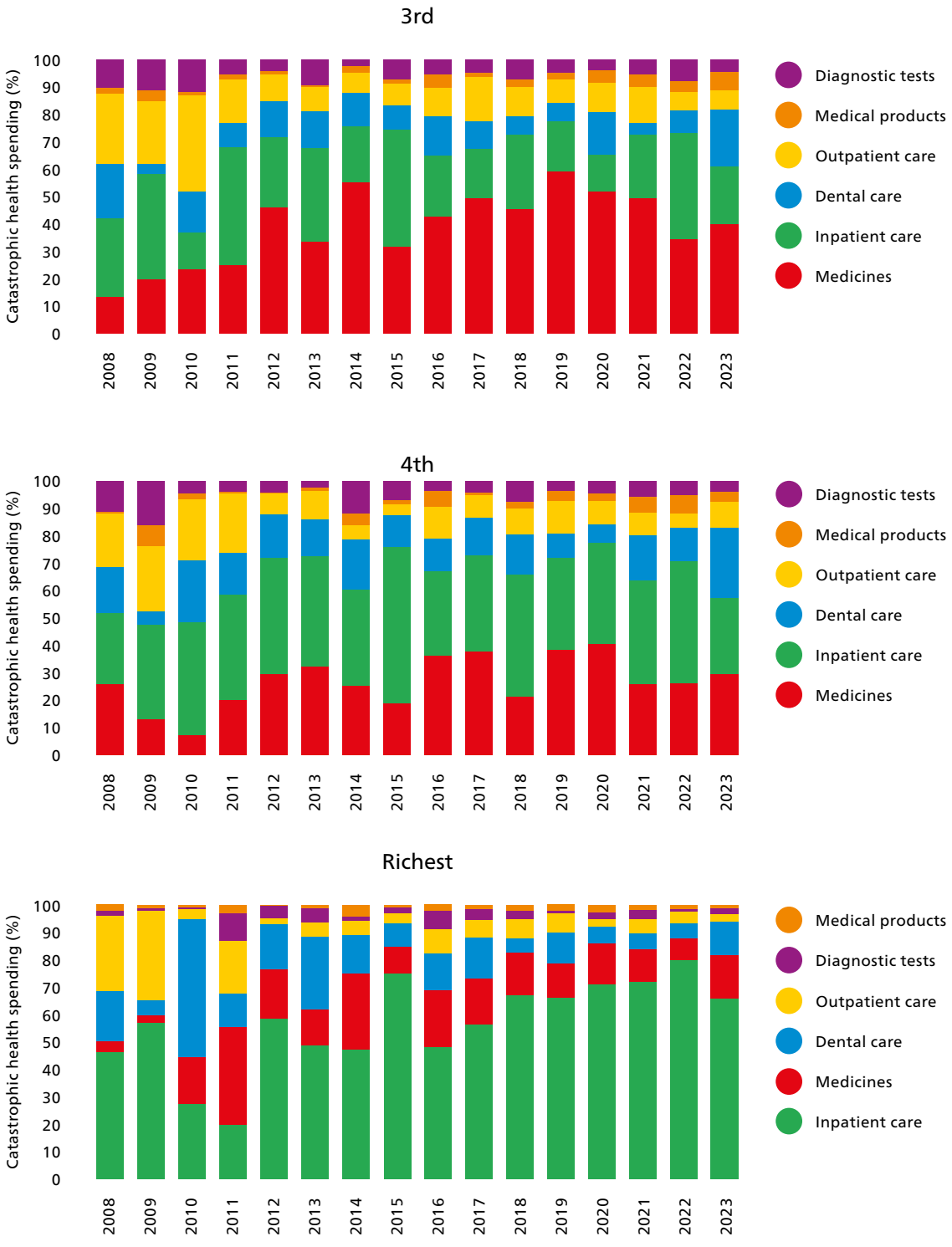
Fig. 24. Breakdown of catastrophic health spending by type of health care and consumption quintile



Notes: diagnostic tests include other paramedical services. Medical products include non-medicine products and equipment.

Source: authors, based on household budget survey data provided by ELSTAT.

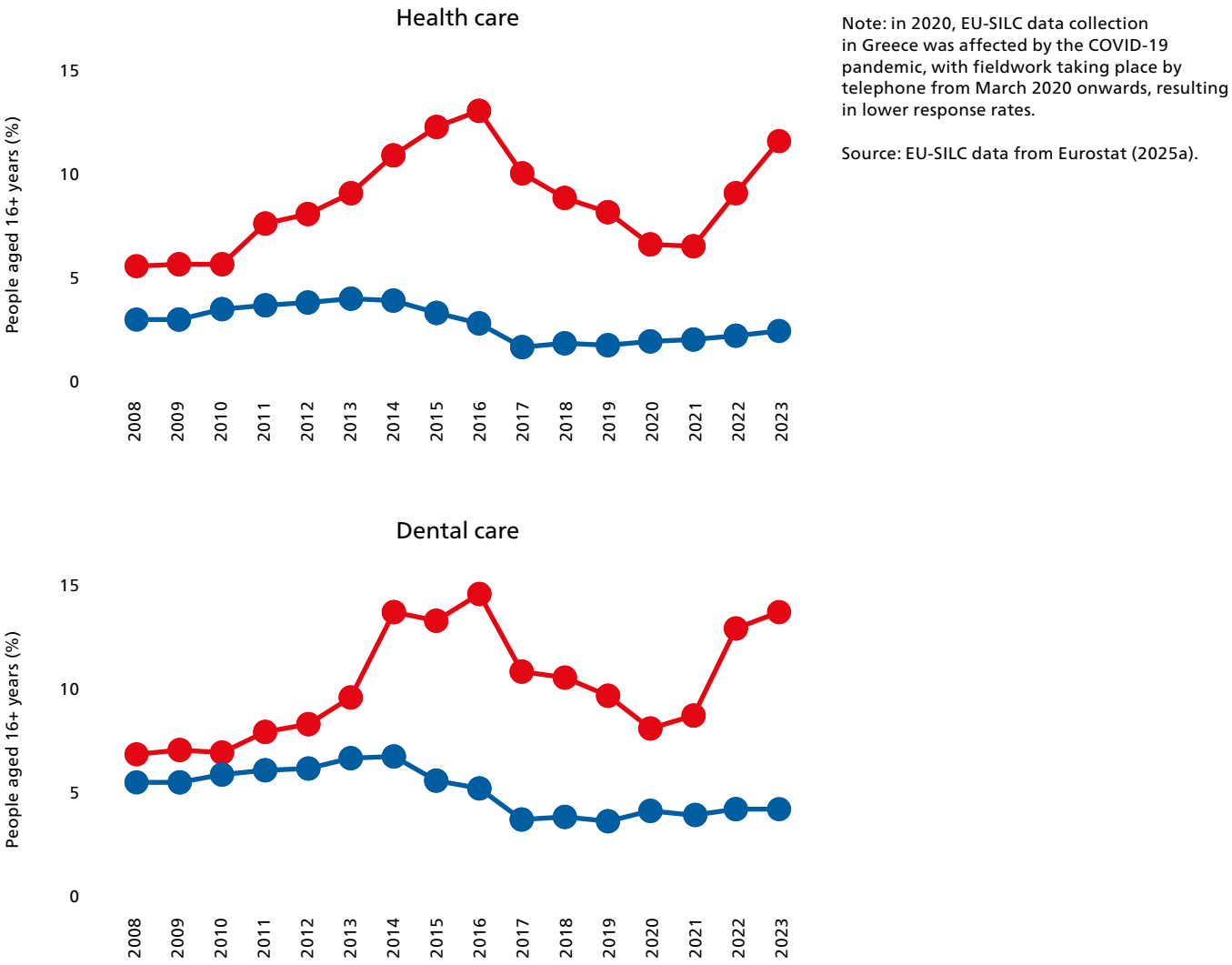
Fig. 24. (contd.)


3rd
Catastrophic health spending (%)
100
90
80
70
60
50
40
30
20
10
0
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
Diagnostic tests
Medical products
Outpatient care
Dental care
Inpatient care
Medicines
4th
Catastrophic health spending (%)
Diagnostic tests
Medical products
Outpatient care
Dental care
Inpatient care
Medicines
Richest
Catastrophic health spending (%)
Medical products
Diagnostic tests
Outpatient care
Dental care
Medicines
Inpatient care

5.3 Unmet need for health care

Unmet need measures instances in which people report that they do not receive health care when they need it due to cost, distance or waiting time (health system factors) (see Box 1 in section 2.3). EU-SILC data indicate that levels of unmet need in Greece are consistently well above the EU average for health care and dental care (Fig. 25) and this is largely driven by cost (data not shown). Unmet need for health care and dental care rose steadily during the economic crisis; rates began to fall from 2017 but rose sharply again from 2022 (Fig. 25).

Fig. 25. Unmet need for health care and dental care due to cost, distance and waiting time, Greece and the EU



Note: in 2020, EU-SILC data collection in Greece was affected by the COVID-19 pandemic, with fieldwork taking place by telephone from March 2020 onwards, resulting in lower response rates.

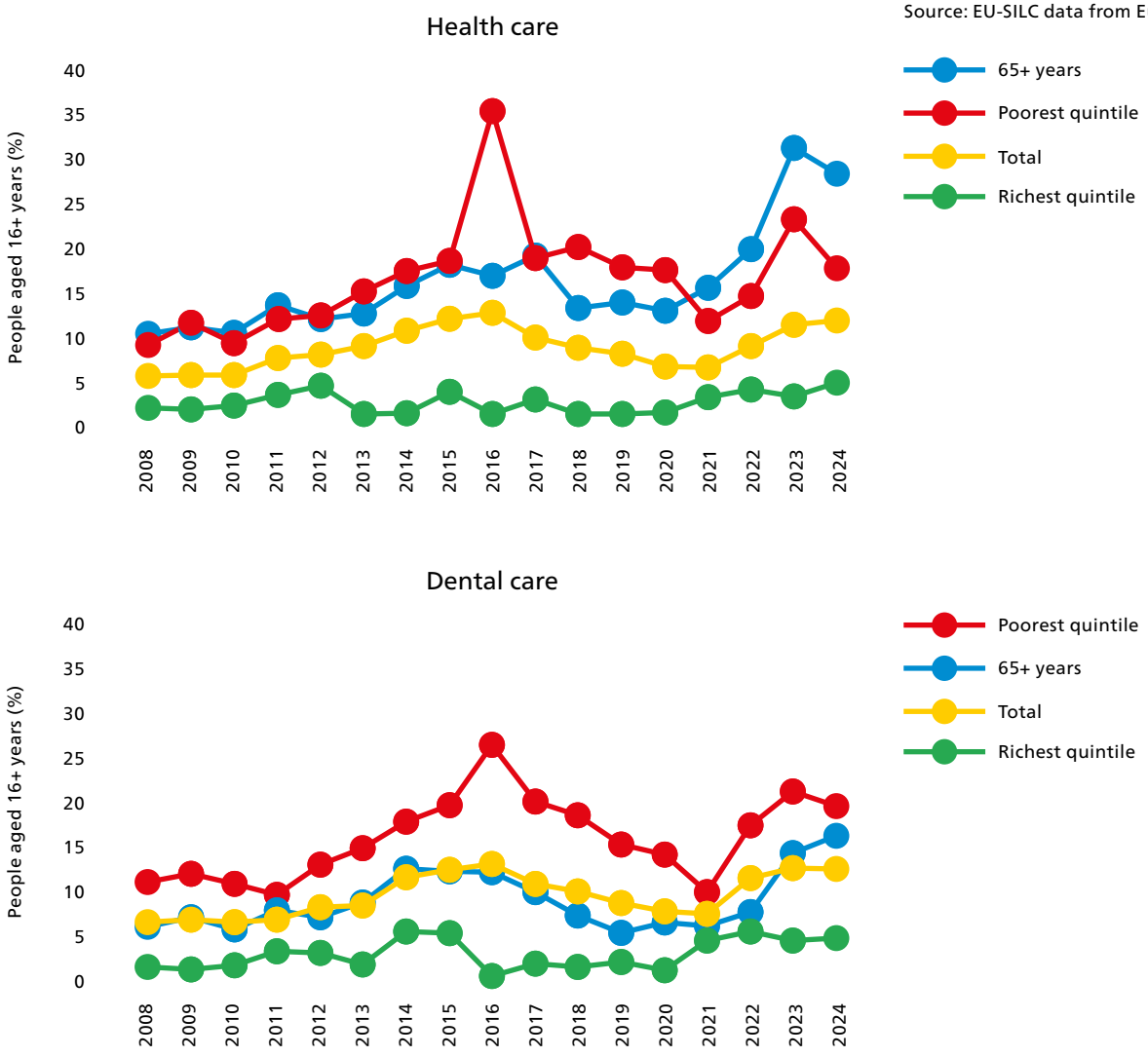
Source: EU-SILC data from Eurostat (2025a).

Substantial income inequality in unmet need for health care and dental care grew sharply during the economic crisis; by 2016 over a third of people in the poorest consumption quintile experienced unmet need for health care and over a quarter for dental care. The gap between the poorest and richest quintiles narrowed after that before spiking again in 2022 but decreasing in 2024 (Fig. 26). The lockdown measures introduced in response to COVID-19 and high inflation pushed up poverty rates, particularly among older people, which may be one factor behind the recent sharp increase in unmet need in older people and in people in the poorest quintile (Fig. 26).

Fig. 26. Income inequality in self-reported unmet need due to cost, distance and waiting time by type of care, income and age

Notes: quintiles are based on equivalized disposable income. In 2020, EU-SILC data collection in Greece was affected by the COVID-19 pandemic, with fieldwork taking place by telephone from March 2020 onwards, resulting in lower response rates.

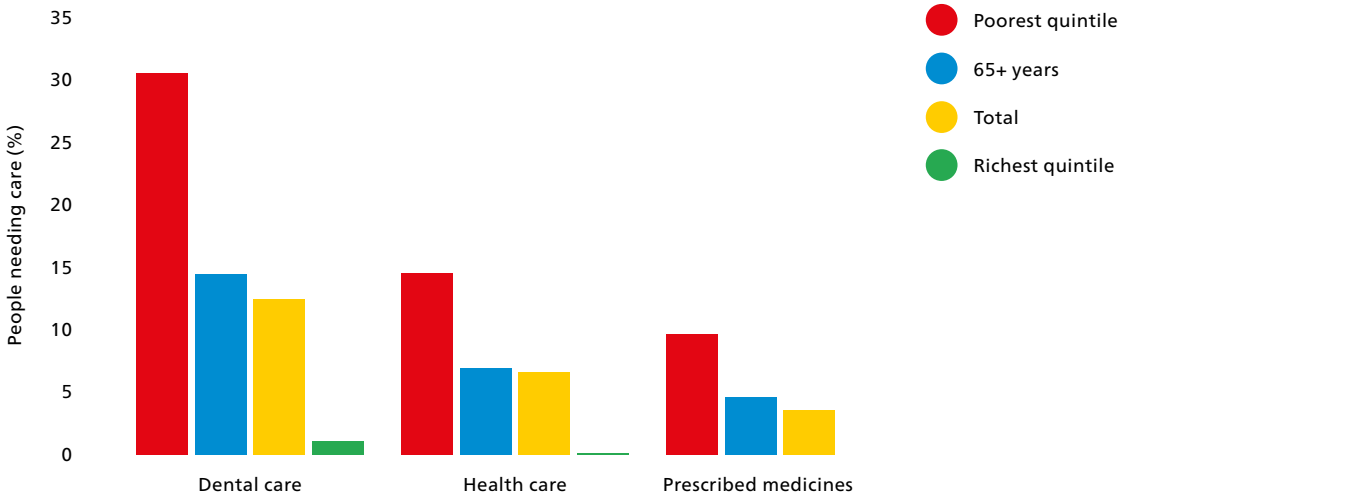
Source: EU-SILC data from Eurostat (2025a).



EHIS data for 2019 (the latest available year) show that unmet need due to cost was highest for dental care, followed by health care and prescribed medicines (Fig. 27). There is substantial income inequality in unmet need for all three types of care: unmet need is consistently more than double the average in the poorest quintile (nearly triple for prescribed medicines) and far higher than in the richest quintile, which reported no unmet need for medicines and almost none (0.1%) for health care (Fig. 27).

Unmet need for all three types of care is only slightly higher than average among older people (Fig. 27). This may suggest that policies to reduce unmet need and financial hardship should focus more on income-related factors than on age alone, although age may also be relevant.

Fig. 27. Self-reported unmet need due to cost by type of care, income and age, 2019



Note: people needing care refers to people over 15 years old.

Source: EHIS data from Eurostat (2025b).

5.4 Summary

In 2023 3% of households were impoverished or further impoverished after out-of-pocket payments for health care and almost 10% of households experienced catastrophic health spending. This severity of health spending increased markedly between 2010 and 2015, partly due to a sharp decline in people's capacity to pay for health care as unemployment and poverty soared during the economic crisis.

The incidence of catastrophic health spending is higher in Greece than in many EU countries, but lower than in EU countries with a similarly heavy reliance on out-of-pocket payments, such as Bulgaria, Latvia and Lithuania.

Catastrophic health spending is consistently heavily concentrated in the poorest consumption quintile, which accounted for nearly two thirds of the total in 2023. A third of households in the poorest quintile experienced catastrophic health spending in 2023, compared to just under 10% on average and 3% in the richest quintile. Incidence in the poorest quintile has risen sharply over time, from 23% in 2008; it was higher in 2023 (32%) than in any other year in the study. Catastrophic health spending is also much higher than average in households headed by people who are categorized as other inactive (17%), aged over 60 years (15%), retired (15%) or unemployed (14%).

In 2023 catastrophic health spending was mainly driven by inpatient care and outpatient medicines on average. Between 2016 and 2018 the average share spent on inpatient care increased, then fell in 2019 as medicines became the largest driver. The average share spent on outpatient care and dental care fell over time. In the poorest quintile catastrophic health spending is mainly driven by outpatient medicines and outpatient care. Inpatient care and dental care are larger drivers in the richest quintiles.

EU-SILC data indicate that levels of unmet need for care in Greece are consistently well above the EU average for both health care and dental care. Unmet need rose steadily during the economic crisis in Greece and began to fall from 2017 but rose sharply again from 2022, particularly among older people and people in the poorest quintile (in 2022 and 2023). Substantial income inequality in unmet need widened during the economic crisis.

EHIS data for 2019 (the latest available year) show that unmet need due to cost was highest for dental care, followed by health care and prescribed medicines and marked by stark income inequality, particularly for prescribed medicines. Unmet need for all three types of care is only slightly higher than average among older people, which may suggest that policies to reduce unmet need and financial hardship should focus more on income-related factors than on age alone, although age may also be relevant.

6. Factors that strengthen and undermine financial protection

This section considers the factors within the health system that may be responsible for financial hardship caused by out-of-pocket payments in Greece and which may explain the trend over time. It looks at financial protection in three phases: the situation in 2008, the impact of the economic crisis and the current situation.

6.1 The situation in 2008, before the economic crisis

Although financial protection was weaker in Greece than in many other EU countries in 2008, it looked as though the situation might be improving in the years before the global financial crisis. Heavy reliance on out-of-pocket payments had been falling due to steady increases in public spending on health per person, which grew by about a third between 2004 and 2008 (see Fig. 2).

In 2008 the incidence of catastrophic health spending was high by EU standards, affecting 7% of households on average and 23% of households in the poorest consumption quintile (see Fig. 18 and Fig. 22). Levels of unmet need in Greece were above (but close to) the EU average (see Fig. 25). Catastrophic health spending was driven roughly equally by out-of-pocket payments for inpatient care, outpatient medicines, outpatient care and dental care on average, but in the poorest quintile it was mainly driven by outpatient medicines and, to a much lesser extent, outpatient care and dental care (see Fig. 23 and Fig. 24).

Relatively weak financial protection reflected the health system's long-standing reliance on out-of-pocket payments: in 2008 out-of-pocket payments accounted for 32% of current spending on health (see Fig. 1). However, the out-of-pocket payment share of current spending on health had been falling and was already much lower than a peak of 39% in 2004 (see Fig. 1), largely due to the above-mentioned steady increases in public spending on health per person between 2004 and 2008 (see Fig. 2). As a share of GDP, public spending on health had reached the EU average by 2007 (see Fig. 5).

6.2 The impact of the economic crisis

The economic crisis – and budgetary cuts and restrictions to coverage introduced in response to the crisis – had a large negative impact on financial protection.

Out-of-pocket payments per person fell in the early years of the crisis, from 2008 to 2012 (see Fig. 2 and Fig. 8), as rates of unemployment and poverty soared (see Fig. 15 and Fig. 16), but catastrophic health

spending and unmet need for care rose rapidly, reaching a peak of 10% of households in 2015 (catastrophic health spending) and around 13% of the adult population in 2016 (unmet need for health and dental care) (see Fig. 18 and Fig. 25).

Income inequality also increased for both indicators. In the poorest consumption quintile catastrophic health spending grew to around 30% of households (up from 23% in 2008) (see Fig. 22), while unmet need for health and dental care grew to over a quarter of adults.

The drivers of catastrophic health spending also shifted during the economic crisis, moving away from dental care and other outpatient services to outpatient medicines and inpatient care. Between 2008 and 2012 outpatient medicines and inpatient care together rose from about half to two thirds of out-of-pocket payments in households with catastrophic health spending on average (see Fig. 23) and from about half to over 70% in households in the poorest quintile (see Fig. 24). Spending on these other types of care crowded out spending on dental care in the three poorest quintiles, pushing up unmet need for dental care.

This marked deterioration in financial protection and the strong shift towards household spending on outpatient medicines and inpatient care reflect three main factors:

- large and sustained cuts to public spending on health (particularly inpatient care and outpatient medicines), which shifted costs onto households and pushed up waiting times;

- coverage restrictions through new or increased co-payments for outpatient care (visits, prescribed medicines and diagnostic tests) and inpatient care, as well as caps on the volume of outpatient care, which increased formal and informal payments and waiting times; and

- underlying weaknesses in coverage policy, which were exacerbated by high rates of unemployment and led to a major gap in population coverage.

As a result of sharp cuts to the health budget, public spending on health nearly halved in five years, falling from €1435 per person in 2009 to €796 in 2014 (WHO, 2025). The cuts mainly affected inpatient care (a reduction of €3.1 billion between 2010 and 2014), outpatient medicines (€2.2 billion) and outpatient care (€2 billion) (ELSTAT, 2018).

Cuts to the budget allocated to hospitals increased waiting times and informal payments in public facilities. The increase in informal payments – combined with an increase in user charges for inpatient care (later reversed) – may explain the shift towards spending on inpatient care in the poorer consumption quintiles, while increased use of private facilities among those able to pay for faster access may explain the shift towards spending on inpatient care in the richer quintiles. An increase in user charges and the introduction of volume caps for outpatient care may explain why outpatient care is often the second-largest driver of catastrophic health spending (after outpatient medicines) in the poorest quintile.

Levels of public spending on medicines more than halved between 2011 and 2015 (Economou et al., 2017). Although cuts to the budget for medicines were accompanied by several policies to reduce medicine prices and improve efficiency in the prescribing, dispensing and use of medicines (see Table 2), these measures were not enough to prevent a substantial shifting of costs onto households. Out-of-pocket payments for outpatient medicines fell in the early years of the economic crisis and then rose sharply from around €100 per person in 2011 to €170 in 2015 (see Fig. 12).

Health care coverage in Greece has long been characterized by complexity, fragmentation and gaps (Economou et al., 2017). The economic crisis exposed these weaknesses and showed the extent to which coverage policy lacked resilience to shocks. The most significant weakness was the basis for entitlement to the SHI scheme, which was (and remains) linked to employment and payment of mandatory contributions and does not extend entitlement to long-term unemployed people. As unemployment and long-term unemployment increased sharply, around 20% of the population (over 2 million people) lost SHI coverage due to unemployment or inability to pay contributions.

Two early policy responses to this major gap in coverage (the Health Voucher Programme in 2013 and joint ministerial decisions in 2014) were not effective. A third response – legislation introduced in 2016, which extended coverage to non-covered citizens and legal residents, self-employed people, people with low incomes, refugees and asylum seekers – was an important step forward in improving access to publicly financed health care for people no longer covered by the EOPYY's SHI scheme. However, it did not change the basis for entitlement to SHI benefits and also perpetuated inequality in entitlement; people not covered by the EOPYY had to rely on public facilities and therefore faced greater barriers to access due to longer waiting times and shortages of staff and equipment, particularly in geographically remote areas.

6.3 The current situation

GDP grew steadily in Greece from 2017 to 2019 and 2021 to 2023, with a large dip in 2020 due to the COVID-19 pandemic (Eurostat, 2025c).

Catastrophic health spending fell between 2016 and 2019, spiked in 2020, and has fallen since then. However, at 9% in 2023 it remained higher than in many other EU countries. Averages also conceal a worrying trend in the poorest households. The incidence of catastrophic health spending in the poorest consumption quintile was higher in 2023 (close to 32%) than at any time during the study period (see Fig. 22), while the incidence of impoverishing health spending was higher in 2023 than at the peak of the economic crisis (see Fig. 17).

Unmet need had been improving before the pandemic but increased in 2021 and increased even more sharply in 2022 and 2023, particularly in the poorest quintile and among older people – a pattern that was not repeated on average across the EU (see Fig. 25).

These findings are likely to reflect continued underfunding of the health system and persistent gaps in health coverage.

Public spending on health per person has risen slowly from its low during the economic crisis of €800 in 2014 but in 2021 and 2022 it was on a par (in real terms) with spending levels from nearly 20 years earlier (in 2003 and 2004: around €1040), and far from its peak of €1435 in 2009 (see Fig. 2). As a share of GDP public spending on health was just under 5% in 2022, still well below the EU average of 7% (see Fig. 5). This in turn reflects the very low priority given to health in allocating the government budget; health accounted for only 9% of government spending in 2022, which was lower than in any other EU country and far below the EU average of 15% (see Fig. 4).

Gaps in all three dimensions of health coverage persist in Greece: population coverage, service coverage and gaps caused by user charges (co-payments). This affects financial protection because coverage policy is the primary mechanism through which households are exposed to out-of-pocket payments. Coverage policy also determines how out-of-pocket payments are distributed across different groups of people.

The 2016 reform was an important step forward, but it did not address the root cause of Greece's major gap in population coverage, which is the linking of entitlement to health care to employment status and payment of contributions. Although there are no data on the share of the population currently lacking EOPYY coverage, it is assumed to be significant given that 6.2% of the active population was registered as long-term unemployed in 2023 (see Fig. 15) and that long-term unemployed people under the age of 55 years are not entitled to EOPYY benefits.

Without further changes to the basis for entitlement to EOPYY benefits, the following challenges will remain.

- Inequality in access to health care: there is now a significant share of the population with a lower level of entitlement to health care than those covered by the EOPYY because they are reliant on health care in public facilities.

- Increased unmet need and financial hardship: people no longer entitled to EOPYY benefits are likely to face longer waiting times and may have to pay informally for treatment from public providers or pay the full cost of treatment by private providers; many (if not all) of these people are likely to have low incomes and be in the poorest consumption quintile, making it more difficult to reduce unmet need and financial hardship for high-risk groups.

- Inequality for taxpayers: substantial tax revenues are used to finance health care for people covered by the EOPYY (transfers from the government budget accounted for 34% of EOPYY spending in 2022) but many taxpayers are not entitled to EOPYY benefits, including people who may have paid contributions to the EOPYY (or its predecessors) throughout their working life but are unfortunate enough to experience long-term unemployment. However, there are no publicly available data on the number of legal residents who lack EOPYY coverage.

These challenges can be resolved by extending EOPYY benefits to all residents, as in Czechia and France; the basis for entitlement to SHI benefits in Czechia has always been residence and France formally changed the basis for entitlement to SHI benefits from payment of mandatory contributions to residence in 2000 (WHO Regional Office for Europe, 2023).

There are several gaps in service coverage, including very limited coverage of dental care, long waiting times and the incidence of informal payments.

Health accounts data for 2022 show that there was no public spending on dental care in Greece (see Fig. 6), even though children are entitled to free dental care in public facilities and adults are entitled to free emergency dental treatment in public facilities. The Dentist Pass Programme introduced in 2022 has so far provided some publicly financed access to dental care to around 200 000 children aged 6–12 years, but its effectiveness in reducing unmet need in households with lower incomes is not clear.

Waiting times have become a challenge in public hospitals since the economic crisis and informal payments have become an even greater challenge since the introduction of volume caps for covered outpatient care (including doctor visits in ambulatory and hospital settings, prescribed medicines and diagnostic tests). Although some policies have been put in place to monitor and reduce waiting times, there are still no guarantees or targets. Some of the more recent policies (e.g. allowing people to pay large co-payments to bypass surgical waiting lists in public facilities) may widen inequalities in access to publicly financed health care.

There are several weaknesses in the current design of user charges (co-payments): they are widely applied to most types of outpatient care and to inpatient care and diagnostic tests provided in private facilities contracted by the EOPYY; percentage co-payments are used for some types of care (instead of or in addition to fixed co-payments); there are very few exemptions from co-payments targeting people with low incomes; and there is no overall cap on co-payments. International evidence and experience suggest that these weaknesses are likely to undermine financial protection, particularly for people with low incomes (WHO Regional Office for Europe, 2023; Cylus et al., 2024).

The design of co-payments for outpatient prescribed medicines is particularly weak due to:

- complexity – it involves a mix of fixed co-payments, percentage co-payments and internal reference pricing;
- very limited protection mechanisms – only people with extremely low incomes (households with an income of less than €300 a month) and a short list of other people are exempt, the cap on internal reference pricing is set very high (€20 per prescription) and there is no cap on percentage co-payments; and
- the use of percentage co-payments. These reduce transparency and financial certainty (people may not know in advance how much they

have to pay out of pocket); are unfair (people with conditions requiring more expensive medicines have to pay more out of pocket); and expose people to health system inefficiencies (people have to pay more out of pocket in contexts where medicine prices are relatively high due to inadequate regulation or where doctors and pharmacists are not required or do not have incentives to prescribe and dispense cheaper alternatives such as generic medicines).

In addition to co-payments for prescribed medicines, out-of-pocket payments for outpatient medicines may arise through the purchase of both prescribed and non-prescribed medicines over the counter. This is facilitated by weak enforcement of regulation governing the dispensing of medicines (Economou et al., 2017).

6.4 Summary

In 2008, before the economic crisis, financial protection was already relatively weak in Greece, reflecting the health system's long-standing reliance on out-of-pocket payments. It looked as though things might be getting better, however, because reliance on out-of-pocket payments had been falling due to steady increases in public spending on health per person, which grew by about a third between 2004 and 2008.

The economic crisis – and budgetary cuts and restrictions to coverage introduced in response to the crisis – led to a marked deterioration in financial protection, with a particularly negative effect on households with low incomes and a strong shift towards household spending on outpatient medicines and inpatient care. During this time, financial protection was undermined by:

- large and sustained cuts to public spending on health (particularly on inpatient care and outpatient medicines), which shifted costs onto households and pushed up waiting times;
- coverage restrictions through (new or increased) co-payments and caps on the volume of outpatient care, which increased formal and informal payments and waiting times; and
- underlying weaknesses in coverage policy, which were exacerbated by high rates of unemployment and led to a major gap in population coverage.

The economic crisis exposed the complexity and fragmentation of health care coverage in Greece and its lack of resilience to shocks – especially the basis for entitlement to the SHI scheme, which was (and remains) linked to employment and payment of mandatory contributions and does not extend entitlement to long-term unemployed people. By 2014 around 20% of the population were without SHI coverage due to unemployment or inability to pay contributions. The law introduced in 2016 was an important step forward in improving access to publicly financed health care for people no longer covered by the SHI scheme.

Financial protection improved between 2016 and 2019 on average but, for people with low incomes, financial hardship and unmet need are no better now than they were during the economic crisis. This is likely to reflect two main factors: continued underfunding of the health system and persistent gaps in all three dimensions of coverage policy, which have a disproportionately negative impact on people with low incomes. Public spending on health has risen since the economic crisis but, as a share of GDP, it remains well below the EU average, reflecting the very low priority given to health in allocating the government budget.

- The abovementioned 2016 law did not address the root cause of the gap in population coverage – entitlement based on payment of mandatory contributions. It perpetuated inequality in entitlements because people not covered by the EOPYY rely on public facilities and face greater barriers to access due to longer waiting times and shortages of staff and equipment, particularly in geographically remote areas. It has also led to unfairness because many taxpayers contribute to the financing of the EOPYY through the government budget but are not entitled to EOPYY benefits, including people who may have paid contributions to the EOPYY (or its predecessors) throughout their working life but experience long-term unemployment.

- Gaps in service coverage include very limited coverage of dental care, waiting times and informal payments.

- Weaknesses in the current design of co-payments (particularly for outpatient prescribed medicines) also lead to coverage gaps: co-payments are widely applied, including complex percentage co-payments and internal referencing pricing; there are very few exemptions from co-payments targeting people with low incomes; and there is no overall cap on co-payments.

7. Implications for policy

Financial hardship caused by out-of-pocket payments is higher in Greece than in many EU countries. Almost 10% of households experienced catastrophic health spending in 2023 (the latest available year of data), up from around 7% in 2008.

Catastrophic health spending is consistently heavily concentrated in the poorest consumption quintile, which accounted for two thirds of the total in 2023. A third of households in the poorest quintile experienced catastrophic health spending in 2023, up from 23% in 2008.

Catastrophic health spending is mainly driven by outpatient medicines and outpatient care in the poorest quintile. Inpatient care and dental care are larger drivers in the richer quintiles.

Levels of unmet need for care are consistently above the EU average. Unmet need due to cost is highest for dental care, followed by health care and prescribed medicines and is marked by stark income inequality, particularly for prescribed medicines.

Financial protection was already relatively weak in 2008, but it looked as though things might be getting better. Heavy reliance on out-of-pocket payments had been falling due to steady increases in public spending on health per person, which grew by about a third between 2004 and 2008.

Financial protection deteriorated during the economic crisis, which exposed the complexity and fragmentation of health care coverage in Greece and its lack of resilience to shocks. Financial protection was undermined by large and sustained cuts to public spending on health; coverage restrictions through new or increased co-payments and caps on the volume of outpatient care; and underlying weaknesses in coverage policy. These policy responses had a particularly negative effect on households with low incomes and led to a strong shift towards household spending on outpatient medicines and inpatient care.

Financial protection improved on average after the economic crisis but not for people with low incomes. Financial hardship and unmet need are not much better for the poorest quintile now than they were during the economic crisis, reflecting continued underfunding of the health system and persistent gaps in coverage.

Building on steps already taken, the Government can consider the following options for action to address key gaps in coverage and reduce financial hardship and unmet need, particularly for households with low incomes.

Extend EOPYY benefits to all residents to reduce inequalities in access to health care. Basing entitlement to EOPYY benefits on employment and payment of mandatory contributions undermines health system resilience to shocks. Although the law introduced in 2016 improved access for many people, it perpetuated a two-tier system in which those not covered by the EOPYY rely on health care in public facilities and face greater barriers to access due to longer waiting times and shortages of staff and equipment. The two-tier system is also unfair because many taxpayers are not entitled to EOPYY benefits even though they contribute to the financing of

EOPYY (e.g. by paying the taxes that make up the government budget and accounted for 34% of EOPYY revenue in 2022); this includes (but is not limited to) people who have paid contributions to the EOPYY (or its predecessors) while working but are no longer eligible for EOPYY benefits due to long-term unemployment.

These challenges can be addressed by changing the basis for entitlement to EOPYY benefits from payment of contributions to residence, as in Czechia or France; the basis for entitlement to SHI benefits in Czechia has always been residence and France formally changed the basis for entitlement to SHI benefits from payment of mandatory contributions to residence in 2000 (WHO Regional Office for Europe, 2023). Changing the basis for entitlement would not require any fundamental change in the way the EOPYY is financed. Rather, it would mean that:

- all residents would be entitled to the same health care benefits; and
- non-payment of contributions would be treated in the same way as non-payment of other taxes (that is, through fines rather than by denying access to services).

Simplify and strengthen the design of co-payments, particularly for outpatient medicines and other forms of outpatient care. International evidence and experience show that this can be done by:

- extending exemptions from all co-payments (including the avoidable co-payments caused by internal reference pricing) to more households with low incomes;
- introducing an income-based cap on all co-payments – caps that give stronger protection to people with lower incomes are not only more likely to improve financial protection but will also ensure equity and efficiency in the use of public funds and soften the impact on the health budget (García-Ramirez et al., 2025); and
- replacing percentage co-payments with low, fixed co-payments – this would improve transparency, equity and financial protection and give the EOPYY greater incentive to tackle inefficiency in the prescribing and dispensing of outpatient medicines (WHO Regional Office for Europe, 2023).

Analysis suggests that using all three approaches could lead to a substantial reduction in the risk of catastrophic health spending (Cylus et al., 2024). Protection mechanisms should also be applied automatically, with the help of digital tools, to maximize take up (Kasekamp & Habicht, 2025).

Continue efforts to:

- **improve financial protection for people who need outpatient medicines and other forms of outpatient care** – in addition to strengthening protection from co-payments, this can be achieved by ensuring appropriate prescribing and dispensing; encouraging greater use of generics; and lowering medicine prices;

- **expand access to publicly financed non-emergency dental care**, going beyond the limited services provided at present – particularly for people with low incomes, who currently experience very high levels of unmet need;

- **monitor and address long waiting times and informal payments**, ensuring that existing and new measures do not exacerbate inequalities in access to health care (WHO Regional Office for Europe, 2018); and

- **strengthen the purchasing and governance of publicly financed health care**, so that public resources are better able to meet equity and efficiency goals.

Support these efforts by increasing the priority given to health in allocating the government budget. Although public spending on health has risen since the economic crisis, it remains well below the EU average as a share of GDP. In itself, an increase in public spending on health is not a guarantee of better financial protection. Any additional public spending on health should be carefully used to reduce financial hardship and unmet need for care for households with low incomes.

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