# Addressing public health and health system challenges in Greece: reform priorities in a changing landscape

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**Health systems are under growing pressure from ageing populations, chronic diseases, and financial constraints, compounded by challenges, such as COVID-19 and climate change. In Greece, these pressures have converged in the past 15 years, exposing structural weaknesses and testing the health system's resilience. Despite successive reforms targeting funding, care delivery, and public health, persistent structural weaknesses, poor planning, and limited monitoring have undermined progress. Most policy responses have remained fragmented and are unable to fulfil their potential to address current public health challenges or prepare for future crises. Building health system sustainability and resilience requires more than enacting reforms. The reform process demands evidence-informed policy making, sustained political commitment, strong institutional capacity, and effective multisectoral coordination. Greece offers valuable lessons for countries facing similar pressures: resilience depends not only on policy adoption, but also on the institutions, resources, and accountability mechanisms that support implementation and translate policies into sustained action.**

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## Introduction

Health systems globally face growing challenges, including ageing populations, increasing prevalence of chronic diseases, and limited resources to fund advances in health care. Emerging issues, such as climate change, infectious disease outbreaks, large-scale migration, and geopolitical instability, are placing additional strain on already burdened health systems. In Greece, many of these stressors have converged in the past 15 years, exposing structural vulnerabilities and testing health system resilience.[1–3]

Against this backdrop, Greece has implemented a series of reforms to improve service delivery and address public health challenges, but their long-term sustainability remains uncertain. The COVID-19 pandemic offered an illustrative example; the initial response was effective and driven by the prompt adoption of public health measures and interministerial coordination. However, as the pandemic progressed, persistent weaknesses and underdeveloped public health infrastructure exposed crucial vulnerabilities, ultimately undermining the health system's capacity to sustain an effective response.[4] Examining the Greek health system's adaptive capacity more broadly offers important insights for policy makers, in Greece and in other contexts facing comparable structural and fiscal constraints.

This Health Policy paper explores the key and emerging public health and health system challenges in Greece. The paper also provides an overview of recent reform efforts, identifying crucial gaps and opportunities for strengthening the health system to ensure its long-term sustainability.

## Main public health challenges in Greece

Greece faces a complex array of public health challenges driven by demographic change, socioeconomic pressures, climate events, and new threats to health. Greece's population is ageing rapidly with declining fertility rates, positing it among the oldest populations of the Organisation for Economic Co-operation and Development (OECD) countries. Projections indicate that by 2050, more than a third of the Greek population will be older than 65 years, with nearly 13% older than 80 years.[5] Consequently, self-reported chronic illnesses have risen. In particular, 59·0% of those aged 65 years and older, 72·8% of those aged 75 years and older, and 85·3% of those aged 85 years and older report long-standing illnesses or health problems.[7] Greece also exhibits some of the highest multimorbidity rates in the EU, affecting over half of those aged 65 years and older compared with the EU average of 44%.[7]

Compared with other high-income countries, Greece performs poorly on key behavioural risk factors, including smoking, physical activity, and obesity. Overweight and obesity rates in adults and children have steadily increased since the 1990s, surpassing neighbouring countries and ranking among the highest in Europe.[8] Both adults and children have increasingly adopted a Western diet, with adherence to the traditional Mediterranean diet remaining low to moderate.[9] Childhood overweight and obesity rates are among the highest in Europe, affecting 41% of children aged 5–9 years and 35·3% of adolescents aged 10–19 years.[10] Although smoking prevalence has declined, Greece maintains the second highest rate in the EU, at 25%.

Socioeconomic factors, differing exposure to chronic stressors, and gaps in health literacy contribute to disparities in health behaviours. For example, a pronounced socioeconomic gradient is evident in dietary habits and obesity rates; individuals with lower education attainment have a 64% obesity rate compared with an EU average of 54%.[6] These inequalities have been exacerbated by the prolonged economic crisis and ongoing cost-of-living crisis.[11,12] Recent inflationary pressures have further affected housing costs, food prices, and energy bills. More than one-quarter of the population is at risk of poverty or social exclusion, and

nearly 14% have severe material and social deprivation.[6,13–15]

In parallel, increased migration from neighbouring regions of political and economic instability has stretched the provision of health services. Migrant arrivals peaked in 2015, exceeding 860 000 individuals,[2] further stretching the provision of health services.[3] Approximately one in three refugee households has at least one member with health needs, such as chronic illness, disability, or mental health disorders.[16] Poor livings conditions, inadequate hygiene, and restricted access to health care have exacerbated both physical and mental health issues, particularly among those residing in hotspot facilities.[17]

Greece has also seen an increase in extreme weather events, including wildfires, floods, and heatwaves[18,19] leading to the highest number of heat-related deaths in Europe in 2023.[20] Worsening air quality, particularly in urban area, compounds the health impacts of heatwaves. Exposure to fine particulate matter ($PM_{2.5}$), nitrogen dioxide ($NO_2$), and ozone ($O_3$) was associated with more than 15 000 deaths and 133 200 life-years lost in 2022.[21] These climate-related hazards pose additional challenges to the capacity, preparedness, and resilience of health services.[22]

Antimicrobial resistance (AMR) is also a crucial concern, with Greece reporting some of the highest resistance rates in Europe.[23] More than 68% of bacterial isolates show resistance, the highest rate in the EU alongside Romania.[24] Greece has the highest estimated resistance proportions for 12 priority antibiotic-bacterium combinations among OECD countries, along with Türkiye.[25] As a result, Greece reports the second-highest prevalence of hospital-associated infections in the EU besides Cyprus, with more than 12% of hospitalised patients acquiring an infection, compared with an EU average of approximately 7%.[24]

These multifaceted shocks, threats, and crises have tested the resilience of the Greek health system and underline the necessity for comprehensive reforms. While initiatives have been introduced to address longstanding inefficiencies and respond to emerging public health challenges, many of these efforts have yet to be fully implemented or realised. Fragmented and inefficiently integrated measures to address climate change, exposure to risk factors, migration, and AMR require a renewed focus and consolidated approach. This paper will highlight key reform efforts to date and assesses their scope, implementation, and limitations.

## The health system and its efforts to address current and emerging public health challenges

Since the early 2010s, the Greek health system has implemented several reforms to address evolving public health challenges (appendix pp 1–4). This section outlines the key initiatives aimed at improving financial sustainability and efficiency, strengthening health-care delivery, enhancing the quality of care, tackling health workforce challenges, and responding to major emerging public health concerns.

See Online for appendix

### Ensuring financial sustainability

Financial sustainability has long been a challenge for the Greek health system, historically characterised by low health expenditure and a fragmented structure.[26] In 2022, Greek health expenditure totalled 8·6% of gross domestic product, approximately US$3000 per capita (purchasing power parity-adjusted), and less than the OECD average of $5000. This underfunding is primarily driven by low public spending, which has declined further since 2010 (figure).

Compared with other OECD countries, Greece allocates a larger share of health spending to inpatient care, while investing less for outpatient services, long-term care, and prevention. Out-of-pocket expenses are among the highest in the EU—accounting for 34% of total health expenditure compared with the EU average of 15%—with a substantial portion directed toward inpatient care and medicines. Notably, out-of-pocket payments for hospitals have increased from 1·6 to €2·2 billion (in current prices) from 2019, to 2023.[28] Nearly 9% of Greek households have catastrophic health expenditure,[29] disproportionately affecting lower-income households.[30]

To improve revenue collection and resource pooling, social health insurance funds were unified into a single fund with the National Organization for Health Care Services (EOPYY), now providing coverage for most of the population.[22] However, EOPYY has not fully leveraged its purchasing power and falls short of functioning as a strategic purchaser. Contracts and reimbursements lack clear criteria linked to performance, outcomes, quality, efficiency, or population needs, due to factors such as staffing constraints, underdeveloped processes, limited data integration, and digital infrastructure constraints. Crucially, EOPYY lacks institutional autonomy, operating under tight Ministry of Health control and facing political influence. As a result, the EOPYY's role diverges from its strategic mandate, functioning primarily as a claim clearing fund rather than an active purchaser of health services. Additionally, the design of the benefits package and the resource allocation decisions remain highly centralised within the Ministry of Health, largely shaped by historical precedent and political considerations.[31] While progress has been made, health technology assessment processes remain restricted due to the absence of a comprehensive institutional framework, capacity constraints, and staffing shortages.

Provider payment methods have yielded limited success in promoting efficiency or quality. Primary care facilities are mainly contracted without clear performance criteria, with services (eg, diagnostic tests and examinations) being paid on a fee-for-service basis according to a standardised price list. Patients often incur additional out-of-pocket payments in primary care.[31]

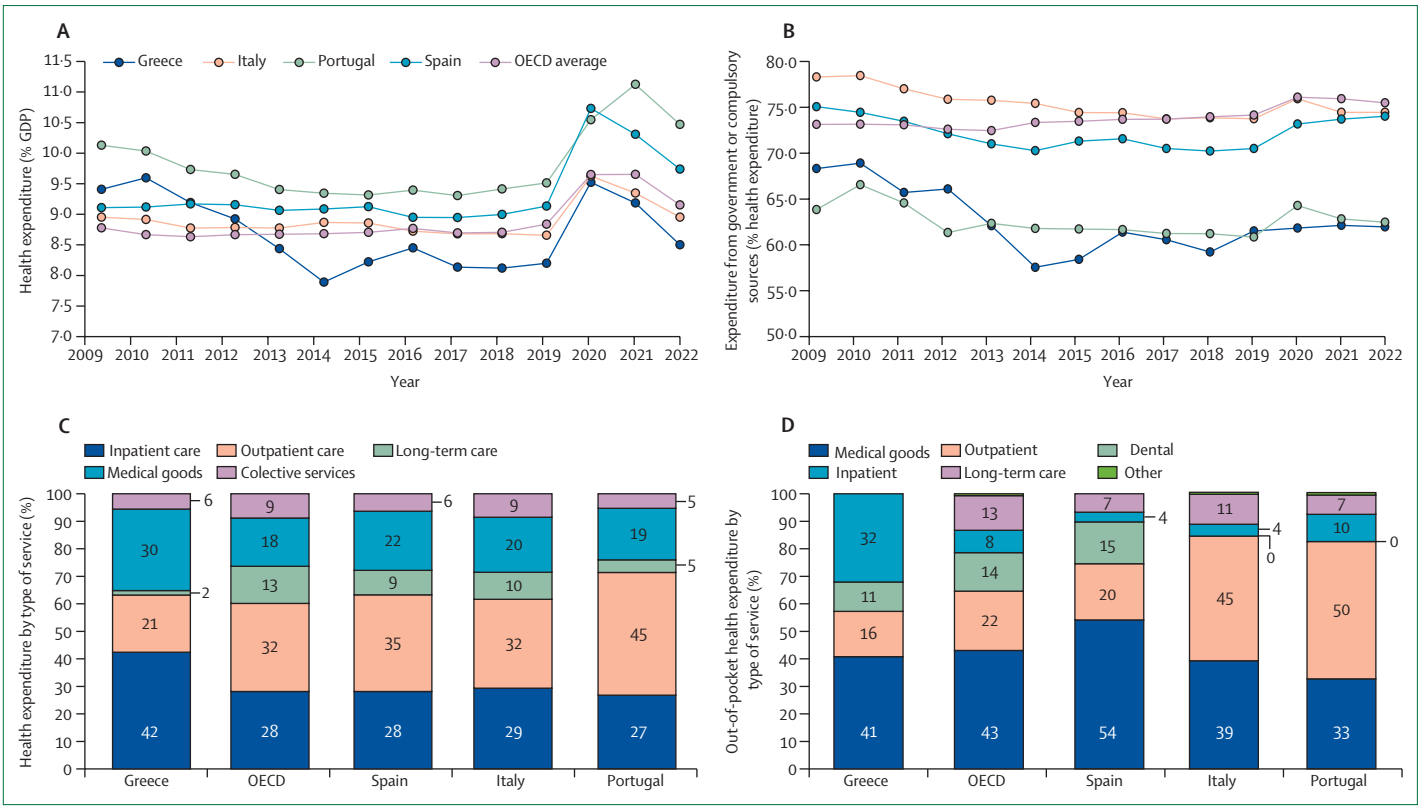


***Figure:*** **Health expenditure in Greece and selected European countries, 2009–22**
(A) Health expenditure (% GDP) of Greece compared with other European counties. (B) Percentage of health expenditure from government or compulsory sources. (C) Percentage of health expenditure by type of service. (D) Percentage of out-of-pocket health expenditure by type of service. This figure is based on OECD data.[27] GDP=gross domestic product. OECD=Organisation for Economic Co-operation and Development.

Despite repeated attempts from 2011 onwards to introduce a diagnosis-related group (DRG) system for hospital reimbursement, this is still not fully functioning.[32] Until at least 2024, public hospitals were partly reimbursed with retrospective state subsidies to cover budget deficits—a practice that weakens incentives for efficient procurement and service delivery.[22] While refinements to the DRG system have been introduced, the scope of implementation and its actual effect on efficiency and quality remain uncertain. In addition, it remains unclear how EOPYY will monitor and address potential unintended consequences of the DRG system, such as upcoding and unnecessary readmissions.

Physicians in public hospitals are salaried, with no incentives to increase productivity. Renumeration is not linked to patient volume, case complexity, or quality of care.[31] In 2024, considerable changes were introduced to improve physician retention and income. These changes allow for dual practice for physicians employed in public hospitals—including medical trainees—provided that such arrangements do not adversely affect the productivity or functioning of public hospitals and primary care units. This regulatory framework also introduces several challenges. In the absence of clearly defined operational guidelines for maintaining clinical activity and measuring productivity in the public sector, patients can also be implicitly encouraged or, in some cases, compelled to seek care in the private sector.[33] Careful consideration of the potential adverse consequences of dual practice is essential, as its effectiveness depends heavily on robust monitoring, oversight, and enforcement mechanisms,[34,35] which in Greece remain weak and fragmented.

Primary care doctors are paid either by salary or on a fee-for-services basis, depending on whether they practice in the public or private sector. A 2022 policy change allowed some office-based physicians to register as personal doctors, serving as gatekeepers and paid via capitation. Although approximately 57% of the eligible population has enrolled, there are limited data on the scheme's effect on service use, quality, referrals, or out-of-pocket spending, due to limited monitoring and data systems. The current capitation model provides few incentives, as physician income is determined solely by the number of registered patients, with no linkage to clinical quality or performance, potentially introducing incentives for risk selection and under-treatment.

Although the potential efficiency gains from hospital system reform have been recognised in policy discussions in the past three decades, little substantive progress has

been made to date.[36] Public provider deficits are largely covered by state subsidies,[37] and transparency and accountability issues persist in public procurement of supplies and equipment.[38] Furthermore, the expansion of the public hospital sector has been driven by political considerations rather than by population health needs, primarily to address local political priorities.[36] Despite the adoption or consideration of several efficiency-improving measures, most have yet to fully achieve their intended outcome. For instance, EOPYY still struggles to negotiate effectively with providers.[22] Potential efficiency gains could be realised with efforts to rationalise prescribing behaviours. However, standard demand–control mechanisms—eg, clinical guidelines, prescribing quotas, medical audits, and feedback on prescription patterns—are either lacking or implemented inconsistently, despite the existence of an electronic prescribing system since 2011. Weak regulation and monitoring of prescribing and dispensing further drive inefficiencies in spending and sustain reliance on out-of-pocket payments.

### Adapting care to meet demographic and health needs

Greece's care delivery model should be modified to better meet the needs of its ageing and increasingly multimorbid population. Delivery of care in Greece is hospital-oriented, hindering chronic disease management, care coordination, continuity, and comprehensiveness.[39] Due to the absence of a well-functioning primary care system, patients often directly seek services via self-referral to hospital outpatient clinics or emergency departments,[40] resulting in unnecessary workload and overcrowded hospitals.[22,41] A large private sector for primary care exists, including 211 private polyclinics, 2766 diagnostic centres, and more than 25 000 private physicians' practices.[42,43] Most primary care consultations and diagnostic tests are delivered by private specialists and centres, which might have contributed to overprescription and supplier-induced demand.[41] More than half of outpatient care spending is paid out-of-pocket.[28]

Previous reform attempts to rationalise demand for inpatient services and strengthen primary care have faltered due to inadequate planning, funding, and workforce considerations.[40] Due to the limited number of general practitioners (GPs), a policy change legislated in 2024, aimed to expand both the role and the number ozsonal doctors, allowing physicians without a medical specialty or postgraduate training to practice in this capacity. However, managing complex multimorbidity remains a challenge and is unlikely to be effectively managed by personal doctors working in isolation within solo practices. In fact, this policy contravenes international trends, which increasingly discourage solo practice in favour of team-based, multidisciplinary primary care models.[44]

Historically, Greece has lacked comprehensive policies for preventing and managing non-communicable diseases, leading to a focus on treatment rather than health promotion.[22] The absence of these policies has resulted in fragmented services operating under separate administrative bodies, including the Ministry of Health and the National Public Health Organization (NPHO), and inconsistently implemented policies to address key risk factors, such as obesity and smoking. For example, while Greece introduced a smoking ban in indoor public spaces in the early 2010s, and reintroduced it in 2019, law violations persist, albeit to a lesser extent.[8,45] Similarly, although childhood obesity has received periodic policy attention, regulatory compliance has been limited. In 2024, the National Nutrition Policy Committee issued recommendations to improve the nutritional quality of school canteen offerings; however, similar guidelines in the past were not adopted or enforced.[46] Several initiatives are currently underway to address childhood obesity, but their effects remain uncertain and have not been assessed yet. While secondary prevention screening programmes for breast, cervical, and colorectal cancer, and cardiovascular disease have been introduced since the early 2020s, a lack of systematic evaluation and publicly available reporting hinders assessments of their effectiveness. For example, there is no systematic evidence regarding diagnostic, clinical, and socioeconomic characteristics of individuals identified from screening programmes. Additionally, concerns have been raised about the sustainability of these programmes, as they are currently funded by the EU Recovery and Resilience Fund, which does not provide a stable long-term funding source.[8]

Despite having a population that is more likely to require long-term care needs than most of their counterparts in Southern Europe,[47] formal long-term care services—including residential, community, and home care—are underfunded and understaffed. Public structures address a small part of long-term care needs, and access to services is also restricted by stringent eligibility criteria and financial barriers.[48] Only 10% of long-term care users in Greece received formal services free-of-charge compared with an EU average of 37%. Additionally, almost 55% of those paying faced great difficulties in affording home care services compared with an EU average of only 12·1%.[49]

Perceptions that personal care of older adults is the family's—rather than state's—responsibility has been embedded within the Greek community, much more than in other countries.[50] As such, long-term care is mainly provided informally by family members and untrained care workers in several forms, including personal care, domestic assistance, and emotional support.[31] Greece has the highest share of population providing informal care, approximately at a third of the total population.[51] Caregiving responsibilities predominantly fall on women, affecting their mental health and labour market participation.

The prolonged economic crisis and the COVID-19 pandemic have increased mental health burden.[52,53]

Greece has the second highest age-standardised disability-assisted life-year rates for mental health disorders in Europe.[54] Since the 1990s, reforms have promoted deinstitutionalisation and gradual development of community-based mental health services.[31,55] However, key challenges remain, including poor coordination, gaps in access, workforce shortages, underfunding, and insufficient focus on mental health promotion and prevention. Recent policy initiatives seek to restructure governance and service delivery via national and regional mental health networks, with enhanced information systems for epidemiological surveillance, and the expansion of telepsychiatry and tele-counselling.

### Improving quality of care

Although an agency for quality of care was established in 2020, Greece still does not systematically monitor clinical effectiveness and patient outcomes. Due to the absence of relevant data, information on variations in the quality of care between public and private providers—and on their efficiency and productivity—remains scarce. The introduction of a cancer registry in early 2025 is a considerable step, although its role in clinical practice and policy remain uncertain. Clinical guidelines and therapeutic protocols are gradually being developed for specific conditions. However, training health professionals to apply these guidelines effectively remains a challenge, hindering their full integration into routine clinical practice.

In January 2025, Greece launched the National Strategy for Quality of Care and Patient Safety (2025–2030). The actual impact of this strategy remains to be seen, but it is of major importance given that Greece ranks 30th of 38 OECD countries in patient safety.[56] Although Greece's preventable and treatable mortality rates are close to the EU average,[7] the reduction in avoidable cardiovascular mortality has been slower compared with most EU countries in recent decades.[57]

Patient satisfaction in Greece has historically been among the lowest in high-income countries.[39] In 2022, only 44% of the Greek population reported being satisfied with the availability of quality health care, placing Greece 35th of 38 OECD countries.[5] Additionally, only a quarter of Greek respondents believed they would have access to good quality and affordable public services for health care, the lowest percentage among all OECD countries.[58] A recent analysis of patient-reported experience measures showed that Greece ranks lower than most of the 19 high-income countries examined across all five key indicators: confidence in self-management, experienced care co-ordination, person-centred care, experienced quality, and trust in the health system.[59]

### Addressing capacity challenges

Health workforce supply in Greece is poorly aligned with population needs, exhibiting considerable disparities. Although Greece has the highest number of doctors per 1000 people in the EU, which is a disproportionate number are specialists, only 6% of doctors are licensed as GPs compared with an EU average of 21%.[7] This imbalance extends to specific specialties, including internal medicine and anaesthesiology. Further exacerbating this challenge, Greece also has the lowest nurse-to-population ratio in the EU, with only 2·2 nurses per 1000 people—considerably lower than the EU average of 7·5 per 1000 people. This situation stems from a lack of strategic planning, including inadequate assessments of the required number of physicians, their specialties, and their geographical distribution.[22] For example, in 2023, there were 1159 practicing urologists but only 388 medical oncologists, and the country has nearly as many cardiologists as Germany, despite having a population more than eight times smaller.[60,61]

Recent efforts to address shortages in some specialties and remote areas have primarily focused on financial incentives for recruitment and retention, but these measures fall short of a comprehensive health workforce strategy. A major obstacle to planning is the absence of detailed data on workforce distribution, skill mix, and performance.[22] Furthermore, no substantial steps have been taken to improve working conditions in public hospitals where precarious circumstances persist, particularly during and after extended night shifts.

Persistent deficiencies in medical education also undermine health workforce capacity.[62] Current curricula overlook important topics, such as primary care, epidemiology, public health, and artificial intelligence. There are no centralised accreditation exams for medical graduates and specialty training is allocated on a first-come, first-served basis rather than merit-based criteria. Furthermore, Greece has not adopted a comprehensive approach for continuous medical education, nor for systematically disseminating new clinical knowledge and skills. Participation in such activities remains voluntary and ad hoc.[31] Opportunities for reskilling and upskilling are scarce, placing the burden solely on the workforce to adapt to the increasing demand for new competencies in care delivery. As such, skill mismatch can arise from an inadequate alignment between training and clinical practice needs, and the lack of workforce strategy to address future needs, including digital skills.

Overall, health workforce policy is doctor-centric, with the implementation of policies for other health professionals being very limited. This narrow focus fosters a siloed approach to care delivery, limiting opportunities for task-sharing and task-shifting among health providers.[63] For example, despite the high number of community pharmacies in Greece, the role of pharmacists remains limited. Pharmacists are not routinely involved in monitoring treatment adherence, managing drug–drug interactions, or providing basic diagnostic and preventive services. Greece also lacks strategies for developing human resource capacity in

public health and social care, despite their importance in addressing potential public health crises in the future. Moreover, strengthening the health workforce extends beyond care delivery and requires skilled professionals to support broader health system functions. Therefore, initiatives are needed to train, reskill, and upskill a substantial workforce with expertise in areas, such as health policy, management, and health data analytics.

### Efforts to respond to new challenges

The NPHO—Greece's agency for public health—primarily focuses on epidemiological surveillance and health promotion. Policy responses to emerging health threats, such as AMR, climate change, and migration remain fragmented across multiple agencies and ministries. These responses reflect both proactive planning and reactive measures via the development of national plans. While these efforts represent an initial step toward addressing complex threats, they remain insufficiently integrated into the broader public health and health-care systems. Many initiatives are short term in nature, lack sustained funding, and are not subject to systematic monitoring or evaluation. These limitations undermine both the effectiveness and long-term sustainability of these initiatives.

For example, the National Plan for AMR 2019–2023 was not fully implemented and no formal impact assessment has been conducted.[64,65] Despite recent European Centre for Disease Prevention and Control recommendations prioritising AMR as a public health situation of the highest priority, concrete steps have yet to be taken.[65] Coordination and collaboration challenges persist, preventing the effective adoption of a multisectoral One Health approach. Urgent and effective measures are needed, such as improving data collection, strengthening infection prevention and control practices in hospitals, recruiting additional personnel to work on AMR, and monitoring antibiotic prescription and consumption.

Although emergency responses to climate-related health crises have been developed,[66] climate resilience has not been effectively integrated into public health policy or health system planning. For example, beyond disaster risk management, neither the National Action Plan for Public Health 2021–2025 or the Annual Action Plan of the Ministry of Health explicitly address adaptation and response measures for mitigating the health effects of climate change or enhancing health system preparedness for climate-related health needs.[67,68]

Regarding migration, several international programmes have been created to meet the multiple challenges that migrants and refugees faced in accessing care.[69] However, these too are often not fully integrated to the system and suffer from short-termism. In 2017, the EU-funded PHILOS emergency health response to refugee crisis programme was introduced to strengthen health system capacity to meet refugee health needs. However, the programme was partly successful, primarily due to challenges in recruiting health professionals and administrative and programming inefficiencies.[70] In July 2024, Greece transitioned to the Hippocrates project with the aim of addressing medical and psychosocial needs while reducing the strain on local health services and communities.[71]

## Policy recommendations

### Prioritising public health

Public health has historically occupied a secondary position in Greece's policy agenda. Although several ambitious programmes have been implemented in recent decades, the absence of systematic evaluation has left their impact unclear, limiting opportunities for performance feedback and necessary adjustments. This issue affects crucial areas, such as risk factor management, population-based screening, refugee crisis responses, and AMR. Future public health initiatives should incorporate rigorous evaluation, supported by comprehensive data collection and robust methodological frameworks, alongside clear continuity, accountability, and monitoring mechanisms to track progress and effects.[22]

To enhance effectiveness, public health interventions developed by the Ministry of Health and the NPHO should integrate expertise beyond epidemiology and medicine, embracing insights from risk communication, operational research, behavioural science, implementation science, and data science. The COVID-19 pandemic highlighted the benefits of this multidisciplinary approach, emphasising the need for holistic preparedness and response strategies.[72,73] Additionally, strengthening policy integration and inter-agency cooperation is essential to effectively address climate-related hazards.[18,66] Achieving this multidisciplinary approach requires redefining governmental roles and enhancing cross-sector collaboration among public health, environmental sciences, urban planning, and other relevant fields. Improved coordination is particularly important given the overlapping responsibilities among the Ministry of Health, regional health authorities, and administrative regions.[66] To ensure coherent action, a high-level interministerial committee will be essential for enabling horizontal coordination, clear role delineation, and effective implementation.

Addressing social determinants of health is also crucial as these factors drive persistent health inequalities observed within Greece's population. Greece should implement systematic, individual-level data collection to monitor health inequalities effectively in time. Authorities should prioritise epidemiological surveillance and screening focused on social determinants and adopt a Health In All Policies approach to ensure coordinated cross-sectoral actions aimed at reducing disparities.

### Ensuring sustainable and equitable financing

The creation of EOPYY has been important for addressing past fragmentation and inefficiency. Currently, EOPYY acts as a single payer responsible for resource collection, pooling and allocation, and negotiation with providers. However, further improvements are necessary, including greater operational independence, capacity building, institutional strengthening, and strategic purchasing. EOPYY should invest in digital transformation, enhance clinical and financial audit and monitoring systems,[39] establish quality standards, and negotiate with providers more effectively.[22]

Major reforms are also necessary to the design of the benefits package, including routine reassessments, the use of clearly specified criteria, robust evidence collection, and meaningful stakeholder engagement. This process should incorporate value-based approaches and a comprehensive system for assessing health technologies and interventions while also expanding coverage to include other types of care, such as dental and long-term care.

Increasing funding from public sources is another crucial priority. As Greece's public finances continue to improve, greater emphasis should be placed on strengthening public health and the health-care system with increased and more balanced investment. Funding is particularly important, given that Greece allocates the lowest share of total government spending to health among OECD countries.[5] Furthermore, there should be targeted policies aimed at reducing out-of-pocket spending, an area that has yet to be prioritised in Greece. Potential measures include means-tested exemptions from user charges for specific socioeconomic groups, annual caps on household user charges, low fixed co-payments instead of percentage co-insurance rates, and a reduction of balance billing.[29,30]

Furthermore, linking provider payments to performance indicators is essential as existing payment models do not sufficiently incentivise providers to improve quality of care, enhance health outcomes, or use resources more efficiently. For instance, payments to primary care providers could be linked to prevention activities or disease management targets, fostering a more outcomes-oriented delivery of care.

### Modernising health care delivery to address complex health needs

To effectively address the care needs of an ageing population, Greece's primary care system should extend beyond the personal doctor model. Leveraging the country's large pool of specialists working in primary care settings and transitioning to a team-based care model could serve as an effective and pragmatic policy approach. In an era of increasing multimorbidity and complex health needs, multidisciplinary teams are essential, as a personal doctor alone might not manage patients effectively.

Given that several hospitals in Greece have largely been developed based on political considerations,[74] restructuring the hospital sector according to epidemiological and geographical factors is crucial. This restructuring should be further accompanied by governance reforms that ensure decision-making independence from the Ministry of Health and improvements in hospital management practices. Additionally, the systematic monitoring of key efficiency and quality indicators would enhance transparency, accountability, and overall hospital sector performance.

Establishing a universal, community-based, long-term care system and integrating the health and social care systems is also crucial.[22] This need is particularly pressing as reliance on informal familial care becomes increasingly unsustainable.[75] Additionally, these efforts should be complemented by reforms in governance structures, support for informal caregivers, and measures to reduce informality in care delivery.

Beyond reforms at all levels of care, comprehensive health information systems and data governance structures should be developed. Although some progress has been made with the establishment of a cancer registry and the introduction of electronic health records, further steps are needed to improve data availability, accessibility, timeliness, and interoperability. Health data are essential for guiding reforms, monitoring outcomes, and ensuring accountability.[22,76] Furthermore, the development of a national biobank could enhance research and drive advancements in health care.

A systematic national approach on the digital transformation of the health system, developed with close collaboration between the Ministry of Health and the Ministry of Digital Governance, is needed. Such a policy plan should incorporate clear policy direction, institutional coordination, and investment in workforce capacity to support health data governance and the adoption of digital health technologies, including artificial intelligence. For example, Greece should establish a health data network of institutions capable of effectively analysing health data with state-of-the-art approaches.

### Depoliticising health system and public heath structures

Health system and public health in Greece have historically been characterised by perennial reforms. While part of this failure stems from vested interests, party politics, and a lack of political continuity and bipartisan consensus, it also reflects weak governance structures and insufficient accountability mechanisms.[37,74] Addressing future challenges requires the gradual insulation of health governance from political interference, which includes the establishment of de facto arm's-length bodies that operate with institutional autonomy and operational independence, particularly for key organisations, such as EOPYY and the NPHO.

### Search strategy and selection criteria

We conducted a narrative literature review to synthesise peer-reviewed and grey literature on the Greek health system. This approach enabled us to identify key themes, reforms, policies, and evidence regarding the organisation, financing, delivery, and performance of the health system, and broader public health trends. The initial search was conducted in July and August 2024, with an update in March 2025. We searched three primary databases—MEDLINE (via PubMed), EconLit, and Google Scholar—using combinations of search terms across four thematic domains: health system structure, governance, and financing (eg, "health reform", "health financing", "health governance", and "health system performance"); public health and health outcomes (eg, "population health", "public health services", "mortality", "health inequalities", "preventive care", "antimicrobial resistance", "refugee health", and "climate change and health"); health workforce and service delivery (eg, "health workforce", "primary care", "hospital services", "access to care", "continuity of care"); and health policy and crisis response (eg, "austerity", "COVID-19 and health system", "economic crisis and health policy", "health system resilience"). Boolean operators were used to combine terms, adapted to each database's indexing structure. The search was restricted to publications from 2005 and onwards. We included publications in English and Greek, acknowledging that key national policy analyses, programme evaluations, and technical reports might only be available in Greek. In addition to academic databases, we searched grey literature from organisations, such as the relevant Greek ministries, the Hellenic Statistical Authority, the National Organization for the Provision of Health Services, the Organisation for Economic Co-operation and Development, European Centre for Disease Prevention and Control, European Environment Agency, WHO Regional Office for Europe, UN Refugee Agency, World Bank, and the European Observatory on Health Systems and Policies. We included studies and reports focused on system-level dimensions of health care in Greece, such as governance, financing, access, equity, workforce, and service delivery. Literature solely focused on clinical, biomedical, or disease-specific topics without relevance to broader system-level concerns was excluded, as were studies outside the scope or objective of this Review.

Moreover, strengthening interministerial collaboration is essential to adopt a Health In All Policies approach, integrating health considerations across sectors.[22] Ensuring transparent and meritocratic recruitment processes for leadership positions—from hospital managers to senior roles within public health and health system institutions—is also crucial. Currently, these positions are often filled with political appointments[77] and are subject to frequent turnover following governmental changes or even shifts in the Ministry of Health leadership. Lastly, enhancing accountability and transparency, increasing the active participation of civil society, and progressing towards a health pact—a cross-party agreement aimed at strengthening the future health system and public health response—are essential for meeting the challenges that lie ahead.

## Conclusion

The Greek health system is navigating a period of major challenge and opportunity. As the country faces mounting pressures from demographic change, non-communicable diseases, climate threats, and financial constraints, recent reforms have sought to improve sustainability, equity, and system performance. However, implementation has been inconsistent, and many initiatives lack adequate monitoring, integration, and long-term funding. Persistent structural weaknesses—eg, fragmented governance, underinvestment in public health, and a misaligned workforce—continue to undermine progress. Addressing these challenges will require a strategic shift toward evidence-informed policy, robust institutional capacity, and multisectoral coordination. Strengthening primary care with team-based models, expanding public health capacity, improving quality monitoring, and ensuring equitable financing are essential for building a more resilient and responsive system. Furthermore, the depoliticisation of health governance and the strengthening of monitoring and accountability mechanisms should be central to future reform efforts, as these are cross-cutting issues that span all health system and public health domains. As Greece's fiscal situation stabilises, increased investment in public health and health care should be prioritised, not only to meet current needs, but also to prepare for future crises. Without sustained political commitment, rigorous evaluation, and a coherent long-term vision, reform efforts risk remaining fragmented and short lived. Careful prioritisation, phased planning, and clear assignment of responsibilities are essential to navigating the inherent reform implementation complexities. The Greek case offers valuable lessons for other countries confronting similar pressures: resilience is built not solely on policy adoption, but with the institutions, resources, and accountability mechanisms that ensure its translation into practice.

**Contributors**

IK contributed to conceptualisation, reviewed the literature, wrote the original draft, and reviewed and edited the manuscript. KA, EM, and IP contributed to conceptualisation and reviewed and edited the manuscript. ST reviewed and edited the manuscript.

**Declaration of interests**

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