Greece: Resuscitation required – The Greek health system after a decade of austerity - Annex I[1]

AI Index: EUR 25/2229/2020

Illustrations of Health-sector specific conditionalities in the Economic Adjustment Programs and Stability Support Program

First Economic Adjustment Program for Greece

General stipulations	Stipulations around pharmaceutical spending	Stipulations around hospital expenditure
Memorandum of Understanding on Specific Economic Policy Conditionality, 3 May 2010[2]		
Government completes the programme of hospital computerisation, upgrading hospital budgeting systems, and the reform of management, the accounting (including double-entry accrual accounting) and financing systems. Government ensures greater budgetary and operational oversight of health care spending by the Finance Minister, the publication of audited accounts and improvement in pricing and costing mechanisms.	Government adopts legislation on the institutional framework for health supplies (Law 3580/2007), establishes new systems for the management of drugs that favour more use of generic medicines, including a new system for the electronic monitoring of doctors' prescriptions.	
Updated Memorandum of Understanding on Specific Economic Policy Conditionality, 6 August, 2010[3]		
Government completes the programme of hospital	Government adopts legislation on the institutional framework for health	Government seeks technical assistance from

[1] For full report please see: Amnesty International, *Greece: Resuscitation required – The Greek health system after a decade of austerity*, April 2020, https://www.amnesty.org/en/documents/eur25/2176/2020/en/

[2] Memorandum of Understanding on Specific Economic Policy Conditionality, 3 May 2010, https://publications.europa.eu/en/publication-detail/-/publication/64c89a77-ddc4-46f4-9bb0-18d7e80f6f0c/language-en

[3] Updated Memorandum of Understanding on Specific Economic Policy Conditionality, 6 August, 2010, https://publications.europa.eu/en/publication-detail/-/publication/0d77133c-9787-4dd9-bbe7-5f2e851254dd/language-en

computerisation, upgrading hospital budgeting systems, and the reform of management, the accounting (including double-entry accrual accounting) and financing systems. Government ensures greater budgetary and operational oversight of health care spending by the Finance Minister, the publication of audited accounts and improvement in pricing and costing mechanisms.	supplies (Law 3580/2007, as revised in May 2010 by Law 3846/2010), establishes new systems for the management of drugs that favour more use of generic medicines, including a new system for the electronic monitoring of doctors' prescriptions. The aim is to move to the average EU generic drug penetration rate, including by procurement of pharmaceutical products by hospitals and doctors' prescriptions on the basis of drastic substances. Government enforces the payment of EUR 3 for regular outpatient services in public hospitals and extends the 'all day' functioning of hospitals (afternoon shift) in order to develop and improve healthcare services and increase revenue, including by increasing co-payment of outpatients and diagnostic services.	independent international experts on all aspects of the efficiency and effectiveness of the health procurement system and management of hospitals, aiming at enhancing efficiency and reducing waste.
Memorandum of Understanding on Specific Economic Policy Conditionality, 22 November 2010[4]		
Government adopts a comprehensive reform of the health care system and modifies the allocation of health-related tasks among ministries. The overarching objective is to keep public health expenditure at or below 6 percent of GDP, while maintaining universal access and improving the quality of care delivery. In the short-term, the main focus should be on macro-level discipline and cost-control. Government creates an independent task force of health policy experts whose task is to produce, by end May 2011, a detailed report (blue print) for an overall reform of the health system to improve efficiency and effectiveness in the health system (both public and private). This task force has access to all available information and receives adequate administrative support. It will produce an interim report by March 2011.	Regarding pharmaceuticals, the government implements measures yielding savings of at least EUR 2 billion relative to the 2010 level, at least EUR 1 billion of which would materialise already in 2011. This would bring average public spending on outpatient pharmaceuticals to about 1 percent of GDP (in line with the EU average) by the end of 2012. More specifically, the following measures are implemented by end of 2010: Ensure full implementation of a uniform e-prescribing system, by extending the system currently used by OAEE to all the social security funds providing health insurance; Define (through EOF) and publish prescription guidelines for physicians on the basis of international prescription guidelines; Social security funds establish a process to regularly assess the information obtained through the e-prescribing system and vis-à-vis prescription guidelines. Assessment will be done through a common dedicated unit under the authority of Health Benefit Coordination Council (SYSPY) with support of IDIKA. Relevant sanctions and penalties will be enforced as a follow up to the assessment and as foreseen by existing rules and legislation; A yearly report on medicine prescription is published and feedback is provided to each physician on a regular basis (at least annually). The report and feedback analysis look at prescription behaviour with reference to the most costly and mostly used medicines; Publish the complete price list for the medicines in the market, using the new pricing mechanism. This list will be published by December 2010 and replace the partial list introduced in September. It will be updated quarterly; Announce that	Government ensures greater budgetary and operational oversight of health care spending by the Finance Minister, and the publication of audited accounts for hospitals and health centres.

[4] Memorandum of Understanding on Specific Economic Policy Conditionality, 22 November 2010, https://publications.europa.eu/en/publication-detail/-/publication/f1557fb3-aac4-4fb2-ac57-df1ed8146ba1/language-en

	caps to the price reductions used when the price list was first introduced in September 2010 will be lifted by March 2011; Apply the negative list of non-reimbursed medicines and the list of over-the-counter medicines prepared by the EOF; Finalise the new positive list of reimbursed medicines using the new reference price system; Using the information made available through e-prescribing and scanning, Government collect the agreed rebate from pharmaceutical companies; Introduces a monitoring mechanism allowing for developments in pharmaceutical expenditure to be assessed on a monthly basis. If the implementation of the above measures is insufficient to achieve the targeted savings, both in 2011 and for the medium term, the government will implement additional measures, following discussions with the European Commission, the ECB and the IMF staff. An assessment of the impact of measures will be made in the context of programme reviews.	
Memorandum of Understanding on Specific Economic Policy Conditionality, 23 February 2011[5]		
Building on important reforms already undertaken over the recent months, in particular, the move towards the integration of the supplies system and progress in hospital computerisation, Government continues to implement the comprehensive reform started in 2010 with the objective of keeping public health expenditure at or below 6% GDP, while maintaining universal access and improving the quality of care delivery. Government has taken measures yielding savings on pharmaceuticals of at least EUR 2 billion relative to the 2010 level, of which at least EUR 1 billion in 2011. This will bring average public spending on outpatient pharmaceuticals to about 1 % of GDP, in line with the EU average, by end 2012. Government implements the provisions of Article 31 and 32 of Law 3863/2010.	Government takes all necessary measures in order to extend in a cost-effective way the e-prescribing of medicines, diagnostics and doctors' referrals to all social security funds, health centres and hospitals. To this extent, in compliance with EU procurement rules, Government speeds up and finalises the necessary tendering procedures to implement a comprehensive and uniform health care information system (e-health system).	Government (Ministry of Health) completes the program of hospital computerisation. In particular, building on the web-based platform esy.net, it finalises the process of centralisation of information. The Ministry of Health creates a dedicated service/unit to collect and scrutinize data and produce monthly and annual reports. A copy of these reports is transmitted to the competent authority in the Ministry of Finance. Government takes measures to ensure the integration and consolidation of hospitals' IT systems.

[5] Memorandum of Understanding on Specific Economic Policy Conditionality, 23 February 2011, https://publications.europa.eu/en/publication-detail/-/publication/0c88313b-527c-420d-b1ef-d224af32da6e/language-en

Memorandum of Understanding on Specific Economic Policy Conditionality (fourth update), 2 July 2011[6]		
Government continues to implement the comprehensive reform of the health care system started in 2010 with the objective of keeping public health expenditure at or below 6 percent of GDP, while maintaining universal access and improving the quality of care delivery. Policy measures include the integration of primary healthcare, strengthening central procurement and e-health capacity. The provisions of Article 31 and 32 of Law 3863/2010 are implemented. Government equalises the common benefit package for the insurers of EOPYY, with the aim of full equalisation of benefits and contributions across funds by December 2011, and align the contributions paid by OGA members to those of other members of EOPYY, as envisaged in the medium-term fiscal strategy. [July 2011] All necessary steps are taken for EOPYY to initiate its operations as planned 6 months after the adoption of Law 3918/2011, including the appointment of the necessary and qualified staff. To this aim, government sets up a selection committee and devises objective criteria to ensure transparent procedures to govern the selection of the management of EOPYY. Members will be required to be qualified experts of recognised standing in health, management and health administration. [July 2011] EOPYY starts operating. The new fund will lead to a substantial reduction of administrative staff of at least 50 percent and of contracted doctors of at least 25 percent as compared to the four	Government continues to undertake measures yielding savings on pharmaceuticals of at least EUR 2 billion relative to the 2010 level, of which at least EUR 1 billion in 2011. This will bring average public spending on outpatient pharmaceuticals to about 1 percent of GDP (in line with the EU average) by end 2012. Government collects the rebates from pharmacies with sales above a designated threshold against the payment due to pharmacies; it continues to do so on a monthly basis; publishes the complete price list for the medicines in the market, using a new pricing mechanism based on the three EU countries with the lowest prices. The list will be updated on a quarterly basis; lifts the caps to the price reductions used when the price list was first introduced. [Q2-2011] Fees for medical services outsourced to private providers are reviewed with the aim of reducing related costs by at least 15 percent in 2011, and by an additional 15 percent in 2012. [Q4-2011] Starting from 2012, pharmacies' profit margins are calculated as a flat amount or flat fee combined with a small profit margin with the aim of reducing the overall profit margin to no more than 15 percent, including on the most expensive drugs as defined in law 3816/2010. [Q1-2012] Government publishes binding prescription guidelines for physicians defined by EOF on the basis of international prescription guidelines to ensure a cost-effective use of medicines [July 2011]; publishes and continuously updates the positive list of reimbursed medicines using the reference price system developed by EOF. [Q2-2011] Government takes further measures to extend in a cost-effective way the e-prescribing of medicines, diagnostics and doctors' referrals to all social security funds, health centres and hospitals. In compliance with EU procurement rules, Government conducts the necessary tendering procedures to implement a comprehensive and uniform health care information system (e-health system). [Q3-2011]	The aim is to reduce hospital costs by at least 10 percent in 2011 and by an additional 5 percent in 2012 in addition to the previous year. This is to be achieved through: adjusting public hospital provision within and between hospitals within the same district and health region; revising the activity of small hospitals towards specialisation in areas such as rehabilitation, cancer treatment or terminal care where relevant; increasing the mobility of healthcare staff (including doctors) within and across health facilities and health regions; preparing a joint management/operation system in districts with more than one hospital, excluding university hospitals. [Q2-2011] Government sets up selection criteria to ensure transparent procedures to govern the selection of the management of hospitals. Members will be required to be persons of recognised standing in health, management and health administration. [Q2-2011] A system for comparing hospital performance (benchmarking) is set up on the basis of a comprehensive set of indicators. [Q1-2012] Annual reports will be published as of end-2012. Internal controllers are assigned to all major hospitals. [Q3-2011] By Q2-2011, Government starts publishing the monthly report with analysis and description of detailed data on healthcare expenditure by all social security funds with a lag of three weeks after the end of the respective month. Social security funds start publishing an annual report on medicine prescription. Individual prescription reports serve as regular feedback to each physician (at least semi-annually). The annual report and the individual prescription reports examine prescription behaviour with particular reference to the

[6] Memorandum of Understanding on Specific Economic Policy Conditionality (fourth update), 2 July 2011, https://publications.europa.eu/en/publication-detail/-/publication/0a256be3-f327-4cd6-829a-b797d08365db/language-en

originating funds combined. The aim is to achieve a ratio of patients per doctor in line with the European average. [Q3-2011]

Government revokes market regulation 40 (17.12.1990) to abolish the 0.4 percent contribution of wholesale sales prices in favour of the Panhellenic Pharmaceutical Association. [Q3-2011]

An action plan is adopted by early November 2011, based on the final report of the task force (see below), including a timetable for concrete actions. [Q4-2011]

The Ministries of Health and Labour, in cooperation with the Ministry of Finance, prepare the first draft report presenting the structure (age, specialty, grade, regional distribution), levels of remuneration (including fees provisions to consultants and doctors) and the volume and dynamics of employment in hospitals, health centres, and health funds. This report will be updated annually and be used as a human resources planning instrument. The 2011 report will present plans for the allocation and requalification of human resources for the period up to 2013 as well as providing guidance for the education system. It specifies a plan to reallocate qualified and support staff within the NHS and health funds. [Q3-2011]

Government extends the use of capitation payments of physicians, currently used by OAEE, to all contracts between social security funds and the doctors they contract. The new payment mechanism starts for each new contract renewed in 2011 and for all contracts from 2012. It defines a minimum number of patients per doctor, on the basis of the experience of other EU countries. The new system will lead to a reduction in the overall compensation cost (wages and fees) of physicians by at least 10 percent in 2011, and an additional 15 percent in 2012 as compared to the previous

EOPYY and the remaining social security funds establish a process to regularly assess the information obtained through the e-prescribing system and produce regular reports, at least on a quarterly basis, to be

transmitted to the competent authorities in the Ministry of Labour, Ministry of Health, Ministry of Finance and ELSTAT. Monitoring and assessment is carried out through a dedicated common unit under SYSPY. Feedback is provided to each physician at least every quarter and a yearly report is published. Sanctions and penalties will be enforced as a follow-up to the assessment. [Q4-2011]

Government starts to produce a semi-annual report on the prescription and consumption of medicines and diagnostic tests. This report includes information on the rebate received from pharmacies and from pharmaceutical companies and on the volume and value of medicines. It provides a feedback report to all physicians on their prescription volume and value, at least on a quarterly basis. Monitoring and reporting of misconduct and conflict of interest in prescription behaviour are intensified. [Q4-2011]

E-prescribing covers all medical acts (medicines, referrals, diagnostics, surgery) in both NHS facilities and providers contracted by EOPYY and the social security funds. Detailed monthly auditing reports are produced by NHS facilities and by providers. [Q1-2012]

Additional measures are taken to promote the use of generic medicines through: compulsory e-prescription by active substance and of less expensive generics when available; associating a lower cost-sharing rate to generic medicines that have a significantly lower price than the reference price (lower than 60 percent of the reference price) on the basis of the experience of other EU countries; setting the maximum price of generics to 60 percent of the branded medicine with similar active substance. [Q2-2011]

Government takes further measures to ensure that at least 30 percent of

the volume of medicines used by public hospitals is composed of generics with a price below that of similar branded products and off-patent medicines, in particular by making compulsory that all public hospitals procure pharmaceutical products by active substance. [Q3-2011]

Further measures ensure that at least 50 percent of the volume of

most costly and most used medicines. [Q1-2012]

The necessary tendering procedures are carried out to develop the full and integrated system of hospitals' IT systems. [Q3-2011]

The Ministry of Health completes the programme of hospital computerisation. Building on the web-based platform ESY.net, it finalises the process of centralisation of information. The Ministry of Health, through a dedicated service/unit, collects and scrutinises data and produces monthly and annual reports, which are published. [Q2-2011]

Further measures are taken to improve the accounting, book-keeping of medical supplies and billing systems, through: finalising the introduction of double-entry accrual accounting systems and the regular annual publication of balance sheets in all hospitals; the calculation of stocks and flows of medical supplies in all the hospitals using the uniform coding system for medical supplies developed by the Health Procurement Commission (EPY) and the National Centre for Medical Technology (EKEVYL) for the purpose of procuring medical supplies; timely invoicing of treatment costs (no later than 2 months) to Greek social security funds, other EU countries and private health insurers for the treatment of non-nationals/non-residents. [Q4-2011]

The programme of hospital computerisation allows for a measurement of hospital and health centres activity. Government defines a core set of activity and expenditure indicators in line with Eurostat, OECD and WHO health databases. ELSTAT starts providing data in line with the System of Health National Accounts (joint questionnaire collection exercise). [Q4-2011]

The programme of hospital computerisation allows for the setting up of a basic system of patient electronic medical records. [Q4-2011]

In a group of hospitals, Government pilots the set of DRGs (diagnosticrelated groups) developed, with a view to developing a modern hospital costing system for

year. [Q3-2011] Government will move towards centralised procurement of pharmaceuticals and medical goods for the NHS through the Supplies Coordination Committee with the support of the Specifications Committee, using the uniform coding system for medical supplies and pharmaceuticals. [Q1-2012] The independent task force of health policy experts produces, in cooperation with the European Commission, ECB and IMF, a first draft of its policy report, with specific recommendations on policies to be implemented. The report will provide preliminary quantitative targets in the fields above, in order to contribute to keep public health expenditure –constant at, or below, 6 percent of GDP. The task force of health policy experts produces the final comprehensive policy report, with specific recommendations on policies to be implemented. [Q3-2011]. On the basis of this report, the Government adopts an action plan by October 2011, including a timetable for concrete actions. The taskforce produces an implementation report, revising the policies implemented so far. [Q1-2012]	medicines used by public hospitals is composed of generics with a price below that of similar branded products and off-patent medicines, in particular by making compulsory that all public hospitals procure pharmaceutical products by active substance. [Q4-2011]	contracting (on the basis of prospective block contracts). To support the development of DRGs, the government develops clinical guidelines. [Q4-2011]

Second Economic Adjustment Program for Greece

General stipulations	Stipulations around pharmaceutical spending	Stipulations around hospital expenditure
Memorandum of Understanding on Specific Economic Policy Conditionality, March 2012[7]		
The Government continues to implement the comprehensive reform of the health care system started in 2010 with the objective of keeping	The Government continues the efforts undertaken in 2010-11 and intensifies measures to reach savings in the purchasing (accruals basis) of outpatient medicines of close to EUR 1 billion in 2012 compared to	Fees for diagnostic services contracted to private providers are reviewed with the aim of reducing related costs by EUR 45 million in 2012. [Q1-2012] The

[7] Memorandum of Understanding on Specific Economic Policy Conditionality, March 2012, https://ec.europa.eu/economy_finance/publications/occasional_paper/2012/pdf/ocp94_en.pdf

public health expenditure at or below 6 percent of GDP, while maintaining universal access and improving the quality of care delivery. the Government further concentrates all health-related decision-making procedures and responsibilities (including payroll expenditures) under the Ministry of Health by at the latest June 2012. In order to do this, the Government prepares a plan and the necessary legislative changes by end-February 2012. As part of this concentration process, all health insurance funds are merged into EOPYY and come under the responsibility of the Ministry of Health. EOPYY buys services in a cost-effective way from NHS facilities and private providers through contracts. All other welfare / social assistance schemes under the Ministry of Health are moved to the Ministry of Labour by at the latest June 2012. From January 2013 EOPYY will purchase hospital services on the basis of prospective budgets following the development of costing of procedures by treatment/ pathology categories (full absorption cost DRGs). As a result of the concentration process, EOPYY rationalises the number of contracts with private doctors so as to bring down the doctor-to-patients ratio close to the much lower EU average. [Q2-2012] Contributions paid by OGA members are progressively equalised to those of other members of EOPYY, as envisaged in the medium-term fiscal strategy. The process of equalisation of contributions will be completed in 2013. The Government updates the existing report on human resources conducted by the Ministry of Health to present the staff structure according to specialty. This report will be updated annually and will be used as a human resource planning instrument. The 2012 report will also present plans for the allocation and requalification of human resources for the period up to 2013. It will also provide guidance for the education and training system and it will specify a plan to reallocate qualified and support staff within the NHS with a focus in particular on training and retention of	the 2011. This will contribute to the goal of bringing average public spending on outpatient pharmaceuticals to about 1 percent of GDP (in line with the EU average) by end-2014. In order to achieve EUR 1 billion of reduction in outpatient pharmaceutical spending in 2012, the Government will simultaneously implement a set of consistent policies comprising changes in pricing, prescribing and reimbursement of medicines that enhance the use of less expensive medicines, control prescription and consumption and prosecute misbehaviour and fraud. The Government defines a consistent set of incentives and obligations for all participants along the medicines supply chain (including producers, wholesalers, pharmacies, doctors and patients) to promote the use of generic medicines. The Government will revise the co-payment system in order to exempt from co-payment only a restricted number of medicines related to specific therapeutic treatments. [Q1-2012] The Government continues to update, on a quarterly basis, the complete price list for the medicines in the market, using the new pricing mechanism based on the three EU countries with the lowest prices. [Q1-2012] The Government introduces an automatic claw-back mechanism (quarterly rebate) on the turnover of pharmaceutical producers which guarantees that the outpatient pharmaceutical expenditure does not exceed budget limits. [Q1- 2012] Starting from Q1-2012, the pharmacies' profit margins are readjusted, and a regressive margin is introduced - i.e. a decreasing percentage combined with flat fee of EUR 30 on the most expensive medicines (above EUR 200) - with the aim of reducing the overall profit margin to below 15 percent. Government produces an implementation report on the impact of the new profit margins by Q1-2013. If it is shown that this new model to calculate profit margins does not achieve the expected result, the regressive margin will be further revised. Starting from Q1-2012, the wholesalers' profit margins are reduced to converge to 5 percent upper limit. The Government • takes further measures to extend in a cost-effective way the current eprescribing to all doctors, health centres and hospitals. E-prescribing is made compulsory and must include at least 90 percent of all medical acts covered by public funds (medicines, referrals, diagnostics, surgery) in both NHS facilities and providers contracted by EOPYY and the social security funds. [Q1-2012] • introduces a temporary and cost-effective mechanism (until all doctors are able to use the e-prescription system) which allows for the immediate and continuous monitoring and tracking of all prescriptions not covered by eprescription. This mechanism will make use of the web-based eprescription application established by IDIKA, which allows the	government starts publishing a quarterly report on the prescription and expenditure of diagnostic tests. [Q1-2012] The plan for the reorganisation and restructuring is implemented for the short and medium term with a view to reducing existing inefficiencies, utilising economies of scale and scope, and improving quality of care for patients. The aim is to reduce further hospital operating costs by 8 percent in 2012. This is to be achieved through: • increasing the mobility of healthcare staff (including doctors) within and across health facilities and health regions. • adjusting public hospital provision within and between hospitals within the same district and health region. • revising the activity of small hospitals towards specialisation in areas such as rehabilitation, cancer treatment or terminal care where relevant. • revising emergency and on-call structures. • optimise and balance the resource allocation of heavy medical equipment (e.g. scanners, radiotherapy facilities, etc.) on the basis of need. A first annual report comparing hospitals performance on the basis of the defined set of benchmarking indicators will be published by end-March 2012. Internal controllers are assigned to all hospitals and all hospitals adopt commitment registers. [Q1-2012] By end-March 2012, the Government publishes the monthly report with analysis and description of detailed data on healthcare expenditure by all social security funds with a lag of three weeks after the end of the respective month. This report will make it possible a detailed monitoring of the budget execution, by including both expenditure commitments/purchases (accruals basis) and actual payments (cash basis). The report will also (1) describe performance of entities on execution of budget and accumulation of arrears, (2) highlight any defaulters, and (3) recommend remedial actions to be taken. [Q1-2012]. EOPYY and other social security funds (until they merge) start publishing an annual report on medicine prescription. The annual report and the individual prescription reports examine prescription behaviour with particular reference to the most costly and most used medicines. [Q1-2012]

primary care healthcare professionals and hospital nurses. [Q3-2012] The revised payment system used by EOPYY for contracting with physicians, and the efficiency gains in the use of staff (including reduction in overtime costs) will lead to savings of at least EUR 100 million in the overall social security costs associated with wages and fees of physicians in 2012. [Q4- 2012]	pharmacies to electronically register manual prescriptions from a specific doctor to a specific patient. For medicines to be reimbursed by EOPYY (and other funds), pharmacies must register in the web-based application all manual prescriptions. For this service, doctors who prescribe manually will be charged a monthly administrative fee by EOPYY to compensate the pharmacies. The introduction of this temporary mechanism would ensure that all prescriptions are electronically recorded, allowing for the full and continuous monitoring of doctors' prescription behaviour, their compliance with prescription guidelines. [February 2012] • continues publishing prescription guidelines/protocols for physicians. Starting with the guidelines for the most expensive and/or mostly used medicines the government makes it compulsory for physicians to follow prescription guidelines. Prescription guidelines/protocols are defined by EOF on the basis of international prescription guidelines to ensure a costeffective use of medicines and are made effectively binding. [Q1-2012] • enforces the application of prescription guidelines also through the eprescription system, therefore discouraging unjustified prescriptions of most expensive medicines and diagnostic procedures. [Q1-2012] • produces (Ministry of Health and EOPYY together with the other social security funds until they merge) detailed monthly auditing reports on the use of e-prescription in NHS facilities and by providers contracted by EOPYY and other social security funds (until they merge). These reports are shared with the European Commission, ECB and IMF staff teams. [Q1-2012] • implements (Ministry of Health and EOPYY together with the other social security funds until they merge) an effective monitoring system of prescription behaviour. They establish a process to regularly assess the information obtained through the e-prescribing system. [Q2-2012] • produces regular reports, at least on a quarterly basis, on pharmaceutical prescription and expenditure which include information on the volume and value of medicines, on the use of generics and the use of off-patent medicines, and on the rebate received from pharmacies and from pharmaceutical companies. These reports are shared with the European Commission, ECB and IMF staff teams. [Q1-2012] If the monthly monitoring of expenditure shows that the reduction in pharmaceutical spending is not producing expected results, additional measures will be promptly taken in order to keep pharmaceutical consumption under control. These include a prescription budget for each doctor and a target on the average cost of prescription per patient and, if necessary, across-theboard further cuts in prices and profit margins and increases of co-payments. [Q2-2012] In compliance with EU procurement rules, the Government conducts the necessary tendering procedures to implement a comprehensive and uniform health care	The necessary tendering procedures are carried out by HDIKA to develop the full and integrated system of hospitals' IT systems. [Q1-2012] Throughout 2012, further measures are taken to improve the accounting, bookkeeping of medical supplies and billing systems, through: • the introduction of analytical cost accounting systems and the regular annual publication of balance sheets in all hospitals. [Q2-2012] • the calculation of stocks and flows of medical supplies in all the hospitals using the uniform coding system for medical supplies developed by the Health Procurement Commission (EPY) and the National Centre for Medical Technology (EKEVYL) for the purpose of procuring medical supplies. [Q1-2012] • timely invoicing of full treatment costs (including staff payroll costs) - i.e. no later than 2 months to other EU countries and private health insurers for the treatment of non-nationals/non-residents. [Q2-2012] • enforcing the collection of co-payments and implementing mechanisms that fight corruption and eliminate informal payments in hospitals. [Q2- 2012] ELSTAT starts providing expenditure data in line with Eurostat, OECD and WHO databases i.e. in line with the System of Health Accounts (joint questionnaire collection exercise). [Q1-2012] The programme of hospital computerisation allows for a measurement of financial and activity data in hospital and health centres. Moreover, the Minister of Health defines a core set of non-expenditure data (e.g. activity indicators) in line with Eurostat, OECD and WHO health databases, which takes account of the future roll-out of DRG (diagnostic-related groups) schemes in hospitals. [Q1-2012] The programme of hospital computerisation will continue the development of a system of patient electronic medical records. [Q3-2012] In all NHS hospitals, the Government pilots a set of DRGs, with a view to developing a modern hospital costing system for contracting (on the basis of prospective block contracts between EOPYY and NHS). To support the development of DRGs, the government develops clinical guidelines and assesses existing international examples of DRG-base schemes, in particular considering observations on DRG costing and proportionality of DRG-based tariffs. DRGs include a detailed item on costs of personnel. [Q3-2012] An analysis will be made of how hospital accounting schemes integrate DRGs at hospital level in view of

	information system (e-health system). [Q1-2012] A comprehensive set of measures is adopted simultaneously to promote the use of generic and less expensive medicines. The aim of these measures is to gradually and substantially increase the share of the generic medicines to reach 35 percent of the overall volume of medicines sold by pharmacies by end2012, and 60 percent by end-2013. This will be achieved by: • reducing the maximum price of the generic to 40 percent of the price of the originator patented medicine with same active substance at the time its patent expired. This is set as a maximum price; producers can offer lower prices, thus allowing an increased competition in the market. [Q1-2012] • automatically reducing the prices of originator medicines when their patent expires (off-patent branded medicines) to a maximum of 50 percent of its price at the time of the patent expiry. Producers can offer lower prices, thus allowing an increased competition in the market. [Q1-2012] • creating dynamic competition in the market for generic medicines through price reductions of at least 10 percent of the maximum price of each generic follower. [Q4-2012] • associating a lower cost-sharing rate to generic medicines that have a significantly lower price than the reference price for reimbursement (lower than 40 percent of the reference price) on the basis of the experience of other EU countries, while increasing substantially the co-payment of more expensive medicines in the reference category and of new molecules. [Q1- 2012] • deciding about the reimbursement of newly patented medicines (i.e. new molecules) on the basis of objective criteria and, until internal capacity is in place, by relying on best practice health technology assessment of their cost-effectiveness carried out in other member states, while complying with Council Directive 89/105/EEC. [Q1-2012] • excluding from the list of reimbursed medicines those which are not effective or cost-effective, also on the basis of the experience of other countries. [Q1-2012] • making it compulsory for physicians to prescribe by international nonproprietary name for an active substance, rather than the brand name. [Q1- 2012] • mandating the substitution of prescribed medicines by the lowest–priced product of the same active substance in the reference category by pharmacies (compulsory "generic substitution"). [Q1-2012] The Government takes further measures to ensure that at least 40 percent of the volume of medicines used by public hospitals is made up of generics with a price below that of similar branded products and off-patent medicines. This should be achieved, in particular by making compulsory that all public hospitals procure pharmaceutical products by active substance, by using the centralised tenders procedures developed by EPY and by enforcing compliance with therapeutic protocols and prescription guidelines. [Q2-2012] The Government, pharmaceutical companies and physicians adopt a code of good conduct (ethical rules and standards) regarding the interactions	future activity-based cost reporting and prospective budgets payment for hospitals [Q3-2012] Government continues centralised procurement through EPY and regional procurement through the Regional Health Authorities, with the aim of increasing substantially the number of expenditure items and therefore the share of expenditure covered by centralised tender procedures. [Q4-2012] EPY will undertake a major effort to utilise tender procedures for framework contracts for the most expensive medicines used in the outpatient context so as to substantially reduce the price paid by EOPYY. [Q4-2012] Government puts in place the procurement monitoring mechanism. [Q1-2012] The Independent Task Force of Health Policy Experts, established as an advisory group, produces an annual report on the implementation of reforms. [Q4-2012]

	between pharmaceutical industry, doctors, patients, pharmacies and other stakeholders. This code will impose guidelines and restrictions on promotional activities of pharmaceutical industry representatives and forbids any direct (monetary and non-monetary) sponsorship of specific physicians (sponsorship should be attributed through a common and transparent allocation method), based on international best practice. [Q1-2012] The Government simplifies administrative and legal procedures, in line with EU legal frameworks, to speed up the entry of cheaper generic medicines in the positive list. [Q2-2012]	
Memorandum of Understanding on Specific Economic Policy Conditionality, December 2012[8]		
The Government continues to implement the comprehensive health sector reform with the objective of stabilising public health expenditure at, or below 6, percent of GDP, while maintaining universal access and improving the quality of care delivery. Policy measures include reducing the fragmented governance structure, reinforcing and integrating the primary healthcare network, streamlining the hospital network, strengthening central procurement and developing a strong monitoring and assessment capability and e-health capacity. Prior to the disbursement, to strengthen health system governance, improve health policy coherence, reduce fragmentation in the purchasing of health services and reduce administrative costs, the Government finalises the concentration of all health-related decision-making procedures and responsibilities (including payroll expenditures) under the Ministry of Health by merging all health insurance funds, without exception, into EOPYY. 1. From January 2013, hospital services will be purchased directly by EOPYY through prospective budgets based on KEN-DRGs costing procedure (and payroll costs, should be at least reported). 2. EOPYY ensures that the number of doctors is reduced in headcount compared to June 2012 by at least 10% by December 2012 and by a further	The programme measures aim at achieving savings in the purchasing (accrual basis) of outpatient medicines of about EUR 1 billion in 2012 compared to 2011 and to reach spending of about EUR 2.440 billion in 2013 (accrual basis). The goal is to bring public spending on outpatient pharmaceuticals to about 1 percent of GDP i.e. around EUR 2 billion euro (in line with the EU average) in 2014. Total (outpatient plus inpatient) public expenditure on pharmaceuticals should be no more than 1.5 per cent in 2013 and 1.3 per cent in 2014. Prior to the disbursement, the Government: a. adopts legislation which activates contingency measures (including e.g. a cross-the-board cut in prices or entry fee for the positive list), if, for any reason, the claw-back is not able to achieve the target. Such measures produce equivalent amount of savings. b. sets, through Ministerial decree, the new claw back threshold for 2013, based on the above-mentioned targets (Euro 2.44 billion for outpatients). 1. The Government revises the co-payment structure for medicines to exempt from co-payment only a restricted number of medicines related to specific therapeutic treatments. (Q4-2012). In addition, the Government: 1. Revises downward the price of medicines, based on the three EU countries with the lowest prices. In addition, the government re-prices medicines now cheaper than 10 EUR, including implementing a 10% price reduction in the prices of these medicines (quarterly update of price list in line with the provisions of Council Directive 89/105/EEC - next published by December 2012) 2. Applies an automatic claw-back mechanism (every six months) to pharmaceutical producers which guarantees that the outpatient pharmaceutical expenditure (EOPYY budget) does not exceed the above targets (Continuous). 3. Produces an implementation report on the impact of the new profit margins of pharmacies by Q1-2013 and shares	The Government: 1. Implements the plan for the reorganisation and restructuring, as set in Law 4052 / March 2012, with a view to reducing existing inefficiencies, utilising economies of scale and scope, and improving quality of care for patients, thus contributing to better aligning working organisation with Directive 2003/88/EC). This implies reducing hospital operating costs by 8 percent in 2012 and an additional 5% in 2013 and reducing beds substantially, as legislated by MD OG1681/B (28-7-2011). This is to be achieved through: i. increasing the mobility of healthcare staff (including doctors) within and across health facilities and health regions; ii. adjusting public hospital provision within and between hospitals within the same district and health region; iii. revising the activity of small hospitals towards specialisation in areas such as rehabilitation, cancer treatment or terminal care where relevant; iv. revising emergency and on-call; v. optimising and balancing the resource allocation of heavy medical equipment (e.g. scanners, radiotherapy facilities, etc.) on the basis of need. vi. reducing administrative costs notably by removing deputy managers posts; vii. reducing cost with outsourcing services such as IT services, laboratory services and hospital servicing costs (e.g. cleaning services). 2. Produces an annual report comparing hospitals performance on the basis of the defined set of benchmarking indicators (Continuous) 3. Updates a report on human resources for the whole health care

[8] Memorandum of Understanding on Specific Economic Policy Conditionality, December 2012, https://ec.europa.eu/economy_finance/publications/occasional_paper/2012/pdf/ocp123_en.pdf

10% in 2013. Prior to the disbursement, to improve the current financial situation of EOPYY and ensure that the budgetary execution is closer to a balanced budget in 2012 and 2013, a set of measures will be implemented, including: i. restricting the benefit package; ii. increasing cost-sharing for private care; 214 iii. negotiating price-volume agreements and revising case-mix agreements with private providers; iv. revising the fees for and number of diagnostic and physiotherapy services contracted by EOPYY to private providers with the aim of reducing related costs by at least EUR 80 million in 2013. v. introducing a reference price system for reimbursement of medical devices. vi. progressively increasing the contributions paid by OGA members to the average of those paid by other members of EOPYY. 1. The government starts publishing a quarterly report on the prescription and expenditure of diagnostic tests. (quarterly updates - next report Q4-2012)	it with the European Commission, ECB and IMF staff. If it is shown that this new model to calculate profit margins does not achieve the expected result of a reduction of profit margins down to 15%, the regressive margin will be further revised. 4. Ensures that EOPYY negotiates a 5% discount through price-volume agreements on medicines (200 medicines) (Continuous for 2013 and 2014) 5. Extends the application of the 5% rebate on pharmaceutical companies (which exists for hospital-priced medicines) to all products sold in EOPYY pharmacies (legislation adopted by Q4-2012). Prior to the disbursement, the Government updates the price list and the positive list of reimbursed medicines notably by reimbursing only the cost-effective packages for chronic diseases, by moving medicines from the positive to the negative and OTC lists and introducing the reference price system developed by EOF. These lists must be updated at least twice a year. The Government will, 1. Extend the current e-prescribing to all doctors, health centres and hospitals. E-prescribing is made compulsory and must include at least 90 percent of all medical acts covered by public funds (medicines, referrals, diagnostics, surgery) in outpatient facilities and providers contracted by EOPYY and the other social security funds. (Q4-2012); the extension to NHS facilities will be finalised by Q2-2013. 2. Implement the system (API) whereby pharmacies electronically register any residual manual prescriptions from doctors into the e-prescription application established by IDIKA. (Q4-2012); 3. Continue publishing prescription guidelines/protocols for physicians, with priority for the most expensive and/or mostly used medicines, and makes them compulsory (Continuous); 4. Enforce the application of prescription guidelines through the e-prescription system. (Q2- 2013); 5. Further develop monitoring and control of e-prescription by introducing ICD-10 and SPC filters in the e-prescription system (Q2-2013); Produce detailed monthly auditing reports on the use of e-prescription in NHS facilities and by providers contracted by EOPYY. These reports are shared with the European Commission, ECB and IMF staff teams. (Continuous); 7. Continue to provide a regular assessment of the information obtained through the eprescribing system. (Continuous); 8. Produce detailed quarterly reports on pharmaceutical prescription and expenditure which include information on the volume and value of medicines, on the use of generics and the use of off-patent medicines, and on the rebate received from pharmacies and from pharmaceutical companies. These reports are shared with the European Commission, ECB and IMF staff teams. (Quarterly updates); 9. Provide detailed reporting on individual prescription behaviour to each physician relative to the average of comparable (specialty, patient workload) physicians (both in NHS facilities and contracted by EOPYY and other social security funds until they merge) and signals when they breach prescription guidelines. This feedback is provided at least every month	sector annually and uses it as a human resource planning instrument. (Continuous) The Government ensures that: 1. Internal controllers are assigned to all hospitals and all hospitals adopt commitment registers. (Q4-2012) 2. EOPYY publishes a monthly report with analysis and description of detailed data on healthcare expenditure with a lag of three weeks after the end of the respective month. This report will make possible the more detailed monitoring of budget execution, by including both expenditure commitments/purchases (accrual basis, by December 2012) and actual payments (cash basis). The report will also (1) describe performance on the execution of budget and accumulation of arrears, and (2) recommend remedial actions to be taken. (Continuous) 3. Further measures are taken to improve the accounting, book-keeping of medical supplies and billing systems, through: i. the introduction of analytical cost accounting systems (Continuous); ii. the regular annual publication of balance sheets in all hospitals. (Q2-2013); iii. the introduction of the uniform coding system for medical supplies developed by the Health Procurement Commission (EPY) and the National Centre for Medical Technology (EKEVYL) and the use of the observe.net system to monitor the procurement and use of tenders for medical supplies. (Continuous); iv. the introduction of inbound hospital logistics and stock management (Q4-2013) v. timely invoicing of full treatment costs (including staff payroll costs) - i.e. no later than 2 months to other EU countries and private health insurers for the treatment of non-nationals/non-residents. (Q4-2012); vi. enforcing the collection of co-payments and implementing mechanisms that fight corruption and eliminate informal payments in hospitals. (Continuous). 4. ELSTAT starts providing expenditure data in line with Eurostat, OECD and WHO databases i.e. in line with the System of Health Accounts (joint questionnaire collection exercise). (Q4-2012) 5. The programme of hospital computerisation allows for a measurement of financial and activity data in hospital and health centres. Moreover, the Minister of Health defines a core set of non-expenditure data (e.g. activity indicators) in line with Eurostat, OECD and WHO health databases, which takes account of the future roll-out of DRG (diagnostic-related groups)

	and a yearly report is published covering: 1) the volume and value of the doctor's prescription in comparison to their peers and in comparison to prescription guidelines; 2) the doctor's prescription of generic medicines vis-à-vis branded and patent medicines and 3) the prescription of antibiotics. (Continuous); 10. Enforce sanctions and penalties as a follow-up to the assessment and reporting of misconduct and conflict of interest in prescription behaviour and non-compliance with the EOF prescription guidelines (Continuous); 11. Select a number of the most expensive medicines currently sold in pharmacies, to be sold in hospitals or EOPYY pharmacies. (Q4-2012). 12. Implement a mechanism to reduce off-label prescription (Q4-2012) Prior to the disbursement, the Government: a. Makes it compulsory for physicians to prescribe by international non- proprietary name for an active substance, with no reference to any brand name on the prescription form. This constitutes a major health reform. To avoid any potential risk to the health of the patient, brand name prescription will, however, be allowed in limited and duly motivated cases. The share of branded name prescriptions can be no more than 15% of the overall prescriptions of each doctor and the doctor needs to provide the relevant justification in each case. A strict control of the prescription of each doctor is implemented through the eprescription monitoring system, using warning mechanisms to each doctor for when the prescription level by branded name is getting closer to the target. Prior to disbursement, a ministerial decree will explicitly define the exceptions to INN prescription, which must cover a very limited group of products (e.g. with narrow therapeutic index) and known sensitivities of the patient, according to international standards and best practices. b. Mandates the substitution of prescribed medicines by the lowest–priced product of the same active substance in the reference category by pharmacies (compulsory "generic substitution"). The Government also: 1. Increases the share of the generic medicines to reach 35 percent of the overall volume of medicines sold by pharmacies by end-2012 and 60 percent by end-2013. This will be achieved by: i. setting the maximum price of the generic to 40 percent of the price of the originator patented medicine with same active substance at the time its patent (exclusivity period) expired. After this first reduction, when exclusivity period expiry, further reductions are achieved through external reference pricing based on the three EU countries with the lowest prices. This will be done also by linking off-patent (when exclusivity period expires) products to the average of the three lowest prices in the EU and the price of the generic to 80% of the downward revised price of the off-patient. Further reductions are achieved through external reference pricing based on the three EU countries with the lowest prices. Producers are allowed to offer lower prices, thus allowing an increased competition in the market. (Continuous); ii. automatically reducing the maximum price of originator	schemes in hospitals. (Continuous) 6. The government starts to develop a system of patient electronic medical records. (Q1-2013) 7. In all NHS hospitals, the Government, with technical assistance from experts across EU, continue piloting a set of DRGs, with a view to developing a modern hospital costing system for contracting (on the basis of prospective block contracts between EOPYY and NHS). DRGs include a detailed item on costs of personnel. (Continuous) 8. An analysis will be made of how hospital accounting schemes integrate DRGs at hospital level in view of future activity-based cost reporting and prospective budgets payment for hospitals (Q4-2012) The Government increases substantially the number of expenditure items and therefore the share of expenditure covered by centralised tender procedures through EPY. (Continuous) 2. EPY will undertake a major effort to utilise tender procedures for framework contracts for the most expensive medicines used in the outpatient context so as to substantially reduce the price paid by EOPYY. (Q4-2012) 3. In compliance with EU procurement rules, the Government conducts the necessary tendering procedures to implement a comprehensive and uniform health care information system (e-health system) including the full and integrated system of hospitals' IT systems. (Continuous)

	medicines when their patent (exclusivity period) expires (off-patent branded medicines) to 50 percent of its price at the time of the patent expiry. Further reduction will be achieved by linking off-patent products to the average of the three lowest prices in the EU, to be revised periodically with price list. Producers can offer lower prices, thus allowing an increased competition in the market. (Continuous); iii. creating dynamic competition in the market for generic medicines through price reductions of at least 10 percent of the maximum price of each new generic producer entering the market. (Q4-2012); iv. introducing (EOPYY) additional incentives and mechanisms, including a prescription quota system for physicians, to ensure generic substitution (Q4- 2012); v. deciding about the reimbursement of newly patented medicines (i.e. new molecules) on the basis of objective and strict medical and cost-effective criteria and, until internal capacity is in place, by relying on best practice health technology assessment of their cost-effectiveness carried out in other member states, while complying with Council Directive 89/105/EEC. (Continuous); vi. excluding from the list of reimbursed medicines those which are not effective or cost-effective on the basis of objective criteria. (Continuous); 2. Takes further measures to ensure that at least 50 percent of the volume of medicines used by public hospitals is made up of generics with a price below that of similar branded products and off-patent medicines. (Continuous) 3. Makes it compulsory for all public hospitals to procure at least 2/3 of pharmaceutical products by active substance, using the centralised tenders procedures developed by EPY and by enforcing compliance with therapeutic protocols and prescription guidelines. (Q4- 2012) 4. Adopts, with the pharmaceutical companies and physicians, a code of good conduct (ethical rules and standards) regarding the interactions between pharmaceutical industry, doctors, patients, pharmacies and other stakeholders. This code will impose guidelines and restrictions on promotional activities of pharmaceutical industry representatives and will forbid any direct (monetary and non-monetary) sponsorship of specific physicians (sponsorship should be attributed through a common and transparent allocation method), based on international best practice. (Q4-2012) 5. Speeds up administrative and legal procedures, in line with EU legal frameworks for the entry of cheaper generic medicines in the market. (Q4-2012)	
Memorandum of Understanding on Specific Economic Policy conditionality, May 2013[9]		

[9] Memorandum of Understanding on Specific Economic Policy conditionality, May 2013, https://publications.europa.eu/en/publication-detail/-/publication/abc17e97-7815-4271-b8ea-d9b6e343f69d/language-en

The Government continues to implement the comprehensive health sector reform with the objective of stabilising public health expenditure at, or below, 6 percent of GDP, while maintaining universal access and improving the quality of care delivery. Policy measures include reducing the fragmented governance structure, reinforcing and integrating the primary healthcare network, streamlining the hospital network, strengthening central procurement and developing a strong monitoring and assessment capability and e-health capacity. To strengthen health system governance, improve health policy coherence, reduce fragmentation in the purchasing of health services and reduce administrative costs, the Government (i) ensures the effective concentration of all health insurance funds, without exception, into EOPYY, monitoring the transfer of staff and assets; (ii) ensures the effective transfer of all health-related decision making procedures and responsibilities (including payroll expenditures) under the Ministry of Health. 1. From January 2014, hospital services will be purchased directly by EOPYY through prospective budgets based on KEN-DRGs costing procedure (and payroll costs, should be at least reported). 2. EOPYY ensures that the number of doctors is reduced in headcount by a further 10% in 2013. 2.10.3 Reviewing the provision of medical services contracted by EOPYY 1. The government monitors the implementation of the various policies introduced in late 2012 to improve the current financial situation of EOPYY and ensure that the budgetary execution is closer to a balanced budget in 2013. Measures to monitor include: changes in OGA contributions, in the benefit package, in cost-sharing for private care and in the fees for diagnostic and physiotherapy services, as well as the use of price-volume agreements and case-mix agreements with private providers and the use of a reference price system for reimbursement of medical devices. (Continuous) 2. The government publishes a quarterly report on the prescription and expenditure	The programme measures aim at achieving savings in the purchasing (accrual basis) of outpatient medicines to reach spending of about EUR 2.440 billion and inpatient to reach spending of about EUR 0.66 billion in 2013 (accrual basis). The goal is to bring public spending on outpatient pharmaceuticals to about 1 percent of GDP i.e. around EUR 2 billion euro (in line with the EU average) in 2014. Total (outpatient plus inpatient) public expenditure on pharmaceuticals should be no more than 1.5 per cent in 2013 and 1.3 per cent in 2014. In order to reach the 1 percent of GDP target in 2014, the Government steps up its efforts, and further develops the set of incentives and obligations for all participants along the medicines supply chain (including producers, wholesalers, pharmacies, doctors and patients) to promote the use of generic medicines and the cost-effective use of medicines more generally. 2.10.2.1 Contingency measures to deliver the overall targets: 1. The government applies an automatic claw-back mechanism (every six months) to pharmaceutical producers which guarantees that the outpatient pharmaceutical expenditure (EOPYY budget) does not exceed the above targets (Continuous). A note on the collection of claw back for 2013 for the first half of 2013 is submitted by September 2013. 2. Activates contingency measures (including e.g. across-the-board cut in prices or entry fee for the positive list), if, for any reason, the claw-back is not able to achieve the target. Such measures produce an equivalent amount of savings. (October 2013). 3. In addition and if necessary, EOPYY introduces additional incentives and mechanisms, including a prescription quota system for physicians, to ensure generic substitution (September 2013). 2.10.2.2 Pricing of medicines. The Government: 1. Revises downward the price of medicines, based on the three EU countries with the lowest prices (quarterly update of price list in line with the provisions of Council Directive 89/105/EEC, next list to be published by June 2013). 2. On the basis of the report on the impact of the new profit margins of pharmacies, reduce the profit margins down to 15% by June 2013. 3. Ensures that EOPYY negotiates a 5% discount through price-volume agreements on expensive medicines (200 medicines) sold in EOPYY pharmacies (Continuous for 2013 and 2014). 2.10.2.3 Prescribing and monitoring The Government will, 1. Update the positive list of reimbursed medicines and the list of OTC medicines. These lists must be updated at least twice a year (next update June 2013). 2. Ensures full coverage of e-prescription to doctors, outpatient facilities and providers contracted by EOPYY and to all NHS facilities (health centres and hospitals) by June 2013. E-prescribing is made compulsory and must include at least 90 percent of all outpatient medical acts covered by public funds (medicines, referrals, diagnostics). 3. Finalise the implementation of the system (API) whereby pharmacies electronically register any residual manual prescriptions from doctors into	The Government: 1. Implements the plan for the reorganisation and restructuring, as set in Law 4052 / March 2012, with a view to reducing existing inefficiencies, utilising economies of scale and scope, and improving quality of care for patients, thus contributing to better aligning working organisation with Directive 2003/88/EC. This implies reducing hospital operating costs by an additional 5% in 2013 and reducing beds substantially, as legislated by MD OG1681/B (28-7-2011). This is to be achieved through: i. increasing the mobility of healthcare staff (including doctors) within and across health facilities and health regions; ii. adjusting public hospital provision within and between hospitals within the same district and health region; iii. revising the activity of small hospitals towards specialisation in areas such as rehabilitation, cancer treatment or terminal care where relevant; iv. revising emergency and on-call; v. optimising and balancing the resource allocation of heavy medical equipment (e.g. scanners, radiotherapy facilities, etc.) on the basis of need. vi. reducing administrative costs notably by removing deputy managers posts; vii. reducing cost with outsourcing services such as IT services, laboratory services and hospital servicing costs (e.g. cleaning services). 2. Produces an annual report comparing hospitals performance on the basis of the defined set of benchmarking indicators (Continuous; next report 1st June 2013) 3. Updates a report on human resources for the whole health care sector annually and uses it as a human resource planning instrument. (Continuous; next report 1st June 2013) The Government ensures that: 1. The allocation of internal controllers to all hospitals is finalised and that all hospitals adopt commitment registers. (December 2012, New deadline May 2013) 2. EOPYY publishes a monthly report with analysis and description of detailed data on healthcare expenditure with a lag of three weeks after the end of the respective month. This report will make possible the more detailed monitoring of budget execution, by including both expenditure commitments/purchases (accrual basis) and actual payments (cash basis). The report will also (1) describe performance on the execution of budget and accumulation of arrears, and (2) recommend remedial actions to be taken. (Continuous) 3. Further measures are

of diagnostic tests. (Continuous, quarterly, next report July 2013)	the e-prescription application established by IDIKA. (December 2012, New Deadline May 2013). 4. Continue publishing prescription guidelines/protocols for physicians, with priority for the most expensive and/or mostly used medicines and makes them compulsory (Continuous). 5. Enforce the application of prescription guidelines through the e-prescription system starting with at least 5 therapeutic groups by June 2013. 6. Further develop the e-prescription system by introducing compulsory ICD-10 by May 2013 and SPC filters in the e-prescription system (October 2013). 7. Enhance monitoring and assessment through: i. detailed monthly auditing reports on the use of e-prescription in NHS facilities and by providers contracted by EOPYY. These reports are shared with the European Commission, ECB and IMF staff teams. (Continuous); ii. regular assessment of the information obtained through the e-prescribing system. (Continuous); iii. detailed quarterly reports on pharmaceutical prescription and expenditure which include information on the volume and value of medicines, on the use of generics and the use of off-patent medicines, and on the rebate received from pharmacies and from pharmaceutical companies. These reports are shared with the European Commission, ECB and IMF staff teams. (Continuous, Quarterly, new report July 2013); iv. detailed reporting on individual prescription behaviour to each physician relative to the average of comparable (specialty, patient workload) physicians (both in NHS facilities and contracted by EOPYY and other social security funds until they merge) and signals when they breach prescription guidelines. This feedback is provided at least every month and a yearly report is published covering: 1) the volume and value of the doctor's prescription in comparison to their peers and in comparison to prescription guidelines; 2) the doctor's prescription of generic medicines vis-à-vis branded and patent medicines and 3) the prescription of antibiotics. (Continuous); 8. Enforce sanctions and penalties as a follow-up to the assessment and reporting of misconduct and conflict of interest in prescription behaviour and non-compliance with the EOF prescription guidelines (Continuous); 9. Electronic monitoring and the introduction of cancelation mechanisms to barcodes of pharmaceutical products should be finalized by collaboration of EOF and IDIKA (September 2013). 2.10.2.4 Increasing use of generic medicines Prior to the disbursement, the Government: a. Ensures the application of compulsory prescription by international non- proprietary name (INN) for an active substance notably by putting in place an automatic blockage mechanism once prescription by branded name reaches 15% of the overall prescription value of each doctor in real time. b. Prices the large backlog of generic medicines waiting for a price in compliance with EU Transparency Directive at a pace of 400 per month, with 400 medicines priced prior to disbursement. The Government also: 1. Increases the share of the generic medicines in total outpatient and reimbursed medicines to reach 60 percent (in volume) by	taken to improve the accounting, book-keeping of medical supplies and billing systems, through: i. the introduction of analytical cost accounting systems, with the implementation of the respective action plan, due to be finalised, with complete hospital coverage, by November 2013; ii. the regular annual publication of balance sheets in all hospitals. (June 2013); iii. the introduction of the uniform coding system for medical supplies developed by the Health Procurement Commission (EPY) and the National Centre for Medical Technology (EKEVYL) and the use of the observe.net system to monitor the procurement and use of tenders for medical supplies. (Continuous); iv. the introduction of inbound hospital logistics and warehouse management systems using barcode scanning systems for pharmaceuticals and medical consumables. (December 2013); v. implement necessary action to ensure timely invoicing of full treatment costs (including staff payroll costs) - i.e. no later than 2 months to other EU countries and private health insurers for the treatment of non-nationals/non-residents. (Continuous); vi. enforcing the collection of co-payments and implementing mechanisms that fight corruption and eliminate informal payments in hospitals. (Continuous). 4. ELSTAT starts providing expenditure data in line with Eurostat, OECD and WHO databases i.e. in line with the System of Health Accounts (joint questionnaire collection exercise). (May 2013) 5. The programme of hospital computerisation allows for a measurement of financial and activity data in hospital and health centres. Moreover, the Minister of Health defines a core set of non-expenditure data (e.g. activity indicators) in line with Eurostat, OECD and WHO health databases, which takes account of the future roll-out of DRG (diagnostic-related groups) schemes in hospitals. (Continuous) 6. The government starts to develop a system of patient electronic medical records. (May 2013) 7. The Government, with technical assistance from experts across EU, continues to improve the existing KEN/DRG system, with a view to developing a modern hospital costing system for contracting (on the basis of prospective block contracts between EOPYY and NHS). The existing set of KEN/DRGs is used in all hospitals The KEN/DRG Management Institute is established by June 2013. DRGs will include a detailed item on costs of personnel. (Continuous) 8. A follow up analysis of how

	December 2013. This will be achieved by: i. automatically reducing the maximum price of originator medicines when their patent (exclusivity period) expires (off-patent branded medicines) to 50 percent of its price at the time of the patent expiry. Further reduction will be achieved by linking off-patent products to the average of the three lowest prices in the EU, to be revised periodically with price list. Producers can offer lower prices, thus allowing an increased competition in the market. (September 2013); ii. setting the maximum price of the generic to 40 percent of the price of the originator patented medicine with same active substance at the time its patent (exclusivity period) expired. After this first reduction, the price of the generic medicine is set to 80% of the downward revised price of the off-patient products (when the exclusivity period expires) which is to be set on the basis of the average of the three lowest prices in the EU as defined in point i. Producers are allowed to offer lower prices, thus allowing an increased competition in the market. (September 2013); iii. ensuring dynamic competition in the market for generic medicines through a) speeding up administrative and legal procedures, in line with EU legal frameworks; b) applying price reductions of at least 10 percent of the maximum price of each three new generic producer entering the market, according to existing regulation (May 2013) iv. deciding about the reimbursement of newly patented medicines (i.e. new molecules) on the basis of objective and strict medical and cost-effective criteria and, until internal capacity is in place, by relying on best practice health technology assessment of their cost-effectiveness carried out in other member states, while complying with Council Directive 89/105/EEC. (Continuous); v. excluding from the list of reimbursed medicines those which are not effective or cost-effective on the basis of objective criteria. (Continuous); vi. in the frame of the Administrative Reform process of EOF, set up scientific capacity in order to include cost effectiveness criteria in the reimbursement and licensing process. 2. Takes further measures to ensure that at least 50 percent of the volume of medicines used by public hospitals for inpatients is made up of generics with a price below that of similar branded products and off-patent medicines. (Continuous) 3. Ensures that all public hospitals to procure at least 2/3 of pharmaceutical products by active substance, using the centralised tenders procedures developed by EPY and by enforcing compliance with therapeutic protocols and prescription guidelines. (Continuous)	hospital accounting schemes integrate DRGs at hospital level in view of future activity-based cost reporting and prospective budgets payment for hospitals will be submitted by September 2013 2.10.5 Centralised procurement- 1. The Government increases substantially the number of expenditure items and therefore the share of expenditure covered by centralised tender procedures through EPY up to 45% of all the expenditure in medicines and medical devices by 2014. This share goes up to 60% in 2015. The Government ensures the use of such tender procedures. (Continuous) 2. EPY will undertake tender procedures for framework contracts for the most expensive medicines sold in EOPYY pharmacies. (Continuous) In compliance with EU procurement rules, the Government conducts the necessary tendering procedures to implement a comprehensive and uniform health care information system (e-health system) including the full and integrated system of hospitals' IT systems. (Continuous)
Memorandum of Understanding on Specific Economic Policy conditionality, July 2013[10]		
The Government continues to implement the comprehensive health sector reform with the	The programme measures aim at achieving savings in the purchasing (accrual basis) of pharmaceuticals to reach spending on outpatient	2.10.3 Reviewing the provision of medical services contracted by EOPYY - Prior to the disbursement, the

[10] Memorandum of Understanding on Specific Economic Policy conditionality, July 2013, https://op.europa.eu/en/publication-detail/-/publication/11398044-8e4a-4c53-8adf-79421f2c190c/language-en

objective of stabilising public health expenditure at, or below, 6 percent of GDP, while maintaining universal access and improving the quality of care delivery. Policy measures include reducing the fragmented governance structure, reinforcing and integrating the primary healthcare network, streamlining the hospital network, strengthening central procurement and developing a strong monitoring and assessment capability and e-health capacity. To strengthen health system governance, improve health policy coherence, reduce fragmentation in the purchasing of health services and reduce administrative costs, the Government (i) ensures the effective concentration of all health insurance funds, without exception, into EOPYY, monitoring the transfer of staff and assets; (ii) ensures the effective transfer of all health-related decision-making procedures and responsibilities (including payroll expenditures) under the Ministry of Health. 1. From January 2014, hospital services will start to be purchased directly by EOPYY through prospective budgets based on KEN-DRGs costing procedure (and payroll costs, should be at least reported). 2. EOPYY ensures that the number of doctors is reduced in headcount by a further 10% in 2013.	pharmaceuticals of about EUR 2371 billion and spending on inpatient pharmaceuticals of about EUR 0.66 billion in 2013 (accrual basis). The goal is to bring public spending on outpatient pharmaceuticals to about 1 percent of GDP i.e. around EUR 2 billion euro (in line with the EU average) in 2014. Total (outpatient plus inpatient) public expenditure on pharmaceuticals should be no more than 1.5 percent of GDP in 2013 and 1.3 percent of GDP in 2014. 2.10.2.1 Contingency measures to deliver the overall targets 1. The Government applies an automatic claw-back mechanism (every six months) to pharmaceutical producers which guarantees that the outpatient pharmaceutical expenditure (EOPYY budget) does not exceed the above targets (Continuous). A note on the collection of claw back for the first half of 2013 is submitted by September 2013. 2. Activates contingency measures (including e.g. across-the-board cut in prices or entry fee for the positive list), if, for any reason, the claw-back is not able to achieve the target. Such measures produce an equivalent amount of savings. (October 2013). 3. In addition and if necessary, EOPYY introduces additional incentives and mechanisms, including a prescription quota system for physicians, to ensure generic substitution (September 2013). 2.10.2.2 Pricing of medicines The Government: 1. Revises downward the price of medicines, based on the three EU countries with the lowest prices (quarterly update of price list every four months in line with the provisions of Council Directive 89/105/EEC, next lists to be published by end June 2013 and September 2013). 2. On the basis of the report on the impact of the new profit margins of pharmacies, reduce the profit margins down to 15%, starting from 1st January 2014. 3. Ensures that EOPYY negotiates a 5% discount through price-volume or risk sharing agreements focusing on the top spending medicines sold in EOPYY pharmacies (Continuous for 2013 and 2014). 2.10.2.3 Prescribing and monitoring The Government will, 1. Update the positive list of reimbursed medicines and the list of OTC medicines. These lists must be updated after every price bulletin (or the corrective) (deadlines should follow 2.10.2.2.1 with some offset). 2. Ensures full coverage of e-prescription to doctors, outpatient facilities and providers contracted by EOPYY and to all NHS facilities (health centres and hospitals) by September 2013. E-prescribing is made compulsory and must include at least 90 percent of all outpatient medical acts covered by public funds (medicines, referrals, diagnostics) (Continuous). 3. Finalise the implementation of the system (API) whereby pharmacies electronically register any residual manual prescriptions from doctors into the e-prescription application established by IDIKA. (New Deadline September 2013). 4. Continue publishing prescription guidelines/protocols for physicians, with priority for the most expensive and/or mostly used medicines and makes them compulsory (Continuous). 5. Enforce the application of prescription guidelines through the e-prescription system starting with at least 5 therapeutic groups by	Government: a. Takes legislative action that allows the Minister of Health to set a claw back mechanism and targets for non-pharmaceutical expenses of EOPYY in order to meet fiscal targets in the health care sector for the period 2013-2015.Further the Government: 1. Activates contingency measures (including e.g. across-the-board cut in prices and access to private providers or entry fee on contractual arrangement), if, for any reason, the claw-back is not able to achieve the target. Such measures produce an equivalent amount of savings. (October 2013). 2. monitors the implementation of the various policies introduced in late 2012 to improve the current financial situation of EOPYY and ensure that the budgetary execution is closer to a balanced budget in 2013. Measures to monitor include: changes in OGA contributions, in the benefit package, in cost-sharing for private care and in the fees for diagnostic and physiotherapy services, as well as the use of price-volume agreements and case-mix agreements with private providers and the use of a reference price system for reimbursement of medical devices. (Continuous) 3. will implement all the measures included in the "Action Plan towards a Comprehensive Set of New Measures to Control the Expenditure of EOPYY" as agreed with EC/IMF/ECB and produce an implementation report. (Quarterly) 4. publishes a monthly report on the prescription and expenditure of diagnostic tests and private clinics. (Continuous) 5. Initiates tendering procedure for the introduction of in house financial and analytical cost accounting systems of EOPYY. (January 2014) 2.10.4.1 Reorganisation and management of the health care sector The Government: 1. Implements the plan for the reorganisation and restructuring, as set in Law 4052 / March 2012, with a view to reducing existing inefficiencies, utilising economies of scale and scope, and improving quality of care for patients, thus contributing to better aligning working organisation with Directive 2003/88/EC. This implies reducing hospital operating costs by an additional 5% in 2013 and reducing beds substantially, as legislated by MD OG1681/B (28-7-2011). This is to be achieved through: i. increasing the mobility of healthcare staff (including doctors) within and across health facilities and health regions; ii. adjusting public hospital provision within and between hospitals

	September 2013. Further develop the e-prescription system by monitoring the compulsory ICD-10 and enforcing SPC filters in the e-prescription system (At a pace of 500 drugs per month starting October 2013). 7. Enhance monitoring and assessment through: i. detailed monthly auditing reports on the use of e-prescription in NHS facilities and by providers contracted by EOPYY. These reports are shared with the European Commission, ECB and IMF staff teams. (Continuous); ii. regular assessment of the information obtained through the e-prescribing system. (Continuous); iii. detailed quarterly reports on pharmaceutical prescription and expenditure which include information on the volume and value of medicines, on the use of generics and the use of off-patent medicines, and on the rebate received from pharmacies and from pharmaceutical companies. These reports are shared with the European Commission, ECB and IMF staff teams. (Continuous, Quarterly, new report July 2013); iv. detailed reporting on individual prescription behaviour to each physician relative to the average of comparable (specialty, patient workload) physicians (both in NHS facilities and contracted by EOPYY and other social security funds until they merge) and signals when they breach prescription guidelines. This feedback is provided at least every month and a yearly report is published covering: 1) the volume and value of the doctor's prescription in comparison to their peers and in comparison to prescription guidelines; 2) the doctor's prescription of generic medicines vis-à-vis branded and patent medicines and 3) the prescription of antibiotics. (Continuous); 8. Enforce sanctions and penalties as a follow-up to the assessment and reporting of misconduct and conflict of interest in prescription behaviour and non-compliance with the EOF prescription guidelines (Continuous); 9. Electronic monitoring and the introduction of cancelation mechanisms to barcodes of pharmaceutical products should be finalized by collaboration of EOF and IDIKA (September 2013). 2.10.2.4 Increasing use of generic medicines - Prior to the disbursement, the Government: a. Enforces compulsory ICD10 in the electronic prescription. The Government also: 1. Increases the share of the generic medicines in total outpatient and reimbursed medicines to reach 60 percent (in volume) by December 2013. This will be achieved by: i. automatically reducing the maximum price of originator medicines when their patent (exclusivity period) expires (off-patent branded medicines) to 50 percent of its price at the time of the patent expiry. Further reduction will be achieved by linking off-patent products to the average of the three lowest prices in the EU, to be revised periodically with price list. Producers can offer lower prices, thus allowing an increased competition in the market. (September 2013); ii. setting the maximum price of the generic to 40 percent of the price of the originator patented medicine with same active substance at the time its patent (exclusivity period) expired. After this first reduction, the price of the generic medicine is set to 80% of the downward revised price of the off-patient products (when the exclusivity	within the same district and health region; iii. revising the activity of small hospitals towards specialisation in areas such as rehabilitation, cancer treatment or terminal care where relevant; iv. revising emergency and on-call; v. optimising and balancing the resource allocation of heavy medical equipment (e.g. scanners, radiotherapy facilities, etc.) on the basis of need. vi. reducing administrative costs notably by removing deputy managers posts; vii. reducing cost with outsourcing services such as IT services, laboratory services and hospital servicing costs (e.g. cleaning services). 2. Produces an annual report comparing hospitals performance on the basis of the defined set of benchmarking indicators (Continuous; next report 1st April 2014). On the basis of the 2013 annual report produce a benchmarking study by October 2013. 3. Updates a report on human resources for the whole health care sector annually and uses it as a human resource planning instrument. (Continuous; next report 1st April 2014) 4. The Government presents an analysis on healthcare needs of the long-term unemployed (and dependent family members) who lack healthcare coverage by EOPYY. This analysis addresses present and expected patient numbers as well as related public budgets needed. This analysis includes priority settings scenarios varied by clinical needs of impacted patient subgroups. (September 2013) 2.10.4.2 Accounting, costing, control, IT and monitoring systems - The Government ensures that: 1. EOPYY publishes a monthly report with analysis and description of detailed data on healthcare expenditure with a lag of three weeks after the end of the respective month. This report will make possible the more detailed monitoring of budget execution, by including both expenditure commitments/purchases (accrual basis) and actual payments (cash basis). The report will also (1) describe performance on the execution of budget and accumulation of arrears, and (2) recommend remedial actions to be taken. (Continuous) 2. Further measures are taken to improve the accounting, book-keeping of medical supplies and billing systems, through: i. the introduction of analytical cost accounting systems, with the implementation of the respective action plan, due to be finalised, with complete hospital coverage, by

	period expires) which is to be set on the basis of the average of the three lowest prices in the EU as defined in point i. Producers are allowed to offer lower prices, thus allowing an increased competition in the market. (September 2013); iii. Finalises the pricing of the large backlog of generic medicines waiting for a price in compliance with EU Transparency Directive and ensures dynamic price reductions (**September 2013**). iv. deciding about the reimbursement of newly patented medicines (i.e. new molecules) on the basis of objective and strict medical and cost-effective criteria and, until internal capacity is in place, by relying on best practice health technology assessment of their cost-effectiveness carried out in other member states, while complying with Council Directive 89/105/EEC. **(Continuous);** v. excluding from the list of reimbursed medicines those which are not effective or cost-effective on the basis of objective criteria. **(Continuous);** vi. in the frame of the Administrative Reform process of EOF, set up scientific capacity in order to include cost effectiveness criteria in the reimbursement and licensing process and to manage the positive and internal reference price mechanism (October 2013). 2. Takes further measures to ensure that at least 50 percent of the volume of medicines used by public hospitals for inpatients is made up of generics with a price below that of similar branded products and off-patent medicines. **(Continuous)** 3. Ensures that all public hospitals to procure at least 2/3 of pharmaceutical products by active substance, using the centralised tender procedures developed by EPY and by enforcing compliance with therapeutic protocols and prescription guidelines. **(Continuous)**	November 2013; the regular annual publication of balance sheets in all hospitals. (September 2013); iii. the introduction of the uniform coding system for medical supplies developed by the Health Procurement Commission (EPY) and the National Centre for Medical Technology (EKEVYL) and the use of the observe.net system to monitor the procurement and use of tenders for medical supplies. (Continuous); iv. the introduction of inbound hospital logistics and warehouse management systems using barcode scanning systems for pharmaceuticals and medical consumables. (December 2013); v. implement necessary action to ensure timely invoicing of full treatment costs (including staff payroll costs) - i.e. no later than 2 months to other EU countries and private health insurers for the treatment of non-nationals/non-residents. (Continuous); vi. enforcing the collection of co-payments and implementing mechanisms that fight corruption and eliminate informal payments in hospitals. (Continuous). 3. ELSTAT continues providing expenditure data in line with Eurostat, OECD and WHO databases i.e. in line with the System of Health Accounts (joint questionnaire collection exercise). (2012 figures to be released by January 2014) 4. The programme of hospital computerisation allows for a measurement of financial and activity data in hospital and health centres. Moreover, the Minister of Health defines a core set of non-expenditure data (e.g. activity indicators) in line with Eurostat, OECD and WHO health databases, which takes account of the future roll-out of DRG (diagnostic-related groups) schemes in hospitals. (Continuous) 5. The Government starts to develop a system of patient electronic medical records. (Continuous) 6. The Government, with technical assistance from experts across EU, continues to improve the existing KEN/DRG system, with a view to developing a modern hospital costing system for contracting (on the basis of prospective block contracts between EOPYY and NHS). The existing set of KEN/DRGs is used in all hospitals i. The KEN/DRG Management Institute is established (October 2013). ii. DRGs will include a detailed item on costs of personnel. (Continuous) 7. A follow up analysis of how hospital accounting schemes integrate DRGs at hospital level in view of future activity-based cost reporting and prospective budgets payment for hospitals will be submitted by September 2013.

		2.10.5 Centralised procurement - 1. The Government increases substantially the number of expenditure items and therefore the share of expenditure covered by centralised tender procedures through EPY up to 45% of all the expenditure in medicines and medical devices by 2014. This share goes up to 60% in 2015. The Government ensures the use of such tender procedures. (Continuous) 2. EPY will undertake tender procedures for framework contracts for the most expensive medicines sold in EOPYY pharmacies. (Continuous) 3. EPY will publish a detailed annual report on its activity (2012 report published in September 2013) 4. In compliance with EU procurement rules, the Government conducts the necessary tendering procedures to implement a comprehensive and uniform health care information system (e-health system) including the full and integrated system of hospitals' IT systems. (Continuous)
Memorandum of Understanding on Specific Economic Policy Conditionality, April 2014[11]		
The Government continues to implement the comprehensive health sector reform with the objective of stabilising public health expenditure at, or below, 6 percent of GDP, while guaranteeing universal access and improving the quality of care delivery. Policy measures include reducing the fragmented governance structure, reinforcing and integrating the primary healthcare network, streamlining the hospital network, strengthening central procurement and developing a strong monitoring and assessment capability and e-health capacity. To strengthen health system governance, improve health policy coherence, reduce fragmentation in the purchasing of health services and reduce administrative costs, the Government (i) ensures the effective concentration of all health insurance funds, without exception, into EOPYY, monitoring the transfer of staff and assets; and (ii) ensures the effective transfer of all health-related decision making	The programme measures aim at achieving savings in the purchasing (accrual basis) of pharmaceuticals to reach spending on outpatient pharmaceuticals of about EUR 2371 billion and spending on inpatient pharmaceuticals of about EUR 0.66 billion in 2013 (accrual basis). The goal is to bring public spending on outpatient pharmaceuticals to about 1 percent of GDP i.e. around EUR 2 billion euro (in line with the EU average) in 2014. Total (outpatient plus inpatient) public expenditure on pharmaceuticals should be no more than 1.5 percent of GDP in 2013 and 1.3 percent of GDP in 2014. Contingency measures to deliver the overall targets - 1. The Government applies an automatic claw-back mechanism (every six months) to pharmaceutical producers which guarantees that the outpatient pharmaceutical expenditure (EOPYY budget) does not exceed the above targets (Continuous and through to 2015 inclusive). 2. The clawback ceiling is set at 2 billion euro including vaccines and other medicinal products for the uninsured (April 2014): i. A note on the collection of the clawback for the second half of 2013 is submitted by April 2014. ii. A note on the collection of the first half of 2014 is submitted in August 2014. 3. Activates contingency measures (including e.g. across-the-board cut in prices or entry fee for the positive list), if, for any reason, the claw-back is	Further the Government: 1. Immediately implements as a matter of urgency the procedure to check all claims/invoices sent to EOPYY with priority for the private providers under the clawback system. i. By June 2014 all claims referring to 2013 should have been checked for private clinics. If the procedure of concentrating the checks proves ineffective, in-site checking of invoices should be considered. ii. By September 2014 all claims referring to 2013 should have been checked for diagnostics. 2. Implements the clawback mechanism on spending with private providers for 2013 and 2014 and sets the clawback targets for 2014 by April 2014. A report is produced by June 2014. 3. Activates contingency measures (including e.g. across-the-board cut in prices and access to private providers or entry fee on contractual arrangement), if, for any reason, the claw-back is not able to achieve the target. Such measures produce an equivalent amount of savings (April 2014). 4. Implements all the measures included in the "Action Plan towards a Comprehensive Set of New Measures to Control the Expenditure of EOPYY" as agreed with

[11] Memorandum of Understanding on Specific Economic Policy Conditionality, April 2014, https://op.europa.eu/en/publication-detail/-/publication/fe2e91cb-d0e8-47c8-a76f-de6cd8677bb8/language-en

procedures and responsibilities (including payroll expenditures) under the Ministry of Health.	not able to achieve the target. Such measures produce an equivalent amount of savings (April 2014). 4. In addition and if necessary, EOPYY introduces additional incentives and mechanisms, including a prescription quota system for physicians (minimum prescription target of generics for doctors of 60% percent on average and adjusted to specialty), to ensure generic substitution (April 2014). Pricing of medicines - The Government: 1. Revises downward the price of medicines, based on the three EU countries with the lowest prices (full revisions every six months and a monthly pricing of new generics in line with the provisions of Council Directive 89/105/EEC, next list to be published by end June 2014). 2. On the basis of the report on the impact of the new profit margins of pharmacies, introduces regressive mark-ups and reduces the profit margins down to 15%, starting from 1st June 2014. 3. Ensures that EOPYY negotiates a 5% discount through price-volume or risk sharing agreements focusing on the top spending medicines sold in EOPYY pharmacies (continuous). 2.9.1.3. Prescribing and monitoring - The Government will, 1. Update the positive list of reimbursed medicines and the list of OTC medicines. These lists must be updated after every price bulletin (or the corrective) (next one by July 2014). 2. Ensures full coverage of e-prescription to doctors, outpatient facilities and providers contracted by EOPYY and to all NHS facilities (health centres and hospitals). E-prescribing is made compulsory and must include at least 90 percent of all outpatient medical acts covered by public funds (medicines, referrals, diagnostics) (continuous). 3. Continue publishing prescription guidelines/protocols for physicians, with priority for the most expensive and/or mostly used medicines and makes them compulsory (continuous). 4. Enforce the application of prescription guidelines through the e-prescription system. Following the initial 2 therapeutic groups, additional prescription guidelines are included in the system (June 2014). 5. For the guidelines not included in the e-prescription system, a pop-up with guideline is activated when the first-line choice of treatment is not chosen: i. A pilot for most expensive 10 medicines (April 2014). ii. Full process (September 2014). 6. Further develop the e-prescription system by monitoring the compulsory ICD-10 and enforcing SPC filters in the e-prescription system (continuous). 7. Enhance monitoring and assessment through: i. Detailed monthly auditing reports on the use of e-prescription in NHS facilities and by providers contracted by EOPYY. These reports are shared with the European Commission, ECB and IMF staff teams. (continuous). ii. Regular assessment of the information obtained through the e-prescribing system. (continuous). iii. Detailed quarterly reports on pharmaceutical prescription and expenditure which include information on the volume and value of medicines, on the use of generics and the use of off-patent medicines, and on the rebate received from pharmacies and from pharmaceutical companies. These reports are shared with the European Commission, ECB and IMF staff teams (continuous, quarterly,	EC/IMF/ECB and produce an implementation report (quarterly, next report April 2014). 5. Monitors the implementation of the various policies introduced in late 2012 to improve the current financial situation of EOPYY and ensure that the budgetary execution is closer to a balanced budget in 2013. Measures to monitor include: changes in OGA contributions, in the benefit package, in cost-sharing for private care and in the fees for diagnostic and physiotherapy services, as well as the use of price-volume agreements and case-mix agreements with private providers and the use of a reference price system for reimbursement of medical devices (continuous). 6. Introduces blocked /closed contracts with private providers and ex-ante approval of private hospital treatment plans, sets budgets to doctors for diagnostic tests, introduces clinical guidelines for the prescription of diagnostic tests and referrals and considers price reductions (April 2014). It develops indicators for monitoring the compliance with prescription guidelines (April 2014). 7. Publishes a monthly report on the prescription and expenditure of diagnostic tests and private clinics (continuous). 8. Initiates tendering procedure for the introduction of in house financial and analytical cost accounting systems of EOPYY (April 2014). The Government: 1. Implements the plan for the reorganisation and restructuring, as set in Law 4052 / March 2012, with a view to reducing existing inefficiencies, utilising economies of scale and scope, and improving quality of care for patients, thus contributing to better aligning working organisation with Directive 2003/88/EC. This implies reducing hospital operating costs in 2014 in line with the targets set in the MTFS and continuing the reorganisation and streamlining of the hospital network. This is to be achieved through: i. Increasing the mobility of healthcare staff (including doctors) within and across health facilities and health regions. ii. Adjusting public hospital provision within and between hospitals within the same district and health region. iii. Revising the activity of small hospitals towards specialisation in areas such as rehabilitation, cancer treatment or terminal care where relevant. iv. Revising emergency and on-call systems. v. Optimising and balancing the resource allocation of heavy medical equipment (e.g. scanners, radiotherapy facilities, etc.) on

	new report April 2014). iv. Detailed reporting on individual prescription behaviour to each physician relative to the average of comparable (specialty, patient workload) physicians (both in NHS facilities and contracted by EOPYY and other social security funds until they merge) and signals when they breach prescription guidelines. This feedback is provided at least every month and a yearly report is published covering: 1) the volume and value of the doctor's prescription in comparison to their peers and in comparison to prescription guidelines; 2) the doctor's prescription of generic medicines vis-à-vis branded and patent medicines and 3) the prescription of antibiotics (continuous). 8. Enforce sanctions and penalties as a follow-up to the assessment and reporting of misconduct and conflict of interest in prescription behaviour and non-compliance with the EOF prescription guidelines (continuous). 2.9.1.4. Increasing use of generic medicines The Government also: 1. Increases the share of the generic medicines in total outpatient and reimbursed medicines to reach 60 percent (in volume) by December 2014. 2. Decides about the reimbursement of newly patented medicines (i.e. new molecules) on the basis of objective and strict medical and cost-effective criteria and, until internal capacity is in place, by relying on best practice health technology assessment of their cost-effectiveness carried out in other member states, while complying with Council Directive 89/105/EEC. (continuous). 3. Excludes from the list of reimbursed medicines those which are not effective or cost-effective on the basis of objective criteria (continuous). 4. In the frame of the Administrative Reform process of EOF, set up scientific capacity in order to include cost effectiveness criteria in the reimbursement and licensing process and to manage the positive and internal reference price mechanism (April 2014). 5. Takes further measures to ensure that at least 50 percent of the volume of medicines used by public hospitals for inpatients is made up of generics with a price below that of similar branded products and off-patent medicines (continuous). 6. Ensures that all public hospitals to procure at least 2/3 of pharmaceutical products by active substance, using the centralised tender procedures developed by EPY and by enforcing compliance with therapeutic protocols and prescription guidelines (continuous). EPY will undertake tender procedures for framework contracts for the most expensive medicines sold in EOPYY pharmacies (continuous).	the basis of need. vi. Hire financial officers for all hospitals with more than 400 beds through 3 year contracts setting specific financial and operational goals and targets on their performance. vii. Reducing cost with outsourcing services such as IT services, laboratory services and hospital servicing costs (e.g. cleaning services). viii. Introducing a national registry of referrals to outpatient specialist and elective care to improve the monitoring and management of waiting list in view of the development of the primary care system (September 2014). This may be based on the e-prescription system. 2. Defines a set of activity related (input, process, output, outcome) indicators and produces a quarterly report together with the submission of financial data (next report April 2014). Produces an annual report comparing hospitals performance on the basis of the defined set of benchmarking indicators (continuous; next report 1st April 2014). 3. Updates a report on human resources for the whole health care sector annually and uses it as a human resource planning instrument (continuous; next report 1st April 2014). 4. The Government finalises the analysis regarding the number and healthcare needs of the uninsured people in the country; establishes a registry of all beneficiaries of NHS and EOPYY services and the health insurance status of all residents in the country; and proposes measures to ensure access to necessary care by the uninsured specifying the potential budgetary impact and the sources of financing (April 2014). 5. As a result of this analysis and proposal, the government will implement policies that ensure universal access to necessary care including cost-effective primary health care, pharmaceuticals, diagnostics and elective hospital care and in conjunction with existing policies such as the poverty booklet and the social voucher programmes of MoH (health voucher and training voucher) (June 2014). 2.9.3.2. Accounting, costing, control, IT and monitoring systems The Government ensures that: 1. EOPYY publishes a monthly report with analysis and description of detailed data on healthcare expenditure with a lag of three weeks after the end of the respective month. This report will make possible the more detailed monitoring of budget execution, by including both expenditure commitments/purchases (accrual basis) and actual payments (cash basis). The report will also (1) describe performance on the execution of budget and

		accumulation of arrears, and (2) recommend remedial actions to be taken (continuous). 2. Further measures are taken to improve the accounting, book-keeping of medical supplies and billing systems, through: i. The regular annual publication of balance sheets in all hospitals. (continuous, yearly). ii. The introduction of the uniform coding system for medical supplies developed by the Health Procurement Commission (EPY) and the National Centre for Medical Technology (EKEVYL) and the use of the observe.net system to monitor the procurement and use of tenders for medical supplies (continuous). iii. The pilot introduction of inbound hospital logistics and warehouse management systems using barcode scanning systems for pharmaceuticals and medical consumables. (to be finalised by December 2014). iv. Implement necessary action to ensure timely invoicing of full treatment costs (including staff payroll costs) - i.e. no later than 2 months to other EU countries and private health insurers for the treatment of non-nationals/non-residents. (continuous). v. Enforcing the collection of co-payments and implementing mechanisms that fight corruption and eliminate informal payments in hospitals (continuous). 3. ELSTAT continues providing expenditure data in line with Eurostat, OECD and WHO databases i.e. in line with the System of Health Accounts (joint questionnaire collection exercise) (2012 figures to be released by April 2014). 4. The programme of hospital computerisation allows for a measurement of financial and activity data in hospital and health centres. Moreover, the Minister of Health defines a core set of non-expenditure data (e.g. activity indicators) in line with Eurostat, OECD and WHO health databases, which takes account of the future roll-out of DRG (diagnostic-related groups) schemes in hospitals (continuous). 5. The Government starts to develop a system of patient electronic medical records (continuous). 6. The Government, with technical assistance from experts across EU, continues to develop a full DRG costing and reimbursement system while improving the existing KEN system, with a view to developing a modern hospital costing and reimbursement system for contracting (on the basis of prospective block contracts between EOPYY and NHS). The existing set of KEN is used in all hospitals: i. A DRG Management Institute is established (June 2014). ii. The legal framework, coding manuals and cost adaptation methodology will be adopted by end 2014. DRGs cost

		weight methodology will include a detailed item on costs of personnel. iii. In 2015 the DRG system is implemented in a group of pilot hospitals. iv. In 2016 the DRG system is extended to all hospitals (test period). v. In 2017 the DRG system is applied to all hospitals in a budget neutral way (including personnel costs) and EOPYY contracts hospital care on the basis of prospective budgets based on DRGs (including personnel costs).7. A follow up analysis of how hospital accounting schemes integrate DRGs at hospital level in view of future activity-based cost reporting and prospective budgets payment for hospitals will be submitted on a regular basis (twice yearly, next report June 2014). Centralised procurement 1. The Government increases substantially the number of expenditure items and therefore the share of expenditure covered by centralised tender procedures through EPY up to 45% of all the expenditure in medicines and medical devices by 2014. This share goes up to 60% in 2015. The Government ensures the use of such tender procedures (continuous). 3. EPY will publish a detailed annual report on its activity (annual report, next report April 2014). 4. In compliance with EU procurement rules, the Government conducts the necessary tendering procedures to implement a comprehensive and uniform health care information system (e-health system) including the full and integrated system of hospitals' IT systems (continuous).

Stability support program

General stipulations	Stipulations around pharmaceutical spending	Stipulations around hospital expenditure
MoU between the European Commission acting on behalf of the ESM and the Hellenic Republic and the Bank of Greece[12]		
The authorities have committed to continue reforming the health care sector, controlling public	The authorities as prior action committed to reinstate previous key elements of reforms to the health system. In particular, they will a)	To improve financial management of hospitals, the authorities will by December 2015 (key deliverable)

[12] MoU between the European Commission acting on behalf of the ESM and the Hellenic Republic and the Bank of Greece, https://ec.europa.eu/info/sites/info/files/01_mou_20150811_en1.pdf

expenditure, managing prices of pharmaceuticals, improve hospital management, increase centralized procurement of hospital supplies, manage demand for pharmaceuticals and health care through evidence-based e-prescription protocols, commission private sector health care providers in a cost effective manner, modernize IT systems, developing a new electronic referral system for primary and secondary care that allows to formulate care pathways for patients. To assess the performance of health care providers, both public and private, EOPYY will continue to collect and publish relevant data on a monthly/quarterly basis. By June 2016, the authorities will develop an assessment of public sector capacity by region and by specialty and will use this to review the need for commissioning private providers per region; and they will develop a new electronic record for patients. By August 2016 they will develop a new system of electronic referrals to secondary care based on e-prescription and the electronic record and allowing the monitoring of waiting times. By June 2017, the authorities will develop a plan to pre-approve referrals to private sector providers based on the electronic patient record, the system of electronic referrals and the mapping of public sector capacity. Over the next three years, the authorities will develop therapeutic protocols for the patient care pathways (primary and secondary care) for the pathways that have the greatest therapeutic and cost implications, to be implemented through the e-prescription system. The authorities will closely monitor and fully implement universal coverage of health care and inform citizens of their rights in that regard and they will proceed with the roll out of the new Primary Health Care system and the issuing of an MD as envisaged in Law 4238 by December 2015. To this end, they will make use of the available Technical Assistance support.	amend Law 4332/2015 repealing part of Law 4052/2012 (reorganisation and restructuring of the health sector under the MoU) on the appointment of hospital CEOs; b) repeal MD FEK 1117/2015, in order to re-enforce sanctions and penalties as a follow-up to the assessment and reporting of misconduct and conflict of interest in prescription behaviour and non-compliance with the EOF prescription guidelines (re-establish prior MoU commitment); c) re-establish full INN prescription, including by repealing circular 26225/08.04.2015, with the exceptions as set out in art 6.4 to 6.6 of the MD FEK 3057/2012; d) reduce the price of all off-patent drugs to 50 percent and all generics to 32.5 percent of the patent price, by repealing the grandfathering clause for medicines already in the market in 2012; e) establish claw backs for 2015 for diagnostics and private clinics and delink the 2014 claw back for private clinics from the 2013 one. By September 2015 extend the 2015 claw back ceilings for diagnostics, private clinics and pharmaceuticals to the next three years, and, by October 2015, the authorities will (a) apply and collect outstanding claws backs until H1-2015 for pharmaceuticals, diagnostics and private clinics; (b) publish a price bulletin to reduce pharmaceutical prices and publish it every six months; and c) review and limit the prices of diagnostic tests to bring structural spending in line with claw back targets (key deliverables). They will execute the claw backs every six months. By October 2015, the authorities will decide whether to re-establish a means-tested 5 Euro fee for hospital visits or to adopt equivalent measures in fiscal and demand management terms; By December 2015, the authorities will take further structural measures (key deliverable) as needed to ensure that spending for 2016 is in line with the claw back ceilings, including developing new protocols for the most expensive pharmaceutical active substances and diagnostics procedures. Authorities will further reduce generic prices including by making greater use of price-volume agreements where necessary. Over the next three years, they will develop additional prescription guidelines giving priority to those with the greatest cost and therapeutic implications. Ambitious but feasible timelines will need to be set by the Authorities. By December 2015 (and by December 2016, respectively), the authorities will take concrete steps to increase the proportion of centralized procurement to 60 percent (and to 80 percent), the share of outpatient generic medicines by volume to 40 (and to 60 percent), inpatient generic medicines to 50 (and to 60 percent) and the share of procurement by hospitals of pharmaceutical products by active substance to 2/3 (and to ¾) of the total, in 16 line with agreed targets. Generic penetration should be supported by further actions to improve the incentive structure of pharmacists, including on profit structure, by	deliver a plan to adopt DRG or other international standard activity-based costing methodology in hospitals within the next three years; by December 2017 they will implement the new DRG or alternative activity-based costing system; by June 2016 they will deliver a plan to conduct annual independent financial audits of hospital accounts, with implementation to begin in 2017, and for all hospitals to be covered by 2018. To this end, they will make use of the available Technical Assistance support.

	August 2016. The authorities will introduce new drugs into the positive list on the basis of criteria set in MD 2912/B/30.10.2012 and related regulation, subject to prescription guidelines, and with prices set at the level of the lowest three in the EU or lower if the authorities can negotiate a rebate. By December 2017 the authorities will set-up an HTA centre that will inform the inclusion of medicines in the positive list.	
Supplemental Memorandum of Understanding, 16 June 2016[13]		
The authorities have committed to continue reforming the health care sector, controlling public expenditure, managing prices of pharmaceuticals, improve hospital management, increase centralized procurement of hospital supplies, manage demand for pharmaceuticals and health care through evidence-based e-prescription protocols, commission private sector health care providers in a cost effective manner, modernize IT systems, developing a new electronic referral system for primary and secondary care that allows to formulate care pathways for patients To assess and improve the performance of health care providers, both public and private, the authorities will: (a) EOPYY will carry out systematic monthly auditing of private clinics. A report on the outcome of the auditing will be released every six months (starting from December 2016); (b) by June 2016, develop an assessment of public sector capacity by region and by specialty and use this to commission private providers per region subject to insufficient public capacity (by December 2016); and they will develop a full electronic record for patients (progress towards this goal will be assessed every six months, in June and December, starting from June 2016); (c) by December 2016 finalise a new system of electronic referrals to secondary care, with priority for those to diagnostics and elective surgery (to be developed by September 2016), based on e-prescription and the electronic	To support rationalisation of expenditure, the authorities will: a. take concrete steps by December 2016 (and by December 2017, respectively), to increase: (i) the proportion of centralized procurement to 60 percent (and to 80 percent), (ii) the share of procurement by hospitals of pharmaceutical products by active substance to 2/3 (and to ¾) of the total, in line with agreed targets. This includes, as intermediate step, establishing a list of items that must be obtained through centralised procurement by June 2016 and setting the requirement for hospitals to obtain the items through the centralised procurement system by issuing a circular by September 2016. b. Monitor warranted and unwarranted access to emergency care and release a relevant report every six months. If needed introduce measures to control and discourage unwarranted access in order to guarantee effective provision of emergency care. c. take further structural measures by December 2016 as needed to ensure that the estimated gap between spending for 2017 and the claw back ceilings is reduced by at least 30 percent compared to the previous year. The achievement of the spending target will be assessed in June 2017 and December 2017. By December 2017 the authorities will take further structural measures as needed to ensure that the estimated gap between spending for 2018 and the claw back ceilings is reduced by at least an additional 30 percent compared to the previous year. The achievement of the spending target will be assessed in June 2018 and December 2018. d. complete the set-up of the negotiating committee to start developing price volume and risk agreements, such as MEAs, especially for innovative and high cost drugs by June 2016. 17 e. set-up a Health Technology Assessment centre to evaluate which products to reimburse and under what conditions and agreements, in line with existing guidelines and with evidence of best-practice in the EU by December 2017. Progress towards this long-term goal will be assessed every six months, June and December, starting from June 2016. ii. To support generics penetration, the authorities	To improve financial management of hospitals, the authorities will: (a) by June 2016, deliver a plan to conduct annual external financial audits of hospital accounts, with implementation to begin in 2017, and for all hospitals to be covered by 2018. Progress towards this long-term goal will be assessed every six months, in June and December, starting from June 2016; (b) by December 2016, deliver a plan to adopt DRG or other international standard activity-based costing methodology in all hospitals and every three months they will document progress towards the implementation; (c) by December 2017 they will start implementing the new DRG or alternative activity-based costing system for all hospitals to be covered by June 2018 (progress towards this long-term goal will be assessed every three months, starting from June 2016). To this end, they will make use of the available Technical Assistance support

[13] Supplemental Memorandum of Understanding, 16 June 2016, https://ec.europa.eu/info/sites/info/files/economy-finance/ecfin_smou_en1.pdf

record. Based on the electronic referrals system, they will develop a monitoring system of patients' waiting times by treatment, with the goal to reduce them over time; (d) by June 2017, develop a plan to pre-approve referrals to private sector providers based on the electronic patient record, the system of electronic referrals, the system of waiting times and the mapping of public sector capacity. Progress towards this longterm goal will be assessed every six months, in June and December, starting from June 2016. The authorities will closely monitor and fully implement universal coverage of health care and inform citizens of their rights in that regard and they will proceed with the roll out of the new Primary Health Care system as envisaged in Law 4238 by December 2016. To this end, they will make use of the available Technical Assistance support. The progress towards this goal will be assessed in June and December.	should adopt further measures to: a) improve the incentive structure of pharmacists, including on profit structure, by December 2016; (b) promote the use of generics through public campaigning (by June 2016 onwards); (c) revise the current prescription targets for doctors (by December 2016); (d) increase the share of inpatient generic medicines to 50 by December 2016 (and to 60 percent by June 2017); (e) increase the share of outpatient generic medicines by volume to 40 by March 2017 (and to 60 percent by March 2018) Through the programme period, the authorities will: a. further reduce prices of drugs including by making greater use of price-volume agreements through the negotiating committee where necessary; b. develop additional measures to contain excessive spending on diagnostics; 18 c. will develop additional prescription guidelines giving priority to those with the greatest cost and therapeutic implications; d. develop therapeutic protocols for the patient care pathways (primary and secondary care) for the pathways that have the greatest therapeutic and cost implications, to be implemented through the e-prescription system; The progress towards adopting the necessary measures to meet the long-term commitments in this paragraph will be assessed every six months (June and December), starting from June 2016. vi. As continuous/ongoing commitments, the authorities will: a. update on a regular basis and at least every six months the positive and the negative list on the basis of criteria set in MD 2912/B/30.10.2012 and related regulation, subject to prescription guidelines, and with prices set at the level of the lowest three in the EU or lower if the authorities can negotiate rebates or price-volume agreements; b. publish every six months a price bulletin to reduce pharmaceutical prices (May and November); c. execute the claw backs every six months and perform regular audits; d . apply and collect outstanding claws backs (continuously until they are cleared) for pharmaceuticals, diagnostics and private clinics; e. assess existing measures to bring structural spending in line with claw back targets in each area providing reports detailing their features and outcomes (design, relevant legislation involved, outcomes) (June and September); f. continue to collect relevant data from EOPYY and regularly publish it with a lag of three weeks after the end of the respective month, including through, (a) monthly reports with analysis and description of detailed data on healthcare expenditure in the areas of pharmaceuticals, diagnostics and private clinics (including information on the progress against the expenditure ceiling and clawback execution); (b) a monthly report on hospital financial data; (c) a quarterly report based on a set of activity related (input, process, output, outcome) indicators and financial data for hospitals; (d) an annual report on comparing hospital performance based on benchmarking indicators; (e) an annual report on human resources for the whole health care sector (to be used as a human	

	resource planning instrument) with a focus on PHC; g. document the progress on the development of new protocols and registries for the most expensive pharmaceutical active substances and diagnostics procedures (bimonthly); h. document the progress on prescription guidelines (bimonthly); i. undertake regular and documentable public campaigning to support generics; j. document progress towards setting-up of the HTA centre.	
Supplemental MoU (second addendum to the Memorandum of Understanding)[14]		
The authorities have committed to further reforming the health care sector, with the aim of universal, equal and effective care, controlling public expenditure, managing prices of pharmaceuticals, improving hospital management, increasing centralized procurement of hospital supplies, managing demand for pharmaceuticals and health care through evidence-based e-prescription protocols, commissioning private sector health care providers in a cost effective manner, modernizing IT systems, developing a new electronic referral system for primary and secondary care that allows to formulate care pathways for patients. develop an annual report on human resources for the whole health care sector (to be used as a human resource planning instrument) with a focus on PHC (first report to be published by Mayh 2017); g. closely monitor and fully implement universal coverage of health care and inform citizens of their rights in that regard and proceed with the gradual implementation of the new Primary Health Care System. To this end, the authorities will adopt all the necessary legislation to implement this new system by May 2017. Within this framework, EOPYY will change the way it provides primary health care by introducing compulsory patient registration with a family doctor, who will act as a gatekeeper in charge of referrals to specialists. This shall become fully operational (key deliverable) by 1st January 2018. In parallel, the	The authorities will: a. take structural measures focusing on improving efficiency as a means to contain expenditure. These measures will i) address and eliminate half (125 million) of the recent overspending on "other items" in the EOPYY budget for "Other Illness Benefits" by 2017 and the remaining half (125 million) by 2019; and ii) ensure that in 2017 the estimated gap between spending and the respective claw back ceilings, i.e. the amount clawed back, on pharmaceuticals, diagnostics and private clinics for 2017, is reduced by at least 30 percent compared to the previous year. To this end and as a prior action, they will adopt, amongst other structural measures to contain excessive spending in agreement with the institutions, a closed budget (clawback ceiling) to cover items previously not under clawback in the budget category "Other illness benefits (cash & kind)"; b. by December 2017, they will take further structural measures as needed to ensure that the estimated gap between spending for 2018 and the claw back ceilings is reduced by at least an additional 15 percent compared to the previous year; c. by September 2017, develop an assessment of overall public sector capacity and use this to commission private providers per region subject to insufficient public capacity (December 2017); document systematically the finalisation of the electronic record (e-record) for patients (June and December); d. implement a new system of electronic referrals (e-referrals) to secondary care to be used by family doctors to pre-approve referrals to private sector providers (initial plan June 2017, system implementation by November 2017, use of system to preapprove referrals December 2017); e. develop, by June 2017, prescription guidelines and therapeutic protocols for patient care pathways (primary and secondary care) for the pathways that have the greatest therapeutic and cost implications, to feed into the e-prescription system; 2.5.2.2. Execution of claw backs and regular audit a. They will execute the claw backs every six months and perform regular audits. b . They will	2.5.2.3. Measures to improve the financial management and cost effectiveness of hospitals The authorities will: a. take concrete steps to increase the proportion of centralised procurement by December 2017 (and further by December 2018)2 , including, as an intermediate step, by adopting the Law on centralised health procurement as a prior action; b. monitor warranted and unwarranted access to emergency care and, If needed, introduce measures to control and discourage unwarranted access in order to guarantee effective provision of emergency care; c. by June 2018, reduce waiting times (including for elective surgery) in line with other EU countries and reduce unwarranted variation in waiting times across providers and patients (including across socio-economic and other patient characteristics) 3 ; d. by June 2017 deliver a plan to adopt DRG (Diagnosis related Groups) or other international standard activity-based costing methodology in all hospitals and document progress towards the implementation; To this end, they will make use of the available Technical Assistance support; e. produce regular quarterly and yearly reports based on activity related indicators, financial data for hospitals and hospital performance (based on benchmarking indicators). 2.5.2.4. Reducing pharmaceuticals spending through generic penetration and price reduction a. As a prior action, they will publish an updated price bulletin to reduce pharmaceutical prices. They will update and publish on a regular basis, and at least every six

[14] Supplemental MoU (second addendum to the Memorandum of Understanding), https://ec.europa.eu/info/sites/info/files/smou_final_to_esm_2017_07_05.pdf

roll-out of Local Health Units will start by June 2017, as a first step of the planned creation of at least 240 Local Health Units in the coming 2 years (by June 2018). As new Local Health units become operational, the existing contractual arrangements of EOPYY with private GPs will be correspondingly reduced so as to avoid duplications in the local provision of primary care.; As a key deliverable, by June 2017, they will develop a plan in collaboration with the Ministry of Education, the medical faculties, the Central Health Board and the Medical Association to restructure academic curricula and specialty training in medicine in order to increase the availability and enhance the training of general practitioners. First elements of this plan will be implemented in the academic year 22 2017-2018.	continue to collect relevant data from EOPYY, the National Organisation for the Provision of Health Services, and regularly publish it. They will apply and collect outstanding claws backs, continuously until they are cleared. As a prior action, the authorities will make use of the final results from the auditing of private clinics of 2013 submissions, to proceed to the settlement of any amount under dispute. In addition, as a key deliverable EOPYY will offset outstanding clawback amounts for past periods (2013-2015) with accumulated arrears (50% by August 2017 and 50% by November 2017). c. They will continue to collect relevant data from EOPYY, the National Organisation for the Provision of Health Services, and regularly publish it. d. To assess and improve the performance of health care providers, EOPYY will carry out systematic monthly auditing of private clinics.	months, the positive and the negative list. 2 They will adopt further measures to improve generics penetration, amongst which through improving the incentive structure of pharmacists, including on profit structure, so as to encourage the sale of generic drugs (as a prior action). c. To further reduce prices, they will make use of the negotiating committee to develop price volume and risk agreements, such as MEAs (Managed Entry Agreements), especially for innovative and high cost drugs and regularly report on the progress. They will set-up a Health Technology Assessment (HTA) centre to evaluate which products to reimburse and under what conditions and agreements, in line with existing guidelines and with evidence of best-practice in the EU by July 2018. As an intermediate step and key deliverable, they will set up an HTA committee (July 2017).
Supplemental Memorandum of Understanding: Greece (Third Review of the ESM Programme)[15]		
The authorities have committed to further reforming the health care sector, with the aim of universal, equal and effective care, controlling public expenditure, managing prices of pharmaceuticals, improving hospital management, increasing centralized procurement of hospital supplies, managing demand for pharmaceuticals and health care through evidence-based e-prescription protocols, commissioning private sector health care providers in a cost effective manner, modernizing IT systems, developing a new electronic referral system for primary and secondary care that allows to formulate care pathways for patients. As the full implementation of these objectives requires time, the authorities are committed to implement necessary additional necessary measures also beyond the deadlines referred to this document. develop an annual report on human resources for the whole health care sector (to be used as a	2.5.2.1 Rationalisation of health expenditure The authorities will, in line with detailed targets and deadlines set out in the TMU (Section P), a. take structural measures focusing on improving efficiency as a means to contain expenditure. By May 2018 these measures will address the remaining part of the recent overspending on "other items" in the EOPYY budget for "Other Illness Benefits" which was not inlcuded under the clawback (125 million), which will be eliminated by gradual implementation of these measures and/or adoption of 16 additional ones as necessary; to this end EOPYY will contract optometrists as a prior action. By April 2018, EOPYY will directly purchase optometrist services and will contract providers of special education services (key deliverable); b. as a prior action, they will take further structural measures as needed to ensure that the estimated gap between spending for 2018 and the claw back ceilings for pharmaceuticals, diagnostics, private clinics and "other items" is reduced compared to the previous year; as a key deliverable they will, by April 2018, implement the 14 measures included in the EOPYY Action Plan to reduce the amount of excess spending; c. by January 2018, they will develop a mapping of overall public sector capacity; by March 2018, based on this mapping, the authorities will develop an in-depth assessment to be used in the	2.5.2.3. Measures to improve the financial management and cost effectiveness of hospitals The authorities will: a. take concrete steps to increase the proportion of centralised procurement by January 2018, following the adoption of the Law on centralised health procurement; for details see TMU (Section P); in May 2018 present the plan to increase the proportion further in 2019; the appointment procedures under the rules set by Law 4369/2016 must be started by March 2018 at the latest and completed by May 2018 at the latest (key deliverable). b. by May 2018, reduce waiting times (including for elective surgery) with respect to the previous year in line with the Social Pillar and reduce unwarranted variation in waiting times across providers and patients (including across socio-economic and other patient characteristics); for details see TMU (Section P); c. by March 2018, start the implementation of the DRGs system in pilot hospitals; d. produce regular quarterly and yearly reports, based on financial data for hospitals and hospital performance

[15] Supplemental Memorandum of Understanding: Greece (Third Review of the ESM Programme), https://ec.europa.eu/info/sites/info/files/economy-finance/third_smou_-_final.pdf

human resource planning instrument) with a focus on PHC (first report to be published by February 2018); g. closely monitor and fully implement universal coverage of health care and inform citizens of their rights in that regard and proceed with the gradual implementation of the new Primary Health Care System. To this end, the authorities h a v e adopted all the necessary legislation to implement this new system in May 2017. Within this framework, EOPYY will change the way it provides primary health care by introducing compulsory patient registration with a family doctor, who will act as a gatekeeper in charge of referrals to specialists. As a prior action EOPYY will launch the procedure for contracting family doctors. Compulsory patient registration shall be finalised and become fully operational by March 2018 (key deliverable), with gatekeeping to be gradually implemented over 2018. In parallel, the roll-out of Local Health Units will start by December 2017, as a first step of the planned creation of a critical mass of Local Health Units (at least 100) by May 2018, with full implementation to be achieved subsequently. As new Local Health units become operational, the existing contractual arrangements of EOPYY with private GPs will be correspondingly reduced so as to avoid duplications in the local provision of primary care; h. as a prior action, the authorities already have developed a plan in collaboration with the Ministry of Education, the medical faculties, the Central Health Board and the Medical Association to restructure academic curricula and specialty training in medicine in order to increase the availability and enhance the training of general practitioners. First elements of this plan will be implemented in the academic year 2017-2018.	future to commission private providers per region subject to insufficient public capacity; d. implement a new system of electronic referrals (e-referrals) to secondary care to be used by family doctors. (March 2018); e. develop, by January 2018, a critical mass of prescription guidelines and therapeutic protocols for patient care pathways (primary and secondary care) for the pathways that have the greatest therapeutic and cost implications, to feed into the e-prescription system; as a key deliverable, at least additional 20 of these therapeutic protocols will be introduced in the e-prescription system between December 2017 and May 2018.	(benchmarking based on activity related indicators). 2.5.2.4. Reducing pharmaceuticals spending through generic penetration and price reduction a. The authorities will update and publish on a regular basis (for details see TMU Section P), and at least every six months, the positive and the negative list. b. As a prior action, the authorities will publish a revised price bulletin in November 2017. As a key deliverable, they will publish a revised price bulletin in May 2018. 1 Details on specific targets by deadline contained in the TMU (Section M ¶57-59). 18 c. By February 2018, as a key deliverable, the authorities will adopt further measures to improve cost-effectiveness of pharmaceutical spending with a view to reaching the 40% generics penetration target. These measures may target many relevant areas, such as updating the set-up of reimbursed prices and of patients' participation to ensure they promote the choice of cost-effective drugs and by further improving the incentive structure of pharmacists to encourage the sale of less costly drugs for any given active substance prescribed. d. To further reduce prices, they will make use of the negotiating committee to develop price volume and risk agreements, such as MEAs (Managed Entry Agreements), in line with other EU countries standards and international expertise, especially for innovative and high cost drugs and regularly report on the progress. The authorities will set-up a Health Technology Assessment (HTA) centre to evaluate which products to reimburse and under what conditions and agreements, in line with existing guidelines and with evidence of best-practice in the EU, to become active once fully operational after June 2018. As an intermediate step and prior action, they have already set up an HTA committee.
Supplemental Memorandum of Understanding, Fourth Review of the ESM Programme, (DRAFT – 20 June 2018)[16]		

[16] Supplemental Memorandum of Understanding, Fourth Review of the ESM Programme, (DRAFT – 20 June 2018), https://ec.europa.eu/info/sites/info/files/economy-finance/draft_smou_4th_review_to_eg_2018.06.20.pdf

The authorities have committed to further reforming the health care sector, with the aim of universal, equal and effective care, controlling public expenditure, managing prices of pharmaceuticals, improving hospital management, increasing centralized procurement of hospital supplies, managing demand for pharmaceuticals and health care through evidence-based e-prescription protocols, commissioning private sector health care providers in a cost effective manner, modernizing IT systems, developing a new electronic referral system for primary and secondary care that allows to formulate care pathways for patients. As the full implementation of these objectives requires time, the authorities are committed to implement necessary additional necessary measures also beyond the deadlines referred to this document. Develop an annual report on human resources for the whole health care sector (to be used as a human resource planning instrument) with a focus on PHC (first report to be published by May 2018); g. closely monitor and fully implement universal coverage of health care and inform citizens of their rights in that regard and proceed with the gradual implementation of the new Primary Health Care System. To this end, the authorities h a v e adopted all the necessary legislation to implement this new system in May 2017. Within this framework, EOPYY will change the way it provides primary health care by introducing compulsory patient registration with a family doctor, who will act as a gatekeeper in charge of referrals to specialists. As a prior action: a) the complete matching of all Social Security Number (AMKA) holders with the avaliabe family doctors will be finalised by May 2018 and b) the compulsory patient registration system with a family doctor, who will act as a gatekeeper, will be in place and fully operational by end of May 2018, with gatekeeping to be gradually implemented over 2018.In parallel, the roll-out of Local Health Units, started in December 2017, will lead to creation of a critical mass of Local Health Units (at least 85) by May 2018, with full implementation to be achieved subsequently. As new Local Health units become operational, the existing contractual arrangements	2.5.2.1 Rationalisation of health expenditure The authorities will, in line with detailed targets and deadlines set out in the TMU (Section P), a. in order to address the remaining part of the recent overspending on "other items" in the EOPYY budget for "Other Illness Benefits" (125 million in 2017) EOPYY will extend the clawback to include optometrist services and special education services (prior action); b. as a prior action, the authorities will implement the 14 measures included in the EOPYY Action Plan to reduce the amount of excess spending; c. by May 2018, they will develop a mapping of overall public sector capacity; by December 2018, based on this mapping, the authorities will develop an in-depth assessment to be used in the future to commission private providers per region subject to insufficient public capacity; d. implement a new system of electronic referrals (e-referrals) to secondary care to be used by family doctors. (May 2018); e. develop, by May 2018, a critical mass of prescription guidelines and therapeutic protocols for patient care pathways (primary and secondary care) for the pathways that have the greatest therapeutic and cost implications, to feed into the e-prescription system; as a prior action, at least additional (compared to December 2017) 20 of these therapeutic protocols will be introduced in the eprescription. 2.5.2.2. Execution of clawbacks and regular audit1 a. The authorities will execute the clawbacks every six months and perform regular audits. b . The authorities will continue to collect relevant data from EOPYY, the National Organisation for the Provision of Health Services, and regularly publish it. c. The authorities will apply and collect outstanding claws backs, continuously until they are cleared. As a prior action, (i) EOPYY will finalise the legal procedure for the offsetting of the residual outstanding clawback (2013-2015) for all outstanding amounts except those for which it is not legally/technically possible to perform the offset; (ii) any outstanding u n c o l l e c t e d clawback amount related to 2016 will be offset and collected for health care providers and (iii) the authorities will extend the clawback ceilings for diagnostics, private clinics, pharmaceuticals up to 2022. The ceiling will rise in line with the authorities' forecast of the annual growth of GDP at constant prices; (iv) the clawbacks of 2017 (and for 2016, for pharmaceutical companies) will be collected/offset according to the timetable specified in the TMU (Section P). d. To assess and improve the performance of health care providers, EOPYY will carry out systematic monthly auditing of private clinics. 2.5.2.4. Reducing pharmaceuticals spending through generic penetration and price reduction a. The authorities will update and publish on a regular basis (for details see TMU Section P), and at least every six months, the positive and the negative list. b. As a prior action,	2.5.2.3. Measures to improve the financial management and cost effectiveness of hospitals The authorities will: a. take concrete steps to increase the proportion of centralised procurement by May 2018, following the adoption of the Law on centralised health procurement; for details see TMU (Section P); in May 2018 present the plan to increase the proportion further in 2019.The appointment procedures under the rules set by Law 4369/2016 will be started as a prior action (see TMU section P). b. by December 2018, reduce waiting times (including for elective surgery) with respect to the previous year in line with the Social Pillar and reduce unwarranted variation in waiting times across providers and patients (including across socio-economic and other patient characteristics); for details see TMU (Section P); c. by May 2018, start the implementation of the DRGs system in pilot hospitals; d. produce regular quarterly and yearly reports, based on financial data for hospitals and hospital performance (benchmarking based on activity related indicators).

of EOPYY with private GPs will be correspondingly reduced so as to avoid duplications in the local provision of primary care;	the authorities will publish a revised price bulletin in May 2018. c. As a prior action, the authorities will adopt further measures to improve costeffectiveness of pharmaceutical spending with a view to reaching the 40% generics penetration target. These measures may target many relevant areas, such as updating the set-up of reimbursed prices and of patients' participation to ensure they promote the choice of cost-effective drugs and by further improving the incentive structure of pharmacists to encourage the sale of less costly drugs for any given active substance prescribed. d. To further reduce prices, they will make use of the negotiating committee to develop price volume and risk agreements, such as MEAs (Managed Entry Agreements), in line with other EU countries standards and international expertise, especially for innovative and high cost drugs and regularly report on the progress. The authorities will set-up a Health Technology Assessment (HTA) centre to evaluate which products to reimburse and under what conditions and agreements, in line with existing guidelines and with evidence of best-practice in the EU, to become active once fully operational after June 2018.	