

Joint Action on Chronic Diseases and Promoting Healthy Ageing Across the Life Cycle

Good Practice in the Field of Health Promotion and Primary Prevention

Greece Country Review

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Table of Contents

| | |
|---|----|
| Background | 2 |
| The Health Promotion and Chronic Disease Prevention Landscape | 3 |
| Policy design and implementation | 3 |
| Main public bodies and other organisations | 7 |
| Strategies and programmes..... | 8 |
| Financing | 9 |
| Identifying Good Practice and Existing Databases | 9 |
| Cost –Effectiveness Studies | 10 |
| Gaps and Needs | 12 |



This Country Review has been developed based on the questionnaire ‘Good practice in the field of Health Promotion and Primary Prevention’ developed by EuroHealthNet, as part of Work Package 5, Task 1 of JA-CHRODIS.

Background

JA-CHRODIS is a European collaborative initiative that brings together over 60 partners from 26 European Union Member States. The collaborative partners are from areas including the national and regional departments of health and research institutions. They work together to identify, validate, exchange and disseminate good practice approaches for chronic diseases across EU Member States, and facilitate the uptake of these approaches across local, regional and national borders. The focus of JA-CHRODIS is on health promotion and primary prevention, with an additional focus on the management of diabetes and multi-morbid chronic conditions. One of the key deliverables will be a 'Platform for Knowledge Exchange', which will include both an online help-desk for policy makers and an information portal which provides an up-to-date repository of best practices and the best knowledge on chronic care.

Work Package (WP) 5 focuses on these objectives in relation to the package's theme: *Good Practice in the Field of Health Promotion and Primary Prevention*. Furthermore, **the objectives of WP 5 are to promote the exchange, scaling up, and transfer of highly promising, cost-effective and innovative health promotion and primary prevention practices for older populations**. This will involve the identification, review, and validation of health promotion and primary prevention interventions for **cardiovascular diseases, stroke, and type 2 diabetes and their modifiable behavioural and social risk factors**. WP 5 will not only take into account lifestyles and health-related behaviours, but also the wider social and economic determinants that influence them.

The following **Country Review** provides an **overview of the health promotion and primary prevention situation and approaches for cardiovascular disease, stroke and type 2 diabetes in Greece**. This review outlines relevant policies; implementation mechanisms; good practices, and whether and how they have been identified; and forecasting and cost-effectiveness studies that have been undertaken on the topic in Greece. The authors of this report have also identified current gaps and needs of promotion and primary prevention of chronic diseases. The information in this report will contribute to subsequent WP tasks, namely the identification, exchange and transfer of promising practices to promote health and prevent strokes, cardiovascular disease and type 2 diabetes in Greece.

The Health Promotion and Chronic Disease Prevention Landscape

Policy design and implementation

The Greek Law 3370 of 2005 states that public health encompasses all evidence-based action for preventing disease, protecting and promoting health, lengthening life expectancy and improving quality of life. It also clarifies that disease prevention and health promotion are the main functions of public health, while action to support vulnerable groups and to reduce socioeconomic inequalities in health is also an important part of public health.

In Greece, overall health policy issues **are decided centrally** by the **Hellenic Ministry of Health**, which is the main policy-making authority. More precisely, the ministry decides on health policy issues and national health strategies, sets priorities, determines the funding for activities, allocates resources, proposes legislative changes and undertakes the implementation of laws and/or reforms.

The Greek legislation describes the competences of several directorates and departments of the Ministry of Health which are engaged in the development and implementation of public health policies, including health promotion and prevention policies. Briefly, those mainly involved in health promotion and prevention issues are as follows:

- The General Secretary for Public Health at the Ministry of Health is responsible for framing, implementing and overseeing public health policies, including health promotion and primary prevention policies, as well as the workings of the public health services.
- The General Directorate for Public Health and Quality of Life is responsible for implementing public health measures, inspecting public health services and overseeing implementation of EU and WHO policies for protection of public health. In turn, three out of the six directorates of the General Directorate for Public Health and Quality of Life are mainly involved in health promotion and primary prevention issues. Those are: a) the Directorate for Public Hygiene, b) the Directorate for Nutrition, and c) the Directorate for Dependence (including smoking and alcohol).

In the Directorate for Public Hygiene, the Public Health Protection and Promotion Department has responsibilities such as:

- *Study of the distribution and impact of various chronic diseases among the population, as well as the factors affecting them.*
- *Planning, monitoring and evaluation of programmes to prevent and combat chronic diseases.*
- *Setting rules and measures for the good health of mothers, infants and pre-school children.*
- *Submission of proposals for implementation of health education programmes.*
- *Involvement in framing of WHO and EC Directives, monitoring of their implementation and necessary adaptation of Greek legislation.*
- *Cooperation with and involvement in programmes and activities with international organisations.*

In the Directorate for Nutrition, the Department for Nutrition Policy has responsibilities such as:

- *Development of regular reports with data about nutrition and nutrition-related diseases (e.g. prevalence data on obesity and diabetes).*
- *Development of national nutrition policy, as well as dietary guidelines and patterns for the population in Greece.*

Further, the Department for Actions on Nutrition Issues has responsibilities such as:

- *Determining standards for food provided in school canteens, in collaboration with other organisations.*
- *Planning, implementing and overseeing prevention programmes concerning nutrition.*

In the Directorate for Dependence, the Department for Tackling Smoking and Alcoholism has responsibilities such as:

- *Proposing measures and regulations for tackling smoking and alcoholism.*
- *Surveillance of the units for the treatment of alcohol dependence and of the smoking cessation centres.*
- *Coordination of research programmes on alcohol and tobacco control.*
- *Development of a national plan for the prevention of alcohol and tobacco dependence.*
- *Development of a network for informing citizens and students on smoking and alcohol issues.*

The Directorate for Oral Health is responsible for planning and implementing dental health and hygiene policies.

Other Main Bodies:

Apart from the Ministry of Health, other bodies are also involved in the governance and regulation of public health. The Central Health Council (KESY) has an advisory role to the Ministry on various health-related issues. **The National Council of Public Health (ESYDY)** is an independent authority with scientific, coordinating and opinion-issuing duties in the field of public health. It consists of experts in epidemiology, health promotion and public health, and is responsible for the scientific supervision and coordination of public health organisations for the monitoring and promotion of the health of the population. According to the Greek legislation, it is also responsible for the elaboration of a National Action Plan for Public Health.

The National Organization for Healthcare Provision (EOPYY) provides primary health care services. EOPYY is a public corporate body, established under Law 3918/2011, and its primary mission is the provision of health services to insured active members and pensioners, as well as their family dependents. The recent Law 4238/2014 introduced the formation of the National Primary Healthcare Network (PEDY), which is described as a decentralized network that provides primary health care services, including:

- *health needs assessment, design and implementation of prevention measures and programmes, and universal implementation of screening programmes for selected diseases and health promotion*
- *regular monitoring and managing patients with chronic diseases*
- *family planning and maternal- child services*

Seven Health Region Authorities (YPE) are responsible for implementing national priorities at the regional level, coordinating regional activities and organising and managing the delivery of health

and welfare services within their catchment area. They also provide suggestions and measures to the Ministry of Health, while they are responsible for monitoring the implementation of the ministry policies. The Central Council of Health Regions coordinates the policies of the Health Region Administrations, as well as their cooperation with the ministry. The YPE are dependent on the Central Government as they are not autonomously financed.

At the prefectural level, public health directorates of the Prefectural Authorities include health prevention and promotion departments, with competences such as the implementation of immunization and preventive medicine programmes, the implementation of programmes to protect mothers and children, the implementation of programmes for chronic ailments and illnesses not easily susceptible to treatment, as well as health education activities. Overall, according to the relevant legislation, the Prefectural Public Health Services may implement public health programmes organised by the Ministry of Health or other ministries. They may also implement public health programmes funded with European Union resources and organise, alone or in association with the appropriate regional departments, special programmes for the protection and promotion of public health in the area of their competence, targeting special population groups. So far however, regional public health councils have not been implemented.

At the local level, municipalities are responsible for running several public health programmes:

- for the provision of primary health care services and health prevention and promotion programmes, through the municipal health clinics
- for the protection of the elderly, such as the open care centres for the elderly (KAPIs) and the programme “Home Assistance”
- for the protection and support of families, through public infant and child care centres
- for the protection of vulnerable population groups

Several voluntary organisations and nongovernmental organisations implement primary and preventive health and welfare services programmes for specific population groups such as for refugees and socially disadvantaged populations. The Ministry of Health keeps a registry of NGOs which are active in the field of health. The registration is a prerequisite for receiving possible financing from the ministry or for participating in the implementation of programmes that are financed by national or EU resources.

The issue of occupational safety and health is under the responsibility of the Ministry of Labour, Social Security and Welfare. The General Directorate of Working Conditions and Health and the Labour Inspectorate are the principal competent state authorities. The General Directorate of Working Conditions and Health is responsible for legislation, strategy, organisation, information, education, training and research and the Labour Inspectorate is the inspection and enforcement authority for the implementation of the labour legislation.

It should be stressed that the above description depicts only a theoretical picture of reality.

So far Greece, although stated in governmental strategy documents, has not yet implemented any successful strategy for public health. Major barriers are:

- the lack of disease prevention and health promotion vision since the initiation of the National Health Care system in the early 1980s. The focus has always been on curative services. Even today, health is seen in terms of access to curative health services.
- the fragmented and uncoordinated public administration which impedes national-level policy decisions to reach and be implemented at the local level by the public services.
- the weak, fragmented and uncoordinated primary care system that stresses the already overloaded secondary and tertiary health care services, significantly raising the health care expenditure due to the lack of prevention measures. It appears that the main focus of prevention is on uncoordinated health education activities with no evaluation processes.
- the lack of knowledge/training in relevant governmental bodies on the concept of determinants of health and the underlying causes of mortality and morbidity.
- the significant cuts due to the economic crisis (although it should be stressed that the Greek economy accumulated severe structural troubles before the crisis). The majority of efforts focus on retaining the function of tertiary health care, especially for the increasing number of uninsured population groups due to unemployment.

Indicative of the situation is the preparatory work for the **first National Strategy Action Plan for Public health (2008-2013)** which outlined a list of important challenges, including: shifting the focus from hospital care; the risks for communicable diseases, particularly in view of the country's geographical position; the serious lack of essential statistical data; the lack of health professionals trained in health promotion; the present restricted action for public health at the level of the municipalities and the total lack of coordinated programmes for health promotion at that level; the lack of collaboration between the public health services of the municipalities and the health centres; the lack of financial resources for health promotion and of evaluation of such services provided by other organisations; the failure to provide health promotion services in schools; the lack of a strategy for dental care; the need for interdisciplinary collaboration; the staffing of the regional level public health departments, many of which have no or only administrative staff; and finally, the need to set the necessary standards for epidemiological research and its evaluation, and to set priorities in this field. The above Action was never really implemented. One reason was the shift of attention from prevention towards other financial challenges due to the recession.

In an effort to create the conditions for the most cost-effective health system and an international interest in the health care challenges of the system due to the economic crisis, **a second and very recent Health in Action Initiative (2012)** took place, from the Ministry of Health, for the planning and monitoring of the implementation of structural reforms in the health sector in Greece, with the aim of improving citizens' health as well as the efficiency of the National Health System. This latest reform initiative will produce a Policy Paper on the long term vision of the Ministry of Health including the rationale and expected results of the reform process for 2013-2020 in line with the WHO European Health Policy: Health 2020. Since the latest Action Plan is still in the early stages of development, it is not possible to comment on its effectiveness but it is quite possible that it will face great difficulties unless the above-mentioned barriers will be targeted and resolved.

Main public bodies and other organisations

- The **Hellenic Ministry of Health** is the main policy-making authority. It decides on health policy issues and national health strategies, sets priorities, determines the funding for activities, and allocates resources, while it proposes legislative changes and undertakes the implementation of laws and/or reforms.
- The seven **Health Region Administrations** (YPEs) are responsible for implementing national priorities at the regional level, coordinating regional activities and organising and managing the delivery of health and welfare services.
- The **National Council for Public Health** is an independent body consisting of experts in epidemiology, health promotion and public health, and is responsible for the scientific supervision and coordination of public health organisations for the monitoring and promotion of the health of the population.
- The **National Organization for Health Care Services Provision** (EOPYY) is a public corporate body which provides health services to insured active members and pensioners, as well as their family dependents.
- At the prefectural level, **public health directorates of the Prefectural Authorities** include health prevention and promotion departments, with competences such as the implementation of immunization and preventive medicine programmes, the implementation of programmes to protect mothers and children, the implementation of programmes for chronic ailments and illnesses not easily susceptible to treatment, as well as health education activities.
- **Health centres** provide services which include prevention (mainly immunization) and health promotion.
- **Municipalities** are responsible for running several public health programmes and for the provision of primary health care services and health prevention and promotion programmes (e.g. services in the **municipal health clinics**, the open care centres (KAPIs) and the programme “Home Assistance” for the elderly).
- The **Centre for the Control and Prevention of Diseases** (KEELPNO) is responsible for the control of communicable diseases and HIV/AIDS.
- The **Organization Against Drugs** (OKANA) is responsible for the planning and implementation of policies for preventing and combating drug addiction.
- The **Institute of Child Health** (IYP) is responsible for research, educational and preventive activities relating to children.
- The **National Centre for Diabetes Mellitus** (EKEDI) is responsible for the monitoring and coordination of research, prevention and treatment of diabetes mellitus.
- The **Hellenic Food Authority** (EFET) is the main body responsible for inspection of foodstuffs in Greece.
- The purpose of the **National School of Public Health (ESDY)** is to offer postgraduate and further education to graduates of universities and technical colleges, to carry out scientific research and to provide services related to public health, health promotion, health service administration and social policy.

Other organisations

- The Greek Association of General Practitioners (<http://www.elegeia.gr/>)
- The Hellenic Association of Health Visitors (<http://www.psey.gr/>)
- The National Association of Registered Nurses (<http://enne.gr/>)
- Panhellenic Medical Association (<http://www.pis.gr/index.php>)
- The Intermunicipal Network of Health and Social Solidarity of Local Authority (<http://www.eddyppy.gr/Default.aspx?tabid=37&language=en-US>)
- National Network for Workplace Health Promotion (<http://www.neaygeia.gr/>)
- National Network of Health Promoting Hospitals (HPH) (<http://www.neaygeia.gr/>)
- Hellenic Cardiology Foundation (<http://www.elikar.gr/>)
- Hellenic Thoracic Society (<http://www.hts.org.gr/>)
- NGO Praxis (<http://www.praxis.gr>)
- NGO Klimaka (<http://www.klimaka.org.gr/js/>)
- Medecins du Monde (Greek organisation) (<http://www.mdmgreece.gr/>)
- The Centre for Health Services Research (CHSR) (http://healthpromotion.med.uoa.gr/center_for_health_services_research/info.htm)
- The Institute of Preventive Medicine, Environmental and Occupational Health "Prolepsis" (<http://www.prolepsis.gr/new/>)
- The Biomedical Research Foundation of the Academy of Athens (BRFAA) (<http://www.bioacademy.gr/about>)
- Institute of Social and Preventive Medicine <http://www.neaygeia.gr/>

Strategies and programmes

As already mentioned, the first concrete effort on the level of National Strategy was the National Action Plan for Public Health for the period 2008-2013. The emphasis was on 11 major health hazards including cancer, HIV/AIDS, rare diseases, drugs, dietary disorders, smoking, environmental hazards, depression, sexually transmitted diseases, alcohol and dental health. During the above time period only some of these health issues have been targeted and only at a project level within the Structural Funds framework. However, no official data are available regarding the implementation of the aforementioned action plans. Again, no evaluation framework existed in terms of impact at a population level. Within the efforts made, we can stress the actions below:

- Smoke-free legislation for most public places was enforced in September 1, 2010 (Law 3868/2010). The law covers restaurants, bars, cafés, workplaces and public transportation.
- According to the Law 3730/2008 on the protection of minors from tobacco and alcohol use, the consumption of alcoholic beverages in public entertainment places (clubs, bars, restaurants, cafés, pubs, cinemas, etc.) is prohibited for minors.
- Health regulation exists regarding the hygiene conditions and definition of food products provided by kiosks in public and private schools (No. DY/GP/oik 81025).
- The Law 3850/ 2010 ratifies the Code of Laws related to Occupational Safety and Health.

- Currently, a National Action Plan for diabetes has been developed since 2012 by the Hellenic Diabetes Association, the National Centre on Diabetes and the Ministry of Health. A new National Action Plan on Cancer for the period 2011-2015 has also been published.
- The Ministry of Health produced a series of health promotion and health education leaflets and relevant radio/television advertisements, particularly concerning tobacco and alcohol consumption, accidents and hypertension.

On September 17, 2012, a second Health in Action Initiative was established by the Ministry of Health for the planning and monitoring of the implementation of structural reforms in the health sector in Greece with the aim of improving citizens' health as well as the efficiency of the National Health System. This latest reform initiative will produce a **Policy Paper** on the long term vision of the Ministry of Health including the rationale and expected results of the reform process for 2013-2020 in line with the WHO European Health Policy: Health 2020 (<http://www.healthinaction.gr/highlevelconference/about/>).

Financing

So far, without clearly defined policies for tackling major health issues such as NCDs, it is not possible to assess financial resources designated for that purpose. On a whole, we conclude that funding for NCD prevention seems to be on a project basis.

A main problem regarding the financing of public health policies and services is the lack of a dedicated and specific budget for them. The vast majority of the available general fund for health care services, including public health actions, is allocated to tertiary care curative services. Theoretically, public funds, general taxation and health insurance funds could finance the implementation of the existing weak health promotion policy, but this is not the case. Once again the most important barrier is the lack of a health promotion vision and the lack of investment in long term plans in order to improve population health outcomes.

EU Structural Funds are also available and utilized, however their implementation is uncoordinated, leading to overlaps in a less cost effective way. Additionally the targets of the various health prevention programmes are strictly depended on the available funding within the EU framework and not in accordance of the real population needs.

Identifying Good Practice and Existing Databases

There is no national mechanism or criteria to identify good practice and no good practice databases. The Centre for Health Services Research at the University of Athens uses and advocates for the European Quality Instrument for Health Promotion (EQUIHP); however, it has not yet been adopted at a central level for the evaluation processes of the funded projects.

Cost –Effectiveness Studies

Obes Rev. 2014 Aug; 15 Suppl 3: 5-13. doi: 10.1111/obr.12175. **Designing and implementing a kindergarten-based, family-involved intervention to prevent obesity in early childhood: the ToyBox-study.** Manios Y, Androustos O, Katsarou C, Iotova V, Socha P, Geyer C, Moreno L, Koletzko B, De Bourdeaudhuij I; ToyBox-study group.

The development of the ToyBox-intervention was based on the outcomes of the preliminary phase of the ToyBox-study, aiming to identify young children's key behaviours and their determinants related to early childhood obesity. The ToyBox-intervention is a multi-component, kindergarten-based, family-involved intervention with a cluster-randomized design, focusing on the promotion of water consumption, healthy snacking, physical activity and the reduction/ breaking up of sedentary time in preschool children and their families. The intervention was implemented during the academic year 2012-2013 in six European countries: Belgium, Bulgaria, Germany, Greece, Poland and Spain. Standardized protocols, methods, tools and material were used in all countries for the implementation of the intervention, as well as for the process, impact, outcome evaluation and the assessment of its cost-effectiveness. A total sample of 7,056 preschool children and their parents/caregivers, stratified by socioeconomic level, provided data during baseline measurements and participated in the intervention. The results of the ToyBox-study are expected to provide a better insight on behaviours associated with early childhood obesity and their determinants and identify effective strategies for its prevention. The aim of the current paper is to describe the design of the ToyBox-intervention and present the characteristics of the study sample as assessed at baseline, prior to the implementation of the intervention.

Hellenic J Cardiol. 2014 May-Jun; 55(3): 197-203. **A short-term cost-effectiveness analysis of hypertension treatment in Greece.** Athanasakis K, Souliotis K, Tountas Y, Yfantopoulos J, Kyriopoulos J, Hatzakis A.

INTRODUCTION. Hypertension represents one of the major contributors to the disease burden and to healthcare expenditure internationally. The objective of this paper was to conduct a short term cost-effectiveness analysis of hypertension treatment vs. a hypothetical "no-treatment" strategy in Greece.

METHODS. Health-resource use data and clinical outcomes for a cohort of 1453 hypertensive patients in Greece who were prospectively followed for a 1-year period served as the primary data for the analysis. Based on these data, the incremental cost per mmHg lowering in the baseline blood pressure (BP) and the incremental cost per patient that achieved BP control after 1 year of treatment were estimated. Costs were calculated from a social security perspective and are reported in year 2011 values.

RESULTS. The average cost per mmHg lowering of baseline BP for the whole study sample was 13.7 ± 14.2 , ranging from 20.3 ± 21.4 for Grade 1 hypertension patients to 9.9 ± 4.4 for Grade 3. The average cost per patient that achieved control after 1 year of treatment was 603.1 ± 215 , with a range from 496.1 ± 186.6 to 868 ± 258.2 for Grades 1 and 3 baseline BP, respectively. The sensitivity analysis corroborated the results.

CONCLUSIONS. The present study outcomes compare favorably to corresponding results from the international literature and indicate the clinico-economic value of hypertension treatment in Greece, especially to those that are severely ill. In light of the current financial situation, resource allocation based on evidence from economic evaluation can constitute a core input in the decision-making process for health policy.

J Hypertens. 2012 Jan; 30(1): 227-34. doi: 10.1097/HJH.0b013e32834d9f18. **A cost-utility analysis of hypertension treatment in Greece: assessing the impact of age, sex and smoking status, on outcomes.** Athanasakis K, Souliotis K, Tountas Y, Kyriopoulos J, Hatzakis A.

OBJECTIVES. To assess the cost-utility of hypertension treatment versus a hypothetical 'no-treatment' strategy in Greece.

METHODS. A six-state Markov model simulated the occurrence of major cardiovascular events for hypertensive patients over a 20-year period. Baseline population consisted of a cohort of 1453 patients (46.92% men) that were followed up for a 1-year period, during which health-resource use and clinical characteristics of hypertension were documented. Age, sex and smoking status - specific transition probabilities in the model - were estimated via the HellenicSCORE and Framingham risk equations. The analysis followed a third-party payer perspective.

RESULTS. Incremental cost-effectiveness ratios (ICERs) of treatment versus no treatment were 3539€/quality-adjusted life year (QALY), 3986€/QALY, 3957€/QALY and 5485€/QALY gained for men smokers, men nonsmokers, women smokers and women nonsmokers, respectively. ICERs became more favorable with an increase in the years of treatment and advanced age of treatment initiation across all study groups. The probabilistic sensitivity analysis showed that the base-case scenario results were cost-effective for an implicit 30000€/QALY threshold at 97.4, 95.2, 94.8, and 86% of the 10000 Monte Carlo simulations for men smokers, men nonsmokers, women smokers and women nonsmokers, respectively.

CONCLUSION. In the case of hypertension, one of the most prevalent and modifiable diseases/risk factors, that is accompanied by large-scale costs, the above analysis demonstrates that treatment is a highly cost-effective intervention that should be further supported at the patient and the system level.

J Med Food. 2007 Jun; 10(2): 239-43. **Estimating the 10-year risk of cardiovascular disease and its economic consequences, by the level of adherence to the Mediterranean diet: the ATTICA study.** Panagiotakos D, Sitara M, Pitsavos C, Stefanadis C.

In this study this traditional diet was assessed in relation to coronary heart disease risk and its economic consequences, in a cross-sectional study with economic analysis. From May 2001 to December 2002 we randomly enrolled 1,514 adult men and 1,528 women, without any clinical evidence of cardiovascular disease. Adherence to the Mediterranean diet was ascertained through a food-frequency questionnaire and a special diet score that incorporated the inherent characteristics of this dietary pattern. The 10-year absolute risk for coronary heart disease was derived from the

Framingham equations. Persons with a 10-year risk greater than 10% were considered as potential hospitalized patients. The health care cost of hospitalization due to an event was estimated in 690 euro per patient. Of the participants who were "closer" to the Mediterranean diet (i.e., above the median diet score) and of those "away" from this dietary pattern, 4.2% and 39.8%, respectively, had a 10-year coronary risk greater than 10% ($P < .001$). Moreover, participants "closer" to the Mediterranean diet had a 43% (odds ratio = 0.57, 95% confidence interval 0.38 to 0.86) lower likelihood of having a 10-year coronary risk greater than 10%, after adjusting for potential confounders. Total health care cost was estimated to be 336.720 euro in those who were "away" and 35.880 euro in those who were closer to this diet pattern. Life-years lost due to disability was 6.8 in those who were "away" and 0.9 in those "close" to this pattern. The incremental cost-effectiveness ratio was 50.989 euro (i.e., the additive health care cost due to an unhealthy diet for each year lost). The implementation of the Mediterranean dietary pattern may lead to an improvement in life expectancy, a net gain to health, and a reduction in total lifetime costs.

Gaps and Needs

The few identifiable leaders are academic researchers and NGOs. The focus in both depends largely on the personal interests of the individual experts, frequently influenced by their participation in international studies and the availability of international funding in order to implement advocacy activities.

There are no clear policy frameworks relating to health promotion and primary prevention of chronic disease in general, or for cardiovascular disease, stroke and type 2 diabetes in particular.

Equality in health is mentioned in a number of recent documents, usually in terms of access to care. However, it is described in the narrow sense of geographical distribution of services and financial obstacles, with little mention of other factors affecting access to services or health in general. As health challenges have yet to be openly discussed outside academic circles, solutions remain focused mainly on the provision of health care or are linked to the potential for EU funding.

There is no tradition in Greece of preparing public health reports. The universities and large NGOs make fragmented attempts to analyse aspects of the situation, focusing on issues of interest to them, but there is no official published report giving a comprehensive picture of the health challenges and their determinants and the ways in which these might be tackled. By default, the focus remains on the organisation and reorganisation of health care, with passing interest in other issues when these are raised by interested researchers or NGOs.

Guidelines for the implementation of the most effective methods of health promotion and primary prevention for cardiovascular diseases, stroke and diabetes and their modifiable behavioural and social risk factors are not issues at the ministerial level.

The postgraduate course on Health Promotion and Education at the Medical School of Athens, as well as other university departments, train professionals on the best available evidence for preventive interventions. However, the everyday practice of the trained professionals is not

supported by the current policy framework, impeding any serious attempt to intervene appropriately at an individual or community level.

There is no evaluation policy in terms of impact.

The policy frameworks do not support strategic planning for health promotion and primary prevention by improving synergies across sectors, policies and programme areas (e.g. health in all policies), except for a weak link with schools (again, in a uncoordinated manner and not based on evidence in terms of health promotion intervention processes and effectiveness).

Health Impact Assessment Tools are not being applied to evaluate the potential impact of other policy sectors on population health including cardiovascular disease, type 2 diabetes and stroke.

Policies and plans in sectors other than health do not acknowledge their implications and impact on population health in relation to healthy and active ageing, cardiovascular diseases, type 2 diabetes and stroke and their main risk factors.

There are no cross-governmental mechanisms in place to ensure coordination and effective implementation of interventions to address chronic disease prevention and their risk factors, including health inequalities and the socio-economic determinants of health.

At a central level, there are academic advisers and representatives from major NGOs. However, their impact until now is low.

The resources for health promotion and primary prevention are insufficient. There isn't a stable and predictable flow of financial resources for health promotion and primary prevention programmes (i.e. annual allocation of funds) endorsed by financial regulations. The budgetary timeframes do not enable medium and long-term planning to address chronic diseases. Processes to allocate funding for primary prevention and health promotion are not transparent and publicly known.

The health information system is not collecting data in accordance with EUROSTAT, EU-level surveys and WHO data reporting requirements, only in terms of international projects and not at a governmental level. Dissemination of these data (due to the lack of a coordinating body) is also very problematic.

There is a great deal of scattered research related to NCD, but this is not collected to give a comprehensive picture. As said above, there is no tradition in Greece of preparing public health reports. The universities and large NGOs make fragmented attempts to analyse aspects of the situation, focusing on issues of interest to them, but there is no official published report giving a comprehensive picture of the health challenges and their determinants and the ways in which these might be tackled. By default, the focus remains on the organisation and reorganisation of health care, with passing interest in other issues when these are raised by interested researchers or NGOs.

Policies relating to cardiovascular disease, stroke and type 2 diabetes in particular are being implemented only in terms of secondary and tertiary care.

The coordination between the different bodies in the health sector (Ministry of Health, national and regional health institutes, foundations and NGOs focusing on chronic disease, insurance companies,

private organisations) involved in the implementation of primary prevention and health promotion policies and programmes is not adequate.

Are the programmes and interventions sensitive to specific needs of more vulnerable groups (such as: adolescents, socio-economic disadvantaged, elderly, migrants, ethnic minorities and others)? There are specific programmes/interventions that are targeted to the needs of more vulnerable groups but only in the framework of the guidelines of the funding mechanisms of specific individual (national or international) projects.

The programmes and interventions are sensitive with regards to gender, age and other cultural, social or linguistic dynamics only within the framework of the guidelines of funded individual projects.

There are no opportunities and incentives (e.g., career development options, salaries, better working conditions) for professional development in relation to public health/chronic disease prevention and health promotion.

The public health training curricula include information on health equity and the socio-economic determinants of health only in the postgraduate course on Health Promotion and Education at the Medical School of Athens.

Health promotion and primary prevention programmes and interventions are evaluated on a regular/systematic basis only if they are within the framework of funded research projects.

There are insufficient resources/capacity to undertake cost-effectiveness analyses of health promotion and primary prevention programmes and interventions on a regular basis. The outcomes of evaluations and cost-effectiveness analyses are not used to inform and revise practice.

The health care professionals receive training to develop primary prevention and health promotion competencies only at a postgraduate or continuous education level.

There are no multidisciplinary teams in place in primary health care that address health promotion and primary prevention. There are no structures and mechanisms in place within the health care services to respond to the needs and priorities of more disadvantaged or vulnerable groups.

The coordination between the health sector, the social care sector and care services for the elderly is not adequate.

The number of university departments and research institutes engaging in research on effective primary prevention and health promotion programmes and interventions is not sufficient. There is no adequate professional expertise and capacity within university departments and research institutes to establish the effectiveness of primary prevention and health promotion programmes and interventions. Only the postgraduate course on Health Promotion and Education at the Medical School of Athens, and a few other university departments, train professionals on the best available

evidence for preventive interventions. The research findings and results are insufficiently communicated to policy and decision makers and taken up in relevant policies.

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