World Health Organization

European Region

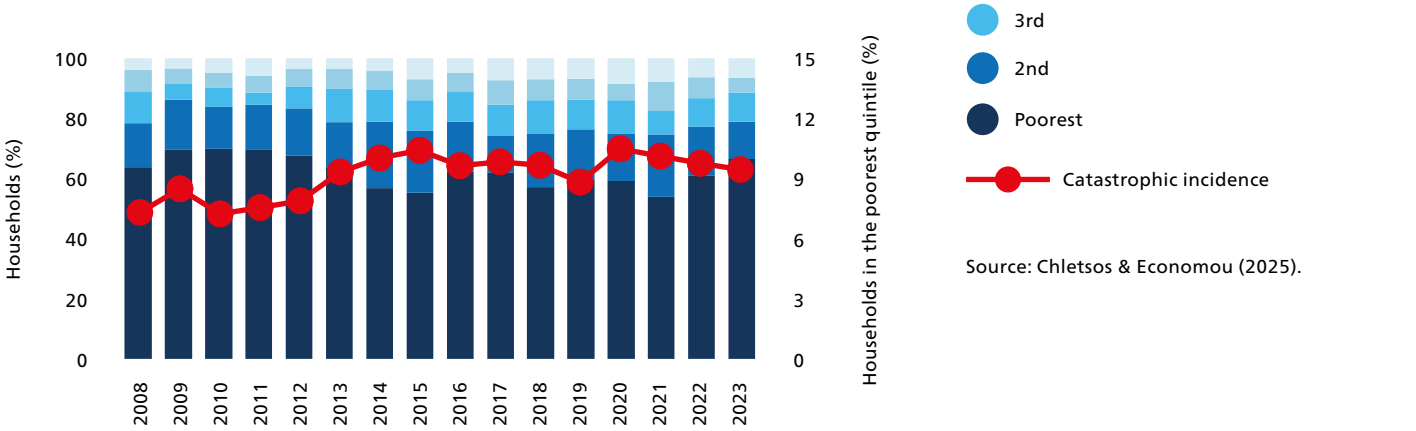
Can people afford to pay for health care? New evidence on financial protection in Greece: summary

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

In 2023 3% of households were impoverished or further impoverished after out-of-pocket payments (data not shown) and almost 10% of households experienced catastrophic health spending, up from around 7% in 2008 (Fig. 1).

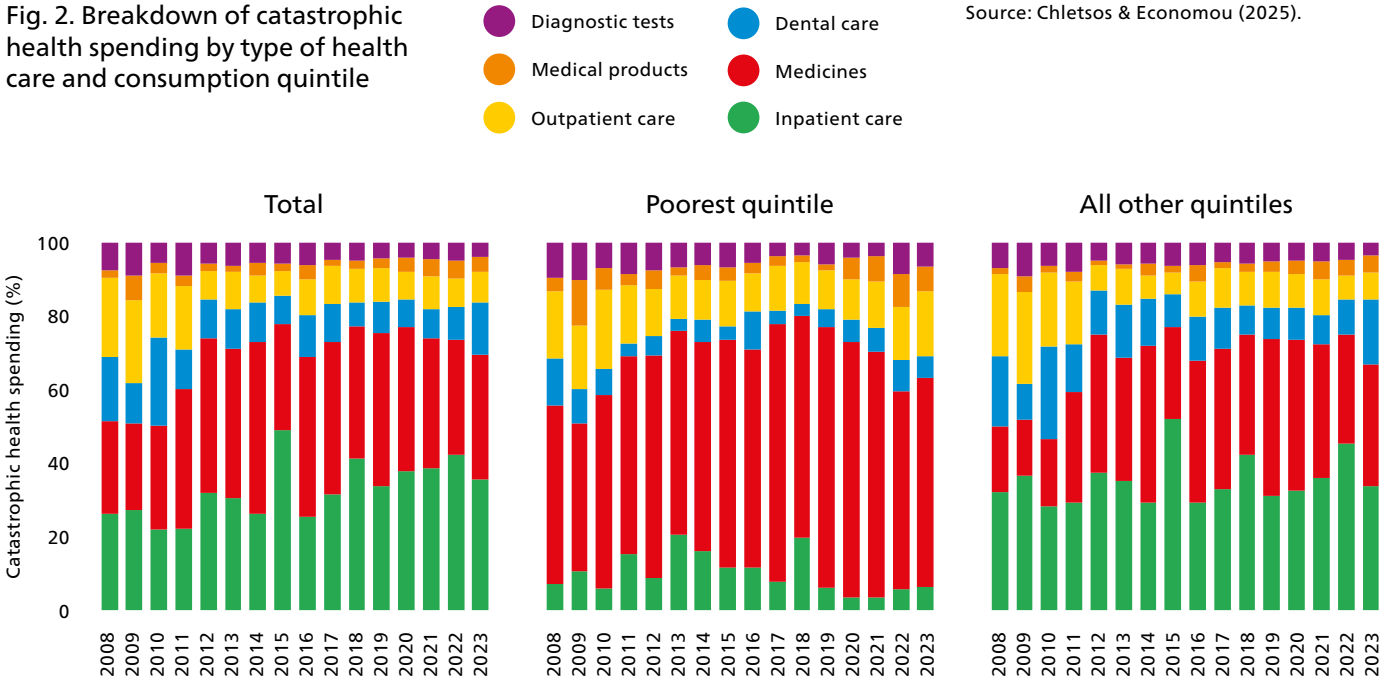
Catastrophic health spending is consistently heavily concentrated in the poorest consumption quintile, which accounted for nearly two thirds of the total in 2023 (Fig. 1). Incidence in the poorest quintile has risen sharply over time, from 23% in 2008 to 32% in 2023, and was higher in 2023 than in any other year in the study. Catastrophic health spending is also much higher than average in households headed by people who are categorized as other inactive (17%), aged over 60 years (15%), retired (15%) or unemployed (14%) (data not shown; Chletsos & Economou, 2025).

Fig. 1. Breakdown of households with catastrophic health spending by consumption quintile and incidence of catastrophic health spending in the poorest quintile



Source: Chletsos & Economou (2025).

Fig. 2. Breakdown of catastrophic health spending by type of health care and consumption quintile



Source: Chletsos & Economou (2025).

In 2023 catastrophic health spending was mainly driven by inpatient care and outpatient medicines on average (Fig. 2). It was mainly driven by outpatient medicines and outpatient care in the poorest quintile and by inpatient care and dental care in the richer quintiles.

How does Greece compare to other countries?

The incidence of catastrophic health spending is higher in Greece than in many European Union (EU) countries, but lower than in EU countries with a similarly heavy reliance on out-of-pocket payments (Fig. 3). In the poorest quintile catastrophic health spending is mainly driven by out-of-pocket payments for outpatient medicines, in common with countries with weaker financial protection (those on the right of Fig. 4) (WHO Regional Office for Europe, 2023).

Unmet need for health care, dental care and prescribed medicines is consistently above the EU average. It is largely driven by cost and income inequality in unmet need is substantial, particularly for prescribed medicines (data not shown; Eurostat, 2025a; 2025b).

What strengthens and undermines financial protection in Greece?

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

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

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

Fig. 3. Households with catastrophic health spending and out-of-pocket payments as a share of current spending on health, WHO European Region, latest available year

Notes: data on catastrophic health spending and out-of-pocket payments are for the same year. The colour of the dots reflects the incidence of catastrophic health spending: green < 2%, yellow < 5%, orange < 10%, red < 15%, dark red over 15%. See page 6 for country codes.

Source: data on catastrophic health spending from UHC watch (2025) and data on out-of-pocket payments from the WHO Global Health Expenditure Database (2025).

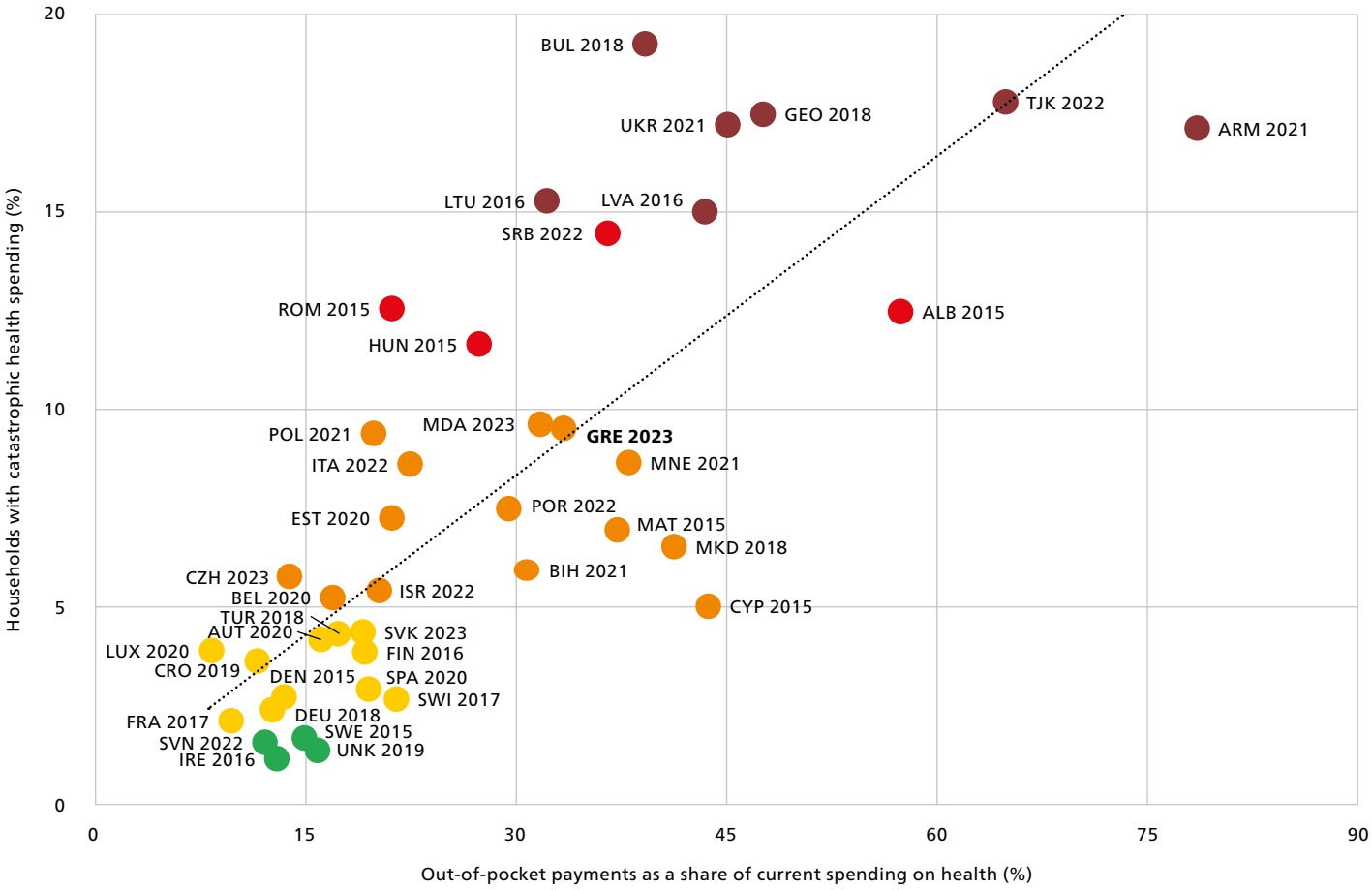
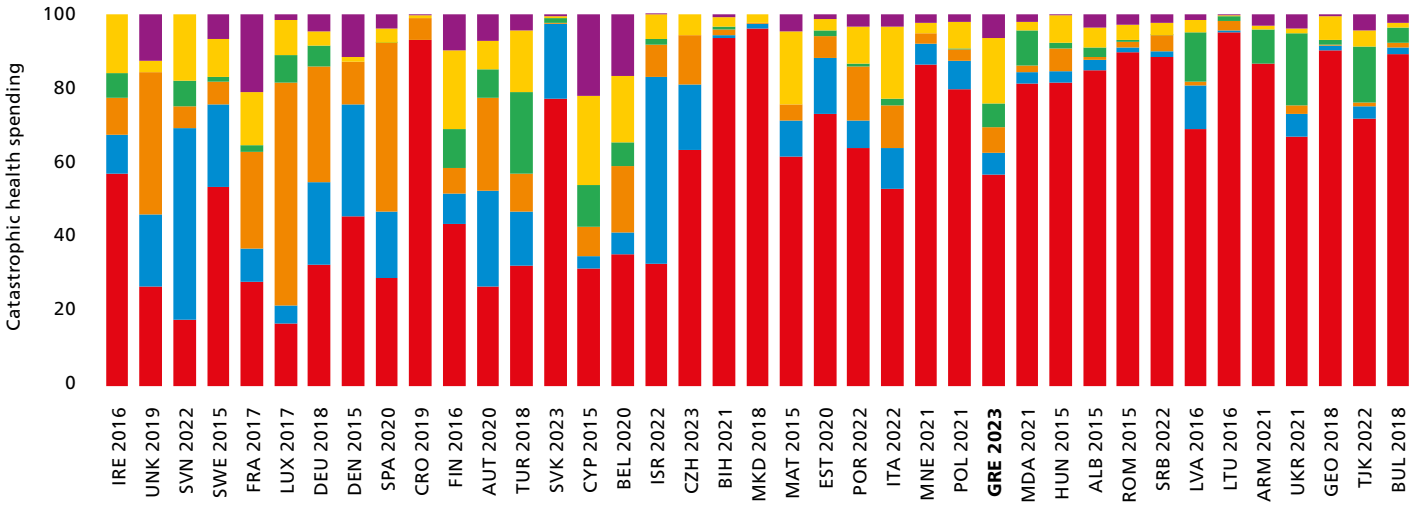


Fig. 4. Breakdown of out-of-pocket payments by type of health care in households in the poorest consumption quintile with catastrophic health spending, WHO European Region, latest available year

Notes: countries ranked from left to right by the incidence of catastrophic health spending. Types of health care are sorted by the unweighted average across all households and all countries. See page 6 for country codes.

Source: UHC watch (2025).



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

- persistent gaps in all three dimensions of coverage policy (see Table 1), which have a disproportionately negative impact on people with low incomes and exacerbate inequalities in access to health care.

How can Greece improve financial protection?

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

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

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

Table 1. Gaps in publicly financed and voluntary health insurance coverage

Source: UHC watch (2025).

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

- all residents would be entitled to the same health care benefits; and

- non-payment of contributions would be treated in the same way as non-payment of other taxes (i.e. through fines rather than through denial of access to services).

Simplify and strengthen the design of co-payments, particularly for outpatient medicines and other forms of outpatient care. International evidence and experience show that this can be done by extending exemptions from all co-payments (including the avoidable co-payments caused by reference pricing) to more households with low incomes; introducing an income-based cap on all co-payments – caps that give stronger protection to people with lower incomes are not only more likely to improve financial protection but will also ensure equity and efficiency in the use of public funds and soften the impact on the health budget (García-Ramirez et al., 2025); replacing percentage co-payments with low, fixed co-payments; and applying protection mechanisms automatically, with the help of digital tools, to simplify access and maximize take up (Kasekamp & Habicht, 2025).

Continue efforts to:

- improve financial protection for people who need outpatient medicines and other forms of outpatient care by strengthening protection from co-payments; ensuring appropriate prescribing and dispensing; encouraging greater use of generics; and lowering medicine prices;

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

- monitor and address long waiting times and informal payments, ensuring that existing and new measures do not exacerbate inequalities in access to health care; and

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

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

References[1]

Chletsos M, Economou C (2025). Can people afford to pay for health care? New evidence on financial protection in Greece. Copenhagen: WHO Regional Office for Europe. (https://iris.who.int/handle/10665/382008). Licence: CC BY-NC-SA 3.0 IGO.

Cylus J, Thomson S, Serrano Gregori M, Gallardo Martínez M, García-Ramírez JA, Evetovits T (2025). How does population ageing affect health system financial sustainability and affordable access to health care in Europe? Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/380710). Licence: CC BY-NC-SA 3.0 IGO.

Eurostat (2025a). European Union Statistics on Income and Living Conditions (EU-SILC) [website]. Luxembourg: Statistical Office of the European Union (https://ec.europa.eu/eurostat/web/microdata/european-union-statistics-on-income-and-living-conditions).

Eurostat (2025b). European Health Interview Survey (EHIS) [website]. Luxembourg: Statistical Office of the European Union (https://ec.europa.eu/eurostat/web/microdata/european-health-interview-survey).

García-Ramírez J, Thomson S, Urbanos-Garrido R, Bouckaert N, Czypionka T, Blümel M et al. (2025). Using income-based caps to protect people from user charges for health care. Lessons from Austria, Belgium, Germany and Spain. Improving affordable access to health care series. Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/380709). Licence: CC BY-NC-SA 3.0 IGO.

Kasekamp K, Habicht T (2025). Using digital solutions to protect people from user charges for health care. Lessons from Estonia. Improving affordable access to health care series. Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/380708). Licence: CC BY-NC-SA 3.0 IGO.

UHC watch (2025). UHC watch [online database]. Copenhagen: WHO Regional Office for Europe (https://apps.who.int/dhis2/uhcwatch/).

WHO (2025). Global Health Expenditure Database [online database]. World Health Organization (https://apps.who.int/nha/database).

WHO Regional Office for Europe (2023). Can people afford to pay for health care? Evidence on financial protection in 40 countries in Europe. Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/374504). Licence: CC BY-NC-SA 3.0 IGO.

1. All references were accessed on 18 July 2025.

Countries

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

Acknowledgements

This summary is based on a review written by Michael Chletsos (University of Piraeus) and Charalampos Economou (Panteion University) and edited by Lynn Al Tayara and Sarah Thomson (WHO Barcelona Office for Health Systems Financing). The authors of the review are grateful to the Hellenic Statistical Authority for making the household budget survey data available to Michael Chletsos. WHO gratefully acknowledges funding from the Government of the Autonomous Community of Catalonia, Spain. This publication was co-funded by the European Union. Its contents are the sole responsibility of WHO and do not necessarily reflect the views of the European Union.

Co-funded by the European Union

Monitoring financial protection in Europe

This study is part of a series of country reports generating new evidence on financial protection – affordable access to health care – in health systems in Europe and central Asia. Financial protection is central to universal health coverage, an indicator of the Sustainable Development Goals, part of the European Pillar of Social Rights and at the centre of the European Programme of Work, WHO's strategic framework for the European Region. The WHO Regional Office for Europe monitors financial protection in over 40 countries through the WHO Barcelona Office for Health Systems Financing. See UHC watch for data, analysis and other resources (https://apps.who.int/dhis2/uhcwatch).

WHO Barcelona Office for Health Systems Financing

The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage. The Office works with Member States in Europe and central Asia to promote evidence-informed policy making. It also offers training courses on health financing. A key part of the work of the Office is to assess country and regional progress towards universal health coverage by monitoring affordable access to health care. The Office supports countries to strengthen financial protection through tailored technical assistance and disseminates country-specific and internationally comparable data and policy analysis through UHC watch, a digital platform tracking progress on affordable access to health care in Europe and central Asia. Established in 1999, the Office is supported by the Government of the Autonomous Community of Catalonia, Spain. It is part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe.

WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

World Health Organization
Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.who.int/europe

WHO/EURO:2025-12555-52329-80560 (PDF)
WHO/EURO:2025-12555-52349-80638 (print)