Greece-OECD Project: Technical Support on Anti-Corruption

Draft Integrity Action Plan for the Ministry of Health: Integrity and Reduced Corruption in the Health Sector
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About the Greece-OECD Project

The Greek government is prioritising the fight against corruption and bribery and, with the assistance of the European institutions, is committed to taking immediate action. Under the responsibility of the General Secretariat Against Corruption, Greece’s National Anti-Corruption Action Plan (NACAP) identifies key areas of reform and provides for a detailed action plan towards strengthening integrity and fighting corruption and bribery. The OECD, together with Greece and the European Commission, has developed support activities for implementing the NACAP. This project is scheduled for completion in 2018 and is co-funded by the European Commission and Greece. For further information, please see the project webpage.
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### Public sector entities

1. **Ministry of Health:**
   - Mr Andreas Xanthos, Minister of Health and Mr Pavlos Polakis, Alternate Minister of Health
   - **Cabinet members:**
     - Mr Papadopoulos, Head of Cabinet of the Minister of Health
     - Mr Nikos Raptis, Special Advisor of the Minister of Health
     - Mr Nikiforos Plytas, Special Advisor of the Alternate Minister of Health
   - **Public officials:**
     - General Directorate of Financial Services, Mr Liakouras
     - Directorate of Development of Health Units, Ms Katsikarou
     - Directorate of Health Professionals, Ms Daniilidou
     - Internal Audit Unit, Mr Dermitzakis
     - Department of Public Procurement, Ms Papanoti
     - Department of E-Government, Mr Milonis

2. **National Organization for Medicines (EOF):** President, Ms Antoniou and Vice-President, Mr Giannoglou

3. **National Organization for the provision of Health Care Services (EOPYY):** President, Mr. Bersimis and senior officials
4. Body of Inspectors for Health and Welfare Services (SEYYP): General Inspector, Mr Evangelatos and senior inspectors

5. National Evaluation Center of Quality & Technology in Health S.A. (EKAPTY): President, Mr Papadakis

6. Health Procurement Committee, President, Ms Sartzetaki

7. Athens General Hospital “Elpis”
   - Mr. Christos Varakis, President
   - Mr Kokkinis, Head of Finance Department,
   - Ms Papantoni, Head of Accounting
   - Mr Arvanitis, Head of Pharmaceutical Department
   - Ms Setaki, Head of Procurement Office

8. Athens General Hospital “Sismanoglio”
   - Mr. Koutalas, President & CEO at a cluster of 3 Public Hospitals in North Athens (Sismanoglio, Amalia Fleming & Paidon Pendelis – approx. 1000 beds and 2000 employees):
     - Mr. Lioulias, Head of Medical Services
     - Ms Alagianni, Head of Pharmaceutical Department
     - Ms Douli, Assistant Director of Finance Department

### Private sector entities

Meetings hosted by the Hellenic Union of Enterprises (SEV) with the participation of Health Sector Companies and Health Sector Professionals and Businesses Associations
# Table of contents

Executive summary .................................................................................................................. 7

Introduction ................................................................................................................................. 15

MoH anti-corruption strategy ....................................................................................................... 17

Part 1: Implementing necessary structural reform ................................................................. 21
1. Much better information availability and transparency ...................................................... 21
2. Tackling corruption in purchasing and stock management ................................................. 22
3. Overly high pricing of medicines and materials ................................................................. 24
4. Corruption in medical practices ......................................................................................... 25
5. Corruption due to inappropriate legal and administrative structures of arms’ length bodies (like OKANA and KELPNO) ......................................................................................... 28
6. Corruption due to the absence of proper management controls ....................................... 30
7. Investigations, sanction and discipline ............................................................................... 31

Part 2: Giving citizens a voice and real information ............................................................. 35
8. Information on waiting lists and usage of key facilities .................................................... 35
9. Information on hospital daily effectiveness – mobile app .................................................. 36
10. Strengthening the patients’ rights offices in every hospital ............................................. 36
Executive summary

The leadership of the Ministry of Health (MoH) is determined that they will be effective in reducing corruption in the health sector and will use every means at their disposal to do this. The Ministry’s anti-corruption strategy is in two parts.

Part 1: Implementing necessary structural reform

There are deep-rooted causes of these corruption problems. So it is necessary to address the serious, structural reforms in order to be more effective and less at risk of corruption. MoH will also work to make early progress whilst the slower structural reforms are being put in place.

The solution is not just technical reforms. At the same time, MoH must moralise the public health system: making it clear to doctors, nurses, officials, patients and everyone involved that allowing corruption in health is a crime, an immoral impediment to the entitlements of the recipient of health services, an action against the nation and against their fellow citizens. They all need to work to solve this problem. MoH will also work with the representatives of the health industry – because their active co-operation is essential – and so that they too impose sanctions on bad industry behaviour.

Part 2: Giving citizens a voice and real information

Giving citizens a voice and real information include:

- routinely providing citizens with real information about key medical matters like waiting lists and use of scarce facilities
- showing how health services and doctors are actually performing
- giving citizens a more powerful voice, so that they feel their complaints, especially about corruption, are being heard and acted upon
- establishing real mechanisms for citizen feedback, which reaches health leadership and health inspectors
- becoming more accountable and transparent.

The MoH plan

The Ministry of Health plan consists of 61 specific measures that the MoH is committed to implementing, as follows.
**Ministerial commitment**

**Measure 1**: To make clear the strength of resolve of the MoH with this plan, the health minister will draft and circulate a “Ministerial Circular” requiring all in the MoH to implement this anti-corruption plan.

**Measure 2**: The health minister will appoint a full-time person at senior level in the ministry to co-ordinate the anti-corruption plan and to ensure there is continuous progress.

**Measure 3**: The health minister will also ensure that progress will be reviewed independently. To this purpose, he/she will establish a new team specifically for this purpose at the organisation of health and welfare inspectors (SEYPP), who will review progress and provide public reports on the progress of the plan every three months.

**Poor operational and management data means that corruption goes undetected and unreported**

**Measure 4**: The Ministry of Health will move rapidly to fully implement its health information system - the BI portal - within the next six months.

**Measure 5**: The MoH will recreate the observatory, as the basis for prices being paid across the health sector, but with more active monitoring.

**Poor forward forecasting of drug use**

**Measure 6**: The MoH will use the stock management system as a basis for forward medicine use estimation.

**Budgets to hospitals and to each part of the health system are not based on a scientific rationale, which encourages perverse behaviour**

**Measure 7**: Hospital budgets will be established on the basis of Diagnosis Related Groups (DRGs).

**Tackling corruption in purchasing**

**Measure 8**: The MoH will start the process of centralising the main health procurement processes in a National Central Health Procurement Authority (NCHPA or EKAPY). This is a key structural reform, with multiple actions. However, it will probably take two years to have a significant impact.

**Measure 9**: The MoH will not wait while the NCHPA is getting established, but will take multiple steps in a transition plan to get better value out of current health procurement. This is already ready.

**Measure 10**: The MoH will proceed carefully in developing framework agreements, and will start this process in a safe, step-wise manner.

**Measure 11**: The MoH will also find ways to dramatically simplify local procurement that is still necessary in hospitals.
Measure 12: As soon as possible, NHCPA will employ people who are professionals in procurement.

*Tackling corruption in stock management*

Measure 13: The MoH will identify and install a standard, local medicines stock management system in all hospitals.

Measure 14: The MoH will standardise coding/barcodes for a targeted group of medicines or medical equipment and other health products - the most commonly used medicines - medical equipment and the most expensive ones - and will require that this core dataset is used by all hospitals. This codifying procedure will in due course expand to all products.

Measure 15: The MoH and EOF have undertaken specific measures and will increase their effort in the control of shortages and parallel trade, the detection of any illegal activity and the reimbursement, e.g. the development and implementation of an effective tool for ensuring authenticity, identification and traceability of medicinal products (a specific sticker) and real-time control of invoices (through a web application, already available since July 2016) of invoices between MAH to everyone.

*Pricing of medicines*

Measure 16: The MoH, through EOPYY, will accelerate the process of negotiated procedures for on-patent drugs. It will create a permanent and coherent connection between the negotiating procedure of on-patent drugs (medicines under the data protection period) and the HTA (health technology assessment) of medicines.

Measure 17: The MoH will start up a mechanism for conducting health technology assessments, effective as from 2018.

*Pricing of health products*

Measure 18: The MoH will immediately increase scrutiny and control over the pricing of health products.

Measure 19: The MoH will complete the central categorisation and codification of products and services (through the existing database of the observatory or EKAPTY), including the codification of technical requirements, within 12 months.

*Unnecessary medical procedures*

Measure 20: The MoH will define a certain number of new clinical protocols each year.

*Improper benefits accepted by health professionals, such as conferences, provided by medical companies*

Measure 21: The need for transparency makes it obligatory for conference organisers to publicise all the major amenities they are providing to event participants. The legal
framework (on the basis of Article 66 of l.4316/2014) needs to be concluded despite the objections of some associations.

**Control of non-interventional studies**

**Measure 22:** The MoH will provide legal tools in order to identify clinical trials, declared as non-interventional studies and to prevent unlawful contact between researchers, industries and patients; a new draft law needs to be rapidly finalised.

**Inappropriate acceptance of donated medical devices that lead to unserviceable operating commitments**

**Reform of improper private law entities (like OKANA and KELPNO)**

**Measure 23:** The Ministry of Health will put all apply general public laws to arms’ length bodies.

**Measure 24:** The MoH will set up a specific reform programme for the two most complex entities, KEELPNO and OKANA. This will include organisational reform and newly defined internal rules for all internal processes.

**Measure 25:** The MoH will then apply similar reform to all the other entities.

**Measure 26:** The MoH will ensure that operational data from arms’ length bodies are fed routinely into the BI portal.

**Constraints on managing organisations for improved effectiveness**

**Measure 27:** The MoH will introduce legislation to enable better use of existing resources in managing hospitals and other MoH agencies (new legislation is already proposed).

**Lack of internal auditors means that weak procedures are not improved, and corruption can persist**

**Measure 28:** The Ministry of Health will establish a MoH internal audit community, appointed under a respected, qualified person who will act as the Chief Internal Auditor.

**Lack of medical/clinical auditors means that poor or corrupt clinical practices are not revealed and corrected**

**Measure 29:** The MoH will establish a group of health professionals to function as clinical/medical auditors.
Sanction and discipline

**Strengthening the operation of regional health disciplinary committees**

**Measure 30:** The MoH will increase the number of disciplinary committees, so as to eliminate the backlog of cases. This will start with the more populous health regions, like Attica.

**Measure 31:** The MoH will ensure that the larger suspected corruption cases are prioritised at the disciplinary committees in every health region. If needed, it will establish a different procedure to make sure they are treated more rapidly.

**Measure 32:** The MoH will make clear to all members of the disciplinary committees the importance of the corruption cases and the need to be strongly focused on the closure of these cases.

**Measure 33:** The MoH will review to see if it is possible for the health minister or some high authority could have a limited authority to suspend somebody until the investigation/disciplinary process is completed, with appropriate safeguards. This could be of particular use in cases of corruption where the defendant is arrested on the spot.

**Measure 34:** The MoH will examine the possibility of having just one committee structure that covers both doctors and non-doctors. The MoH will examine whether this might contradict Measure No. 29. It is necessary to have clear rules on the scope of authority of each committee.

**Measure 35:** The MoH will review the potential of hospital disciplinary boards to have more sanctioning authority.

**Measure 36:** The MoH will make it explicitly clear to hospital CEOs that the resolution of disciplinary board matters is a core part of their role, and that they are expected to be active in pressing for backlogs to be eliminated and cases completed.

**Measure 37:** The key statistics relating to all the disciplinary board should be sent to the BI portal on a monthly basis (number of meetings held, number of 1st level cases treated each meeting, number of in-process cases, number of cases completed each month, number of cases in backlog, date of entry for each case, etc.).

**Measure 38:** The health minister will introduce a law to parliament that obliges all disciplinary cases in health to be treated within two to three months of being presented. In this way, disciplinary cases involving corruption will be treated rapidly and not subject to long delay, as is sometimes currently the case.

**Measure 39:** The members of the Central Disciplinary Committee who also serve on the State’s Legal Council should not be allocated with other duties, other than the disciplinary procedure. This is important because they do all the heavy work.

All these measures should also be reviewed with the Ministry of Finance and the Ministry of Interior.
Requiring the boards of hospitals to use their disciplinary powers to suspend individuals in the case of suspected misconduct

Measure 40: Hospital presidents and their boards will be obliged to suspend individuals in the case of suspected misconduct. In the disciplinary level, these cases are considered severe, so according to Article 104 of Law 3528/2007, an immediate suspension of duties is imposed until the completion of the process. It could be provided that immediate suspension will apply for persons caught in the act, under Article 103 of l.3528/2007, which provides for immediate suspension. These measures are to be reviewed with the Ministry of Interior.

Strengthening the powers and independence of SEYPP to investigate wrongdoing

Measure 41: The organisation of health and welfare inspectors (SEYYP) will become a more independent body, with stronger powers and the ability to prioritise cases according to their assessment of importance. In this way, they can take the lead in pursuing corruption cases within the health sector and can prioritise corruption cases over less important complaints.

Measure 42: Every three months, every hospital will be required to send to SEYPP a list of all corruption complaints against hospital staff, and the status of any and all actions being taken.

Co-operation between inspection authorities

Measure 43 - A common methodology: There is a need for a common system of norms aiming at gathering facts, evidence and information, producing conclusions and proposing actions or solutions. This will be based on the collective experience and methods of the authorities and especially SEYYP.

Measure 44 - A cohesive registry of information: A common database should be established where all essential information should be registered and allocated, to which the competent authorities should have access. This will help co-ordinate the personnel involved in controls.

Measure 45 - A permanent co-ordination: This is feasible at the national and administrative levels (e.g. in matters of health, under the General Inspector of SEYYP; in general matters of public governance, under the General Inspector of Public Administration).

Measure 46 - Reinforcement of control bodies: SEYYP is understaffed and should be reinforced with human resources and (in some cases) equipment. The MoH should also provide for a satisfactory payroll for SEYYP and equalisation of payment in relation to other investigation bodies. This will ensure that SEYYP will recruit personnel that have high skills and qualifications. For the time being, a person applying for a job at SEYYP, might be underpaid in relation to his/her existing position.
**Requiring officials to report suspected misconduct cases to SEYPP**

**Measure 47:** Hospital presidents and boards will be obliged to report misconduct allegations against health professionals to SEYPP.

**Strengthening the legal framework and ethical codes of health professionals**

**Measure 48 - Reform of health professional codes of conduct and ethics:** A specific reference and provision of corruption crimes should be listed, imposing proportional disciplinary penalties.

**Measure 49 - Legal framework for health providers:** Establishment of obligations and penalties for all health providers (laboratories, rehabilitation centres, etc.), in relation to the provision in p.d.121/2008.

**Measure 50:** The MoH will consult with all those professional associations who have a code of conduct (doctors, dentists, pharmacists, nurses, physiotherapists, dental technicians and occupational therapists) to request/require that they strengthen the detailed article in the code that forbids professionals to ask for any kind of economic exchange or other benefit from patients.

**Giving citizens a voice and real information**

**Surgery waiting lists in public hospitals available via the Internet**

**Measure 51:** Article 58 of Law 4368/2016 establishes surgery waiting lists to ensure equity and non-discrimination of patients in providing surgical operations in all public hospitals. To accomplish this goal, it is necessary to put surgery waiting lists in electronic form and make them available on the Internet.

**Measure 52:** The relevant details of those who seem to jump the queue will be published on the clarity website. This will be implemented for all hospitals.

**Average surgery waiting times**

**Measure 53:** Information will be published that shows the average waiting time for each type of operation at each hospital across Greece.

**Surgery success rates**

**Measure 54:** Information on surgical success rates will be published.

**Use of VIP bedrooms and utilisation of ICU beds**

**Measure 55:** Every hospital will have clear medical criteria on the use of VIP bedrooms and other very small wards. These criteria will be published.

**Measure 56:** Every hospital will publish the usage of ICU beds and details of who is using them. Also, a series of medical protocols should be developed to structure the ICU waiting list. This list should be transparent to patients.
Information on hospital daily effectiveness

Measure 57: The MoH will develop and roll out a mobile app that automatically opens in each hospital, and provides this information daily.

Strengthening the patients’ rights offices in every hospital

Measure 58: In each hospital, the special office for patients’ rights – which is currently being implemented - will be strengthened further, so a process will be established whereby complaints may be filed for any case of infringement of patient rights.

Measure 59: The MoH will require that information from every patients’ rights office (e.g. number of complaints each month, categories of complaint, number of corruption cases, number resolved each month) will be uploaded to the BI portal every month. The information from all hospitals will be made public across all hospitals every six months.

Measure 60: The patients’ rights office will build a community of patients, based around those who use the office. Although this will be hard to achieve and will take time, this is essential to build a citizen feedback voice for the MoH. This community will function as a representative group of patients who have the good health and integrity of the local hospital as their aim.

Measure 61: Citizens are to be informed of the new rules about medical corruption. They will be encouraged to complain and informed of what kind of proof is required (e.g. the serial numbers of money) for the complaint to be taken up. In particular, there will be just one, very well publicised way to complain. A web application will be developed, where the patients can file complaints for health professionals that work in the public sector.
Introduction

The vast majority of workers in the health sector are trying to do an honest, professional job, in the difficult situation of under-resourcing due to the economic crisis situation. But they work not only under the economic crisis conditions of today. They also work in a system that is slow and extremely bureaucratic, with multiple vulnerabilities to corruption.

At the same time, the system does not serve patients well. Citizens do not have a strong voice to enable change when they see ineffective services and corruption; there is limited transparency on what is happening and little accountability when things go wrong. A clean, non-corrupt health service needs to promote the dignity of the patient and their access to good, transparent information about their situation and the situation of the overall health system.

This plan is not about austerity. It is about reducing corruption in the health system, identifying to citizens and to health officials where resources are poorly or dishonestly used, and returning the funds for the better care of patients.

Developing this plan

The Government of Greece is implementing anti-corruption plans in all its ministries. This document describes the plan for the Ministry of Health (MoH). It is based on detailed discussions with the health minister, the deputy health minister, many health officials in the ministry, in agencies, in public bodies and in hospitals; and on the anti-corruption experience of the OECD/GSAC team supporting this review.

The proposed approach builds on several existing documents. The most relevant is the draft anti-corruption plan, prepared by the Ministry of Health in late 2016. The review also takes note of the suggested 2014 Action Plan Against Corruption by health experts that was not formally adopted, and the 2015 Report on Public Contracts in the Health Sector by the Independent Authority of Public Contracts.

There has also been a detailed study, “Corruption in the Health Care Sector”, by the European Commission in 2013. This study examined the corruption issues in the

1. According to the law, corruption refers to a form of dishonest or unethical conduct by a person entrusted with a position of authority, often to acquire personal benefit. The term should be clarified with regard to fraud and waste, especially fraud, which is a term with reference to (external) providers.

healthcare systems of all EU nations, and showed Greece to be the country where the perceptions of healthcare corruption were the highest in Europe.\(^3\)

The Ministry of Health has worked together with GSAC and with technical support from OECD to develop an anti-corruption plan. The plan has been developed with significant input from the health minister, the deputy health minister, many people in the ministry, the leaders of most of the relevant agencies (EOF, SEYPP, EOPYY, EPI, EKTAPY, etc.), hospital management in two hospitals and in discussion with private sector health industry associations.

**Areas of corruption vulnerability**

There are several varying situations where people may behave in a corrupt manner:

- **Insiders** – administrative staff, doctors and surgeons - taking advantage of vulnerabilities in the health system for personal enrichment.

- **Officials taking shortcuts to make the system work.** These often start out with good intent, such as speeding up the process to get an essential result, like a vital spare part for a hospital scanning machine. But such shortcuts afterwards can easily become avenues of corruption.

- **Supplier companies** exploiting the complexity, lack of centralisation and poor systems of the health ministry.

- **Patients paying bribes** because this gives them more certainty of outcome, such as achieving a better position on a waiting list or access to an ICU bed. This can be voluntary, but it is also a form of extortion.

For the purposes of this plan, we identify 27 specific corruption vulnerabilities, grouped into 7 areas where structural reforms are needed. The vulnerabilities and the areas for action are shown in the next section.

\(^3\) Ibid, page 243.
**MoH anti-corruption strategy**

The leadership of the Ministry of Health (MoH) are determined that they will be effective in reducing corruption in the health sector. They will use every means at their disposal to do this. The ministry’s anti-corruption strategy will be in two parts.

**Part 1: Implementing necessary structural reform**

There are deep-rooted causes of these corruption problems. There is a multitude of weaknesses in the current system that makes it both inefficient and highly susceptible to corruption. It is necessary to address the serious, structural reforms that are necessary in order to be more effective and less at risk of corruption. At the same time, the MoH will work to make early progress whilst the slower structural reforms are being put in place.

The solution is not just technical reforms. At the same time, the MoH must **moralise** the public health system: making it clear to doctors, nurses, officials and everyone involved that allowing corruption is a crime against the nation and against their fellow citizens; they all need to work together to be part of the solution.

So the MoH will work with key professionals – doctors, nurses, other professional groups – so that they too are equally determined to eliminate the corruption that plagues the health system. The MoH will work with them to ensure that there are strong codes of conduct, a stronger disciplinary code against corruption, and so forth.

The MoH will also work with the health industry – because their active co-operation is essential – and will also be intolerant of bad industry behaviour.

Working with health professionals has a second strategic objective: because the sanctions and discipline system is so weak, the MoH will only become free of corruption if it can make the system **self-cleaning**. That is to say, when the majority of the officials in the system watches out for, and prevents, the corruption taking place or continuing to exist. In addition, the MoH will do everything in its power to strengthen the use of the available sanctions.

In addition to the above mentioned, the MoH strongly believes that a system of universal coverage for all citizens should be established, creating the necessary safety net for patients and health professionals to fight against corruption.
Part 2: Giving citizens a voice and real information

Giving citizens a voice and real information include:

- routinely providing citizens with real information about key medical matters like waiting lists and use of scarce facilities
- showing how health services and doctors are actually performing
- giving citizens a more powerful voice, so they feel their complaints, especially about corruption, are being heard and acted upon
- establishing real mechanisms for citizen feedback, which reaches health leadership and health inspectors
- becoming more accountable and transparent.

The MoH will also put in place strong independent monitoring of the progress of the anti-corruption reforms, based in SEYPP. This way, citizens, parliament and the MoH will have truthful feedback on progress.

Ministerial and MoH commitment

The health minister will own this health sector anti-corruption plan. Responsibility for the plan’s implementation rests with the health minister, and the cabinet of the Ministry of Health (MoH) will co-ordinate it.

Measure 1: To make clear the strength of resolve of the MoH with this plan, the health minister will draft and circulate a “Ministerial Circular” requiring all in the MoH to implement this anti-corruption plan.

Measure 2: The health minister will appoint a full-time person at senior level in the ministry to co-ordinate the anti-corruption plan and to ensure there is continuous progress.

Measure 3: The health minister will also ensure that progress will be reviewed independently. To this purpose, he/she will establish a new team specifically for this purpose at the organisation of health and welfare inspectors (SEYPP), who will review progress and provide public reports on the progress of the plan every three months.

Health sector corruption vulnerabilities

There are 27 corruption vulnerabilities, organised into 7 areas of structural reform, as below.

1. Much better information availability and transparency
   1. Poor operational and management data means that corruption goes undetected and unreported. Gross inefficiencies also persist, which encourages corruption to bypass the system.
2. Poor forward forecasting of drug use means abuse of stocks is easy.

3. Budgets to hospitals and to each part of the health system are not based on a scientific rationale; this leads to perverse incentives or no incentives to reform areas of ineffectiveness or corruption.

4. In a mixed public/private system, competition from the private sector should be driving public sector improvement. Instead, it is driving corruption. The solution is to require much greater transparency of information from the public and private sectors, so inefficiencies and corrupt areas hidden from sight are exposed.

2. More robust purchasing and stock management

5. Almost impossibly complex tendering procedures: the very complexity makes them vulnerable to corruption.

6. Highly decentralised procurement, where purchasing is separately implemented in each hospital and agency, similarly allows for both inefficiency and corruption.

7. Poor stock management. Stocks are needed locally, but there are no central controls, nor any regular review of the appropriateness of use of medicines and supplies.

3. Stronger controls over high pricing of medicines and materials

8. High pricing of medicines. Companies are forever gaming the system to keep medicine pricing as high as possible.

9. The drugs supply chain allows for the legal parallel trade in drugs for export that corrupts the system.

10. High pricing of health products. Almost as much is spent on health products as on medicines, but it receives almost no attention by comparison with medicine price control. It is at least as large, or larger, a corruption risk as medicines.

4. Stronger controls over corruption in medical practices


12. Inappropriate medical procedures. The lack of clinical protocols means that there is no straightforward way, as there should be, for the preferred treatment to be well defined.

13. Inappropriate prescribing of prescriptions and misuse of the electronic prescription system.

14. Improper benefits accepted by health professionals, such as conferences, provided by medical companies.

15. Inadequate control of non-intervention studies.

16. Acceptance of donated medical devices that lead to un-serviceable operating commitments.
5. Clamping down on inappropriate legal and administrative structures

17. Many legal entities in health are not properly under the control of the ministry. In some of them, like KEELPNO and OKANA, there has been large-scale collusion and corruption.

18. Constraints on managing organisations for improved effectiveness. The laws impose many constraints, on re-organisations, on recruitment for skills, on moving staff to other locations, on rationalisations, on sanctioning staff. These heavy restrictions mean that many poor practices and corrupt practices are perpetuated, despite being obvious to everybody.

19. Citizens may prefer to pay bribes. There are two levels of bribing: first, citizens feel that by paying bribes they will receive better quality of medical services. This is in some cases endorsed by professionals. Secondly, whilst they know that it is wrong, citizens find that it is sometimes inevitable to pay bribes in order to get access to surgery or other facilities.

6. Better auditing (admin and clinical) and better controls are needed

20. Internal auditors are essential to monitor procedures. They hardly exist in Greece, and so procedures are not improved, and corruption can persist.

21. Clinical auditing is a powerful control that seems not to exist in the Greek public health system. Lack of clinical (or medical) auditors means that poor or potentially corrupt clinical practices are not revealed and corrected.

22. There is grossly inefficient payment of prescription charges to suppliers. The health sector has a large backlog of invoices to pay for medicines and other products paid out on prescription. This encourages corrupt invoicing.

7. Strengthening and speeding up sanctions and discipline

23. Individual cases of illegal contact of health professionals in the public health sector are often reported, but not concluded. These corruption incidents and cases involve, among others: a) pre-selection of patients; b) directed or nominal prescription of drugs and diagnostics; c) issuing of false documents; d) informal payments; e) illicit or illegal circulation or disposal of medicines and others.

24. The disciplinary processes are usually very slow, very procedural, and very open to error, which allows the corrupt to escape sanction.

25. The sanctions are minor (e.g. maximum one month’s suspension on full pay), so there is no incentive to be honest.

26. Doctors are seen to escape sanction because they are protected by their peers and by their professional association. This is the case in the disciplinary procedures in the Medical Union, but not always in the MoH procedure.

27. Hospital officials mostly do not want to cause problems by speaking out about corruption realities.
Part 1: Implementing necessary structural reform

1. Much better information availability and transparency

*Poor operational and management data means that corruption goes undetected and unreported*

**Issue:** Such data is essential, not only for efficiency but also to reduce corruption risks, as it allows for comparisons between hospitals, pharmacies, specific units, etc., to identify which ones are working well, or badly, and why.

This includes the collection and processing of detailed and aggregate information on operational and fiscal data, in a way that central control and evaluation of any health structure will be possible. Through this system, which is already in an advanced state of preparation (called the BI portal) the following general categories are visible and subject to control:

1. monthly budget
2. purchase of goods and services
3. consumption of materials and pharmaceuticals
4. operational expenditure and incomes
5. reimbursements for medical and clinic care
6. human resources
7. administrative structures (such as hospital units and clinics) and others.

There is one note of caution: The BI portal is very new, so it is quite likely that there will be reporting problems in the first 6-12 months, which may or may not indicate corruption.

**Measure 4:** The Ministry of Health will move rapidly to fully implement its health information system - the BI portal - within the next six months.

**Measure 5:** The MoH will recreate the observatory, as the basis for prices being paid across the health sector, but with more active monitoring.

The procurement authority will do central gathering and monitoring of data through a registry of contracts, expenses, consumptions, prices of products and services at an EU and global level, for all administrative levels that will be taken under consideration in the procurement, resulting in a central databank.

It is planned that EPI staff will manage this process, and they will put the data into the BI portal.
Poor forward forecasting of drug use

Issue: Due to the budgetary limits of the MoH, there is a limit to the total value of drugs that can be purchased each year. Poor forecasting of drug use means that the budget is used ineffectively. It can also be a reason for corruption that certain drugs are ordered well in time or in over-quantities, to the mutual benefit of the ordering person and the supplying company.

Measure 6: The MoH will use the stock management system as a basis for forward medicine use estimation.

Budgets to hospitals and to each part of the health system are not based on a scientific rationale, which encourages perverse behaviour

The issue: Hospitals will work more effectively and with less risk of corruption if their budgets, even if limited, reflect the volume of health work they undertake and its complexity. This is not the case at present.

Measure 7: Hospital budgets will be established on the basis of Diagnosis Related Groups (DRGs).

This system is already established in Law 4286/2014. Its partial implementation will commence in June 2017 and will be fully applicable by December 2018. It distributes the available resources more equitably among providers, based on their real effort. It is based on ICD (International Classification of Diseases) diagnoses, procedures, age, sex, discharge status, and the presence of complications for groups with related characteristics. This system prevents the differentiation of compensation for the same type/category of medical care.

2. Tackling corruption in purchasing and stock management

Issue: Tendering is done almost entirely locally by hospitals. The procedure is slow, complex, inflexible; typically with 15-20 significant steps to complete, as well as full documentation on bidders, even if they are well-known, national contractors to the health sector. Staff are almost never trained as procurement officers. This is hugely inefficient. It has multiple vulnerabilities, gives scope to the companies to provide different prices to different hospitals, and the temptation to do direct purchasing to avoid the complexities of tendering.

Lack of centralisation means that each unit (e.g. hospital) has not only to have staff and procedures to do each process, which is wasteful and risks mistakes, but they are also vulnerable to dealing with companies without expertise or experience to deal properly with them.

The MoH has been taking action in this area already: the new draft for the management in health procurement is already published for public consultation.

Measure 8: The MoH will start the process of centralising the main health procurement processes in a National Central Health Procurement Authority (NCHPA). The MoH will do this by incorporating EPY, the Price Observatory and the registry of EKTAPY, and using...
the existing Committee on Health Procurement. This is a key structural reform, with multiple actions. However, it will probably take two years to have a significant impact.

**Measure 9:** The MoH will not wait while the NCHPA is getting established, but will take multiple steps in a transition plan to get better value out of its current health procurement. An early implementation team will be established that will review pricing and procurement of a limited range of materials and products (maybe 50-100 in the first step) and insist on lower prices across the hospital health system for them.

A key part of the plan for the NCHPA is to set up framework agreements, to get better prices nationally for products. The NCHPA before signing any agreement should have received the necessary measures about the providers’ capability to cover existing needs. However, such framework agreements can be difficult to implement. For example, commercial providers may not be able to fulfil the requirement nationally, perhaps for volume reasons, or for reasons of geographic coverage.

**Measure 10:** The MoH will proceed carefully in developing framework agreements, and will start this process in a safe, step-wise manner.

The MoH will start implementing framework agreements with one of the easier health product groups (e.g. bandages). Individual hospitals and agencies can then call off their requirements against this central framework agreement.

**Measure 11:** The MoH will also find ways to dramatically simplify local procurement that is still necessary in hospitals. The detail of this will be explored later. As part of this simplification, hospitals will be actively encouraged to move to the electronic public procurement platform ESIDIS, which has proved to be a good and simpler technology.

**Measure 12:** As soon as possible, NCHPA will employ people who are professionals in procurement (this is not the case today).

**Poor stock management: Stocks are needed locally, but there are no central controls nor any regular review of appropriateness of use of medicines and supplies**

**Issue:** There is concern and suspicion that drugs may expire unnecessarily; that some of the more expensive drugs may be being sold outside the hospital or overseas for profit. There is no standard IT system for stock management across hospitals. This is a major concern.

**Improvement:** The long-term solution is to have all medicines bar-coded and a single, nation-wide stock management system. But this is too big a task in the short term, even to do just centrally at the MoH medicine storage centre.

**Measure 13:** The MoH will identify and install a standard, local medicines stock management system in all hospitals.

**Measure 14:** The MoH will standardise coding/barcodes for a targeted group of medicines - the most commonly used medicines and the most expensive ones - and will require that this core dataset is used by all hospitals. Hospitals will then find local solutions for coding the other medicines in the stock management system. Over time, the MoH and hospitals will work together so that all medicines are gradually covered.
Measure 15: The MoH and EOF have undertaken specific measures and will increase their effort in the control of shortages and parallel trade, the detection of any illegal activity and the reimbursement, e.g. the development and implementation of an effective tool for ensuring authenticity, identification and traceability of medicinal products (a specific sticker) and real-time control of invoices (through a web application, already available since July 2016) of invoices between MAH to everyone.

3. Overly high pricing of medicines and materials

Pricing of medicines

Issue: The health sector already has a complex system for pricing medicines, developed routinely through EOF and formally approved and negotiated by the Pharmaceutical Committee in the MoH. The expenditure on medicines is very high, compared with other countries in the European Union, and action must be taken. Greek medicines are expensive compared with the other countries, sometimes 150% to 200% more. Companies are forever gaming the system to keep medicine pricing as high as possible. EOF takes the cheapest of the three countries and fixes the price that way. When most EU states are paying, they do it through a negotiating procedure; we have that procedure, but it is not working in practice. Only on one to two products does the MoH have a negotiating committee in place. But it is only at an early stage, with few drugs covered.

The system for off-patent and generic drugs is less satisfactory and has opportunities for corrupt abuse by hospitals, doctors and pharmaceutical suppliers.

Measure 16: The MoH, through EOPYY, will accelerate the process of negotiated procedures for on-patent drugs.

Pricing of health products

Issue: Hospitals spend almost as much on health products (such as bandages, stents, stands for IV bags) as they do on pharmaceuticals. Yet the degree of scrutiny and pricing control is much less. This is a major area for corruption.

Measure 17: The MoH will immediately increase scrutiny and control over the pricing of health products.

Measure 18: The MoH will complete the central categorisation and codification of products and services (through the existing database of the observatory or EKAPTY), including the codification of technical requirements, within 12 months.

This process will commence first with the centralisation of purchases of a small range of health products, such as bandages, probably via a framework agreement. Once this is completed, the agency will move to other health products and services. It is expected that the EPI procurement group will in due course develop a suite of framework agreements, maybe 50, that will be used obligatorily by all hospitals.
**Drug supply chain**

**Issue:** Because of the way the pricing mechanism works, it can be profitable for companies to buy products in Greece and then export them abroad. The drug supply chain allows for the legal parallel trade in drugs for export that corrupts the system.

The effective monitoring of the drug supply chain MAHs-Wholesaler-Pharmacist (private, hospital, EOPYY) is a multifaceted problem. One major reason is the parallel trade (legal and non-legal). The development and implementation of one effective tool for ensuring authenticity, identification and traceability of medicinal products is a specific sticker. It is a unique and mature tool used in the European Union. Since April 2016, MoH has established a procedure for providing information on reduced availability, shortages or emergency measures taken, through the website. There was also the development of a web application on the EOF site for real-time control of invoices from each MAH to every actor (hospitals, wholesaler, pharmacist, etc.). This application has been working since July 2016.

This is a big EU problem; many EU people are against this rule. This is a significant corruption risk at the EU level. No new Greece-specific solution is proposed in this plan.

4. *Corruption in medical practices*

**Choice of more expensive medicines by doctors**

**Issue:** Doctors have high discretion in which drug to prescribe. There are controls, such as pharmaceutical committees in hospitals, but these controls can be circumvented. Companies are adept at assisting the doctors, for example by providing multiple versions of similar drugs, some of which are controlled and some of which are not.

This issue will be largely resolved by some of the measures proposed elsewhere in this plan (use of clinical protocols; fixing the protocols inside the prescription system; specific ACP classification; stronger discipline, measurement of protocols deviation as an indicator).

**Measure 19:** The MoH will start up a mechanism to conduct health technology assessments as from 2018.

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4. Health technology assessment (HTA): This is a well-known system operating in other EU countries, aiming to evaluate the drugs and medical devices that are compensated through state funds, in order to avoid unnecessary use of the above products. It is based on a specific methodology of assessment, based on measures of therapeutic efficacy and safety (mortality, mortality, Health-Related Quality of Life [HRQoL]), rating the quality of evidence, the therapeutic added value (in cases where a drug, even expensive, is considered more efficient compared to its therapeutic result or to combination of other drugs), fiscal impact, etc. Following these parameters, a general rating is provided that establishes an objective overview of each product.
**Unnecessary medical procedures**

**Issue:** Currently, clinical protocols are not defined for particular interventions or treatments. Without these, it is not possible to evaluate whether doctors and clinicians are following the agreed procedure for treating a patient, or whether any unnecessary or overly expensive treatments are being proposed.

**Measure 20:** The MoH will define a certain number of new clinical protocols each year.

**Improper benefits accepted by health professionals, such as conferences, provided by medical companies**

**The issue:** The industries that produce pharmaceuticals and medical devices often organise conferences, in which doctors, health professionals, medical societies and health providers participate and benefit from specific facilities (such as recreational trips, accommodation, presents, food, etc.). Although the majority of these activities are declared as non-promotional, usually they tend to promote specific product brand names.

**Measure 21:** The need for transparency makes it obligatory for conference organisers to publicise all the major amenities they are providing to event participants. The legal framework (on the basis of Article 66 of l.4316/2014) needs to be concluded despite the objections of some associations.

This way, the benefits that each of the health providers and professionals receive will be clear and known to all administrative authorities, and even to patients, indirectly preventing over-dependent and undue relations between professionals and pharmaceutical industries.

The National Organisation of Drugs (EOF) is challenging the Decision of the Hellenic Data Protection Authority to narrow the scope of the provision only to (declared) promotional conventions. In the case the authority insists on such an interpretation of the law, a legislative initiative will take place in order to broaden the scope of implementation to all events, regardless of their characterisation.

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5. Therapeutic protocols and prescription restrictions: Taking under consideration the ATC (Anatomic Therapeutic Chemical) classification in the level of active ingredient (ATC 5), or therapeutic category (ATC 4), specific protocols and restrictions are already created and will be developed for the prescription of medical products. These protocols are created taking into consideration the epidemiological frequency and the economic impact (compensation price) for a category of products. Thus, a general and binding prescription rule is established for private doctors, in order to avoid illicit direction of patients to non-effective and money-consuming medical treatment. An additional system for the electronic record of examinations and results (that will be related to the protocols) and also the electronic prescription of all non-reimbursed drugs will be created.
Control of non-interventional studies

The issue: The European Union regulates clinical trials (through Regulation 536/2014) that are considered as interventional, meaning they study the effects-reactions, etc. of specific medicinal products. The non-interventional studies, meaning the studies that should not interfere with the therapeutic scheme of the patient, are not regulated by EU legislation and are frequently used by industries to promote drugs or benefits to patients and doctors.

Measure 22: In order to provide legal tools in order to identify clinical trials, declared as non-interventional studies and to prevent unlawful contact between researchers, industries and patients, a new draft law needs to be rapidly finalised.

Acceptance of donated medical devices that lead to un-serviceable operating commitments

Issue: The MoH and MoH hospitals are well aware of the dangers of accepting donated equipment. Whilst acceptance may be appropriate, problems arise afterwards, notably that they may not have the staff and/or the expertise and/or the budget to operate them. However, they still do accept donated equipment. The current law, Article 6 of l.2955/2001, stipulates that a donation is forbidden in cases where the medical equipment uses only the expendables of only one company (which practically refers to nearly all cases of donations). So, the only exemption is provided in cases where the donation includes the cost of service and expendables of the equipment.

But this is sometimes not insisted on by hospitals. Such donations may be well intended, but they also have the known side effect of locking the hospital into the system of the providing supplier. This is less of an issue than in the past, as the MoH keeps an eye on this. The proposal goes to the legal service and to the board of directors of the hospital, then it goes to the region for decision. Further, the Court of Audit may not accept the expenditure, so boards are very careful. So no specific remedial proposals are made in this plan.

There is also the wider problem that new health technology needs to be evaluated centrally so that such scarce resources are used in the most effective way. There is also the problem of operating the equipment. Hospitals do not have the staff and/or the training, and companies make it difficult to achieve this.

The health sector needs a centralised way to assess which technologies are required, and in which departments/hospitals/regions. By letting these decisions be decentralised, the local health staff are vulnerable to the pressures from the companies. Such health technology assessments are a well-known part of modern medical professionalism.

6. Charitable foundations are now asking the MoH to change this law to create a five-year limit so that it is not unlimited.
Misuse of prescriptions and usage of the electronic prescription system

**Issue:** The introduction of the electronic prescription system contributed to the reduction of the misuse of prescriptions and usage, because detection of foul prescription patterns is much easier with this IT application. Certain gaps should be filled in, such as: a) the interconnection of medical releases and diagnostic examinations; b) the introduction of medical protocols and diagnostics protocols and connection of the results of medical examinations; c) the supervision of the executions of releases, of the EOPYY contracts with health providers and the verification of the presence of the patient (e.g. through the introduction of the medical card, and also the implementation of the e-prescription for inpatients and the connection for the already existing e-prescription system).

5. Corruption due to inappropriate legal and administrative structures of arms’ length bodies (like OKANA and KELPNO)

Reform of improper private law entities

**Issue:** In the past, a number of legal entities were established, funded partially or fully by the Ministry of Health, that were exempted from rules providing transparency, accountability and objectivity in the public sector, and several proved to be merely vehicles for corruption. These included entities like KEELPNO, OKANA, where there has been major corruption. But there are many other entities of a special regime that undergo the process (like KEELPNO) of being submitted to transparency rules. Some of these entities were based under public law, but the ones where there has been the most

7. Public and private entities under the Ministry of Health: Health Regions (Y.PE.), Hospitals with Special Legal Status, National Emergency Aid Centre, National Organisation for Medicines, Greek Dental Federation, Hellenic Regulatory Body of Nurses, Hellenic Association of Physiotherapists, National School of Public Health, National Blood Centre, Hellenic Associations of Scientists-Midwives, General Hospital Papageorgiou, Organisation Against Drugs (O.KA.NA), Health Institute for Children, Children’s Hospital (The Agia Sofia), Hellenic Centre for Mental Health and Research, Centre for Research, Prevention and Treatment of Diabetes Mellitus and its Complications (EKEDI), Hellenic Centre for Disease Control and Prevention (KE.EL.P.NO.), National Transplant Organization (EOM), Hellenic Pasteur Institute, Biomedical Research Foundation Academy of Athens, Therapy Center for Dependent Individuals, Social Cooperatives Ltd., Buildings’ Infrastructures SA, Health Units SA.

There is also a list connected with the mental health sector (under private sector rules). There are many problems with them also. For example, there is a framework for them but it is not actually working, e.g. pre-fixed prices for beds, but it was not enough. If the MoH pay them enough then MoH will have to control them much more closely.
abuse were established under private law. The inclusion of these legal entities into the general transparency rules of the public sector is a major political goal.\textsuperscript{8}

\textbf{Measure 23}: The MoH will put all the arms’ length bodies under the general public laws.

\textbf{Measure 24}: The MoH will set up a specific reform programme for the most complex entities, like KEELPNO and OKANA. This will include organisational reform and newly defined internal rules for all internal processes.

\textbf{Measure 25}: The MoH will apply similar reform to all the other entities.

\textbf{Measure 26}: The MoH will ensure that operational data from arms’ length bodies are fed routinely into the BI portal.

\textit{Constraints on managing organisations for improved effectiveness}

\textbf{Issue}: The laws impose many constraints, on re-organisations, on recruitment for skills, on moving staff to other locations, on rationalisations, on sanctioning staff. These heavy restrictions mean that many poor practices and perhaps corrupt practices are perpetuated, despite being obvious to everybody.

\textbf{Measure 27}: The MoH will introduce legislation to enable better use of existing resources in managing hospitals and other MoH agencies (new legislation is already proposed).

\textit{Citizens may prefer to pay bribes}

\textbf{Issue}: In an underfunding situation with demand way above the supply of health solutions, it is natural that some citizens prefer to pay, even though they know it is wrong and should not happen, in order to get the operation that they or their family need. There are three typical types: a) the “thank-you” to the specialist, due to patients’ belief that bribing will lead to a higher quality of services; b) where an atmosphere has been created where the citizen knows they have to pay before or after they receive treatment; and c) the pure extortion, where providing the health service is preconditioned to bribing.

\textbf{Improvement}: This has to be addressed via active communication with patients so that they know the hospital will not tolerate such payments. This is discussed in Part 2.

\textsuperscript{8} This is evidenced by: a) public logistics and principles of fiscal management and audit (Law 4270/2014), based on Directive 2011/85/EC; b) public procurement (Law 4412/2016), based on Directives 2014/24/EC and 2014/25/EC; c) objective and pre-determined criteria for the recruitment of personnel, subject to the control of independent authority (ASEP, Law 2190/1994), based on Article 103 of the Constitution.
6. Corruption due to the absence of proper management controls

**Lack of internal auditors means that weak procedures are not improved, and corruption can persist**

Definition: Modern internal audit is quite different from external audit (like the Court of Audit, where they are checking legal procedures) and from investigations. Its purpose is to strengthen procedures and practices by reviewing them on a regular basis.

The issue: A hospital is lucky if it has a single internal auditor, or perhaps one to share across several hospitals. Internal auditors are the third line of defence against general corruption (after the person responsible and their management). There is almost no tradition of their use as a preventive measure in improving processes.

Measure 28: The MoH will establish a MoH internal audit community, appointed under a respected, qualified person who will act as the Chief Internal Auditor.

He/she will work to the new preventive philosophy of modern internal audit. He/she will use the standards and practices of the OECD that are currently being prepared for the Government of Greece. If necessary, a regulation will be introduced to require the use of internal audit as a preventive process in the MoH.

**Lack of medical/clinical auditors means that poor or corrupt clinical practices are not revealed and corrected**

Definition: According to Wikipedia, clinical audit is a process that has been defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. The key component of clinical audit is that performance is reviewed (or audited) to ensure that what should be done is being done, and if not it provides a framework to enable improvements to be made. It had been formally incorporated in the healthcare systems of a number of countries, for instance in 1993 into the United Kingdom's National Health Service (NHS), and within the NHS there is a clinical audit guidance group in the United Kingdom. The clinical audit comes under the Clinical Governance umbrella and forms part of the system for improving the standard of clinical practice."

Clinical auditors scrutinise the current medical procedures in use and the clinical pathways in use to ensure that they align with the agreed protocols agreed prescribing regime, or preferred clinical pathways. They are the real third line of defence against medical corruption. They are also invaluable in scrutinising the cost of clinical procedures and whether it is in line with the clinical pathway.

Issue: Clinical auditing is a powerful control that does not exist in the Greek public health system. Lack of clinical (or medical) auditors means that poor or potentially corrupt clinical practices are not revealed and corrected. Although there is a scientific committee in each hospital, it does not focus on the control of clinical processes in such a structured way. Clinical (or medical) auditing is a key control mechanism.

Measure 29: The MoH will establish a group of health professionals to function as clinical/medical auditors.
**Inefficient payment of prescription charges to suppliers**

**Issue:** The health sector has an enormous backlog of invoices to pay for medicines and other products paid out on prescription. Suppliers know it will take 20 months to get paid, so they increase the price, so this is a normal market practice. This is an equal problem to corruption, even bigger than the corruption problem.

**Improvement:** The MoH is already actively pursuing this problem of non-payment of invoices and payment of inflated invoices, and has implemented a new approach with EOPYY that will go a long way to solving this problem. As a result, no extra measures are proposed in this plan.

**7. Investigations, sanction and discipline**

**Issue:** Greece has weak disciplinary procedures for sanctioning bad or corrupt behaviour by public officials, and a legal framework that is slow and highly restrictive in the definition of corruption and bribery. The only circumstances where an employee can be suspended immediately are: a) jail; b) where there has been a final sentence from the penal court, resulting in the termination of his/her employment; or c) where school teachers are accused of action relating to sexual freedom. Further, disciplinary committees within the MoH are slow and hard to convene. The overall effect is that hospital leadership has very few sanctions against those suspected of corruption.

**Improvements:** There is limited room to work, as the disciplinary system relates to all public employees, not just the MoH. It should also be noted that the current procedure calibrates the protection of public interest and the presumption of innocence. However, there are many smaller changes that are proposed in this plan. At the wider level, the MoH is fortunate that its investigatory body, SEYPP, is strong and active in corruption issues; measures are also proposed to strengthen its operation and independence.

**Strengthening the operation of regional health disciplinary committees**

**Measure 30:** The MoH will increase the number of disciplinary committees, so as to eliminate the backlog of cases. This will start with the more populous health regions, like Attica.

**Measure 31:** The MoH will ensure that the larger suspected corruption cases are prioritised at the disciplinary committees in every health region. If need be, it will establish a different procedure to make sure they are treated more rapidly.

**Measure 32:** The MoH will make clear to all members of the disciplinary committees the importance of the corruption cases and the need to be strongly focused on the closure of these cases.

**Measure 33:** The MoH will review to see if it is possible for the health minister or some high authority could have a limited authority to suspend somebody until the investigation/disciplinary process is completed, with appropriate safeguards.

**Measure 34:** The MoH will examine the possibility of having just one committee structure that covers both doctors and non-doctors. The MoH will examine whether this
might contradict Measure No. 29. It is necessary to have clear rules on the scope of authority of each committee.

**Measure 35**: The MoH will review the potential of hospital disciplinary boards to have more sanctioning authority. According to the disciplinary crime, the authority has a broad discretion of penalties. In most cases for the disciplinary crime of “undignified contact in the service”, the maximum penalty could be imposed (termination). Depending on the nature and the circumstances of the crime, the appropriate penalty should be imposed. In some cases they are imposed, and in others, they aren’t. So it is not actually a question of the disciplinary or sanctioning power of the board, but a question of the way it is used.

**Measure 36**: The MoH will make it explicitly clear to hospital CEOs that resolution of disciplinary board matters is a core part of their role, and that they are expected to be active in pressing for backlogs to be eliminated and cases completed.

**Measure 37**: The key statistics relating to all disciplinary boards should be sent to the BI portal on a monthly basis (number of meetings held, number of 1st level cases treated at each meeting, number of in-process cases, number of cases completed each month, number of cases in backlog, date of entry of the case, etc.).

**Measure 38**: The health minister will introduce a law to parliament that obliges all disciplinary cases in health to be treated within two to three months of being presented. In this way, disciplinary cases involving corruption will be treated rapidly and not subject to long delay, as is sometimes currently the case. This will need review and support by and from the Ministry of the Interior.

**Measure 39**: The members of the Central Disciplinary Committee who also serve on the State’s Legal Council should not be allocated with other duties, other than the disciplinary procedure. This is important because they do all the heavy work.

**Requiring the boards of hospitals to use their disciplinary powers to suspend individuals in case of suspected misconduct**

**Measure 40**: Hospital presidents and their boards will be obliged to suspend individuals in the case of suspected misconduct. At the disciplinary level, these cases are considered severe, so according to Article 104 of Law 3528/2007, an immediate suspension of duties is imposed until the completion of the process. It could be provided that immediate suspension will apply for persons caught in the act, under Article 103 of L.3528/2007, which provides for immediate suspension. These measures are to be reviewed with the Ministry of Interior.

**Strengthening the powers and independence of SEYPP to investigate wrongdoing**

**Measure 41**: The organisation of health and welfare inspectors (SEYYP) will become a more independent body, with stronger powers and the ability to prioritise cases according to their assessment of importance. In this way, they can take the lead in pursuing corruption cases within the health sector and can prioritise corruption cases over less important complaints.
Measure 42: Every hospital will be required to send to SEYPP every three months a list of all corruption complaints against hospital staff, and the status of any and all actions being taken.

Co-operation between inspection authorities

Issue: Up until now there are several inspection or auditing bodies: a) the Inspectors and Auditors of Health Authority (SEYYP, Law 2120/2001), having general auditing powers; b) The Service for Cost Control of Welfare Authorities (YPEDYFKA, Law 2676/1999), having the power to undertake controls on all aspects of welfare services; c) several organisational units inside the Ministry of Health, e.g. the Directorate of Economics, Technical Services, Mental Health or the Internal Audit Unit (p.d.106/2014), controlling several sectors of public health (e.g. the funding of NGOs in mental health or private clinics). These authorities have developed a considerable amount of know-how, results and methodology, pioneered by SEYYP, which is the most elaborate mechanism of control established in the ministry. Among these authorities (and related ones in other ministries, such as police or tax authorities) a common ground should be created, meaning the provision for the following measures.

Measure 43 - A common methodology: There is a need for a common system of norms aiming at gathering facts, evidence and information, producing conclusions and proposing actions or solutions for confronting the problems or reacting effectively to cases of corruption. This will be based on the collective experience and methods of the authorities and especially SEYYP.

Measure 44 - A cohesive registry of information: A common database should be established where all essential information will be registered and allocated, in which the competent authorities will have access to the following fields: a) subject of control; b) object of control; c) controlled period; d) authority (communication with a central unit); e) commencement and (expected) ending of control. This will help co-ordinate the personnel involved in controls.

Measure 45 - A permanent co-ordination: This is feasible at the national and administrative levels (e.g. in matters of health, under the General Inspector of SEYYP; in general matters of public governance, under the General Inspector of Public Administration). Also, such permanent co-operation, including technical support, should be provided with the European Healthcare Fraud and Corruption Network.

Measure 46 - Reinforcement of control bodies: SEYYP is understaffed and should be reinforced with human resources and (in some cases) equipment.

Requiring officials to report suspected misconduct cases to SEYPP

Measure 47: Hospital presidents and boards will be obliged to report misconduct allegations against health professionals to SEYYP.
**Strengthening the legal framework and ethical codes of health professionals**

**Measure 48 - Reform of health professional codes of conduct and ethics**: A specific reference and provision of corruption crimes should be listed, imposing proportional disciplinary penalties.

**Measure 49 - Legal framework for health providers**: Establishment of obligations and penalties for all health providers (laboratories, rehabilitation centres, etc.), in relation to the provision in p.d.121/2008.

**Measure 50**: The MoH will consult with all those professional associations who have a code of conduct (doctors, dentists, pharmacists, nurses, physiotherapists, dental technicians and occupational therapists) to request/require that they strengthen the detailed article in the code that forbids asking any patient for any kind of economic exchange or other benefit, in the case they are working in the public sector, and also to impose severe penalties.
Part 2: Giving citizens a voice and real information

Hospitals and the health system exist to serve citizens, and for no other reason. Everyone would agree with this – in principle – but it is not true in practice. There are no real mechanisms for citizens to make their views known – they have no voice.

They also do not know what is going right and wrong, are very poorly informed about how their own cases are being treated, and have almost no information on which to make decisions about whether they will get good care or not. This means there is no accountability from those working in the health system to citizens.

Without the voice of the citizen and without accountability, corruption is more likely.

The Ministry of Health (MoH) is already starting to take action to improve this. The two main initiatives that are already started are hospital waiting lists and patients’ rights offices in hospitals.

8. Information on waiting lists and usage of key facilities

*Surgery waiting lists in public hospitals*

**Measure 51**: Article 58 of Law 4368/2016 establishes surgery waiting lists for ensuring equity and non-discrimination of patients in providing surgical operations in all public hospitals. It was felt necessary to put surgery waiting lists in electronic form and publish them on the Internet to accomplish this goal. Once lists are published on the Internet, citizens have free access to browse through the lists by means of the registration number as well as by the date of the surgery.

**Measure 52**: Details of those who seem to jump the queue will be published on the clarity website. This will be implemented for all hospitals.

*Average surgery waiting times*

**Measure 53**: Information will be published that shows the average waiting time for each type of operation at each hospital across Greece.

*Surgery success rates*

Patients also have the right to know which operations are most successful in which hospitals.

**Measure 54**: Information on surgical success rates will be published.
**Use of VIP bedrooms and utilisation of ICU beds**

**Measure 55:** Every hospital will have clear medical criteria on the use of VIP bedrooms and other very small wards. These criteria will be published.

**Measure 56:** Every hospital will publish the usage of ICU beds and details of who is using them. Also, medical and clinical protocols that will be published should be created in order to edit the waiting list of ICU beds. This waiting list should be available to patients.

**Accident and emergency waiting and triage**

The problems at accident and emergency (A&E) seem not to be corruption problems (we are led to believe that money is not used to jump the queue), but there are transparency and equity issues. For example: a) there is often no numbering system, so patients do not know where they are in the queue; b) even with a numbering system, there is excessive waiting; c) sometimes there is no system of triage, whereby arrivals could be sorted according to severity. Improving both would not be costly.

Adding to that, and on the scope of universal coverage of the population, the MoH already developed a draft for the primary care system. This will lead to relief of the workload in the A&E units of hospitals

**9. Information on hospital daily effectiveness – mobile app**

**Issue:** It is right that patients should be able to see how well the hospital is performing each day. For example:

- How many doctors are working that day?
- How many operations of each type are being performed that day?
- How many A&E patients were seen that day?

**Measure 57:** The MoH will develop and roll out a mobile app that automatically opens in each hospital, and provides this information daily.

**10. Strengthening the patients’ rights offices in every hospital**

**Issue:** These offices existed but were fading out. The MoH has reorganised them and given them more authority and resources and staff. The MoH encourages the CEOs to monitor their operations and keep following up on their actions.

**Improvement:** The MoH will give patients’ rights offices a clear guideline on how to operate, so as to provide common practices. The MoH is now expecting full implementation across hospitals. The MoH requires an update report every six months on the cases they have handled (and the results).

**Measure 58:** In each hospital, the special office for patient rights that is currently being implemented will be strengthened further, so that complaints may be filed for any case of infringement of patient rights.
Measure 59: The MoH will require that information from every patients’ rights office (e.g. number of complaints each month, categories of complaint, number of corruption cases, number of cases resolved each month) will be uploaded to the BI portal every month. The information from all hospitals will be made public across all hospitals every six months.

Measure 60: The patient rights office will build a community of patients, based around those who use the office. Although this will be hard to achieve and will take time, this is essential to build a citizen feedback voice for the MoH. This community will function as a representative group of patients who have the good health and integrity of the local hospital as their aim.

Measure 61: Citizens will be informed of the new rules about medical corruption. They will be encouraged to complain and informed of what kind of proof is required (e.g. the serial numbers of the money) for the complaint to be taken up. In particular, there will be just one, very well-publicised way to complain, and just one way that the complaints are taken up and analysed.