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## Access to health care in an age of austerity: disabled people's unmet needs in Greece

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### ABSTRACT

Since late 2009, Greece has been dealing with the effects of a debt crisis. The neoliberal principles embedded in the three structural adjustment programmes that the country accepted have required radical cuts in health care funding, which in turn have led to widening inequalities in health. This article focuses on access to health care for people with disabilities in Greece in the context of these structural adjustments. We investigate possible differences in unmet health care needs between people with and without disabilities, using de-identified cross-sectional data from the European Health Interview Survey. The sample included 5400 community-dwelling men and women aged 15 years and over. The results of the logistic regressions showed that people with disabilities report higher unmet health care needs, with cost, transportation, and long waiting lists being significant barriers; experience of all barriers was positively associated with low socio-economic status. These findings suggest that a section of the population who may have higher health care needs face greater barriers in accessing services. Austerity policies impact on access to health care in both direct and indirect ways, producing long-term disadvantage for disabled people. Social policies and comprehensive anti-discrimination legislation might help to address some of the barriers this population faces.

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Disability; health care access; health inequalities; financial crisis; austerity; Greece

### Introduction

Since late 2009, Greece has been dealing with the effects of a financial crisis and subsequent recession (Kentikelenis, 2017). In order to remain in the Eurozone and fulfil its fiscal responsibilities, the Greek state accepted three consecutive structural adjustment programmes/bailouts – in 2010, 2012 and 2015 – from the International Monetary Fund (IMF), the European Commission and the European Central Bank, collectively known as the Troika. These programmes were guided by the neoliberal principles of deregulation, liberalisation, stabilisation and privatisation (see Kentikelenis, 2017 for an overview of these principles and their application in Greece), with the main requirement being a reduction of public spending through an austerity-driven fiscal policy. This led to what Labonté and Stuckler (2016, p. 313) described as a roll-back of health and social protection spending and a 'roll-out of neoliberalism'.

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From 2010 to 2016, the Greek Government enacted 12 rounds of tax increases, spending cuts and reforms, in accordance to the demands of the Troika (OECD, 2016). All of these programmes were austerity-driven and required deep structural changes, further deepening social inequalities (De Vogli, 2014). These reforms have had a negative socio-economic impact: real GDP fell by 26%, general unemployment is at 23% and youth unemployment rate at 44.2%, extreme poverty increased from 8.9% in 2011 to 15% of the total population in 2015, while relative poverty increased from 21.9% to 23.2% during the same period (Eurostat, 2016; Matsaganis, Levendi, Kanavitsa, & Flevotomou, 2016; OECD, 2016). The combination of the economic crisis with austerity measures has led to a rise in unequal income distribution: the Gini coefficient rose from .329 in 2008 to .343 in 2014, and the share of the top 20% to bottom 20% rose from 5.6 to 6.3 during the same period (OECD, n.d.).

The effects of these policies on the health of the general population in Greece, and more broadly on the health system, have been well documented (see for example Ifanti, Argyriou, Kalofonou, & Kalofonos, 2013; Karanikolos & Kentikelenis, 2016; Zavras, Zavras, Kyriopoulos, & Kyriopoulos, 2016). In an effort to reduce public spending and increase revenue, several policies have been adopted, including increased patient participation in co-payments for pharmaceuticals and increased fees to access health care (Economou, Kaitelidou, Kentikelenis, Sissouras, & Maresso, 2014a; Karanikolos & Kentikelenis, 2016; Karanikolos et al., 2013). Due to the financial crisis and their increasing inability to pay for private health care, more people have turned to the public sector. Taking into consideration that since 2009 per capita spending on public health has been cut by nearly a third (in accordance with the demands of the Troika for public spending on health not to exceed 6% of the GDP), that 25,000 health staff have been fired, and that hospitals often lack enough beds and medical supplies to care for their patients, a 'public health meltdown' with severe consequences for people's health is currently taking place in Greece (Smith, 2017). The measures undertaken have also led to a reduction in health care coverage (which has left out 2.5 million Greeks, since health care coverage is linked to employment), and in the health benefits they are entitled to by the coverage (Smith, 2017; World Health Organisation, 2016). The extent to which austerity-driven structural reforms in the health sector can offer a sustainable solution is debatable (De Vogli & Owusu, 2015). In Greece, such measures have resulted in increased barriers in access to health care and in a consequent increase in unmet health care needs among the general population (Zavras et al., 2016). Services such as cancer-screening programmes, mental health services, prevention and treatment programmes for drug use, and municipal public health services have suffered severe cuts (Kerasidou, Kingori, & Legido-Quigley, 2016).

In a recent open letter to the prime minister of Greece, the National Confederation of Disabled People (2017) outlined the impact of austerity policies on people with disabilities, either indirectly, through the broader reforms, or through policies directly targeting them. Co-payment for medications, for example, applies to all but may affect disproportionately people with disabilities, who may not be entitled to any discounts for medication they need regularly (EOPPY, 2017). Law 4387/2016, clause 7, on the other hand, directly targets people with disabilities stipulating a proportionate reduction of their national pension, relative to the severity of their impairment.

The impact of the financial crisis on people with disabilities has received little attention, despite the vulnerability of this population due to the combination of increased health care needs and generally lower socio-economic status (Iezzoni, 2011). The limited existing research either presents the general impact of austerity on the rights of people with disabilities (for example, Hauben, Coucheir, Spooren, McAnaney, & Delfosse, 2012), the effect of economic downturn on employment of disabled people (for example, OECD, 2009), or the impact of the recent economic crisis on general health and well-being (for example, Winters, McAteer, & Scott-Samuel, 2012).

This study addresses a gap in existing literature, both in terms of contribution to general knowledge on disabled people and their access to health care, but also in terms of knowledge about access to health care in crisis-hit Greece. It is imperative to investigate barriers and unmet health care needs of disadvantaged groups – in our case, people with disabilities – in order to decrease possible health inequalities that may become even more accentuated by socio-economic hardship caused by austerity measures. Our specific aim is to explore access to health care for people with disabilities in Greece through an investigation of differences in unmet health care needs between people with and without disabilities, in the context of the ongoing

austerity-driven structural adjustments. Additionally, we investigate the potential impact of educational level, employment status and income on unmet health care needs of disabled people, since socio-economic status (SES) has been recognised as having a significant impact on access and utilisation of health care services, and on individual and community health status (Kirsch & Ryff, 2016). We use the terms *people with disabilities* and *disabled people* to refer to people who have a long-standing (more than six months) health condition or impairment and experience activity limitations. Considering the fact that no comprehensive piece of legislation protecting the rights of people with disabilities exists in Greece, including their right to services such as health care, the need to examine access to health care for this population assumes a clear urgency.

## Methods

### Design

To identify access to health care for people with and without disability, we undertook secondary analysis of de-identified cross-sectional data from the European Health Interview Survey (EHIS, Wave 2) for Greece. The EHIS survey is conducted in several European Union countries, with the main aim to study and provide – at a national and European level – detailed information on the health status of the population (Greek Statistical Authority, 2014). Access to anonymised microdata was gained upon request to the Department of Statistical Information Provision (<http://www.statistics.gr/statistical-data-request>).

The EHIS consists of four modules: (a) socio-economic and demographic variables, such as age, sex, marital status, etc.; (b) variables on health status, for example self-assessed health, chronic conditions, limitations in daily activities, etc.; (c) variables on health care use, such as consultations, unmet needs, preventive actions, etc.; and (d) health determinants, for instance weight, smoking, alcohol consumption, etc. (Eurostat, n.d.). The survey was carried out across Greece from October to December 2014 and included 8223 observations. The survey utilised multistage, layered sampling, with the primary research unit the ‘surface area’ (one or more building blocks or a small settlement), the secondary unit the household, and the final unit a person aged 15 years and over, living in private households (for more information see Greek Statistical Authority, 2014).

### Data and variables

The variable ‘disability’ was derived from answers to two questions: HS2, which required a yes/no answer to: ‘Long-standing health problem: Suffer from any illness or health problem of a duration of at least six months’, and HS3 ‘General activity limitation: Limitation in activities people usually do because of health problems for at least the past six months’, with the possible answers being *severely limited*, *limited but not severely*, and *not limited at all*. The variable *disability* had two possible values: *no disability*, and *with disability* (people who answered *yes* to HS2, and *limited but not severely* and *severely limited* to HS3). There were a total of 6385 observations for the variable *disability*. Due to case-deletion (default in STATA), the sample size varies between 4536 and 5400 observations for the six binary dependent variables assessing unmet health care needs. Since we wanted to maximise sample size/power, we allowed for slight fluctuations in sample sizes. Case-deletion – which analyses cases with available data on each variable – did reduce statistical power; however, since we still have a large sample, statistical power was sufficiently high (for testing and descriptive statistics between the full sample and the sample we used, please see Supplemental data, web appendices 1 and 2).<sup>1</sup>

We used the following six binary variables to assess unmet health care needs: (a) Unmet need for health care in the past 12 months due to long waiting list(s); (b) Unmet need for health care in the past 12 months due to distance or transportation problems; (c) Could not afford medical examination or treatment in the past 12 months; (d) Could not afford dental examination or treatment in the past 12 months; (e) Could not afford prescribed medicines in the past 12 months; and (f) Could not afford mental health care (by a psychologist or a psychiatrist, for example) in the past 12 months.

The control variables study included the following: (a) *gender*: male/female; (b) *age*: 15–29/30–44/45–59/60–79/80+; (c) *civil status*: unmarried/married/widowed (these were the only categories available in

the database); (d) *region*: Northern Greece/Central Greece/Attiki (county where the capital, Athens, is located)/Aegean Islands, Crete; (e) *urbanisation level*: urban area/semi-urban area/rural area; (f) *nationality*: Greek/not Greek; (g) *employment*: employed/unemployed/inactive; (h) *education*: pre-primary and primary/secondary and post-secondary/tertiary; (i) *health self-assessment*: bad/average/good; (j) *income quintiles* (net monthly equivalised household income); and (k) *disability*: no disability/with disability.

## Results

### Descriptive statistics

Table 1 summarises the characteristics of the study sample allowing comparisons between people with and without disability.

Figure 1 shows the frequency distribution of unmet health care needs in Greece between people with and without a disability.

As can be seen in Figure 1, more people with a disability have unmet health care needs compared to people without disabilities. One out of four people with disabilities have unmet health care needs due to cost of dental examination or treatment, and due to cost of medical examination or treatment. All differences are statistically significant.

### Logistic regressions

Logistic regressions were employed using STATA Version SE 11.2 in order to investigate unmet health care needs between people with and without disabilities. No collinearity distorted the results. There was a relatively higher correlation between the five groups of age (with a variance inflation factor-VIF between 3.26 and 5.43). However, this is often the case when dealing with dummy variables that represent a categorical variable with three or more categories, and – being relatively small – they have no effect on the regression (Allison, 2012). The mean VIF for all variables was 2.16.

Table 2 presents the results of the logistic regressions. The first column presents unadjusted odds ratios, the second column shows partially adjusted odds ratios (adjusted for education, employment, and income), while the third column presents the fully adjusted odds ratios (adjusted for all the variables presented in Table 1).

As can be seen from Table 2, people with a disability were more likely to face unmet needs in health care, compared with people with no disability, ranging from 1.8 times to 2.6 times more likely to do so. The largest gap can be seen in the category of *unmet need for mental health care due to cost*, where people with a disability were 2.6 times more likely to face a problem, as well as for the category *unmet need due to cost of prescribed medicines*, where they were 2.2 times more likely to face a difficulty. The smallest gap was observed in *unmet need due to cost of dental examination or treatment*, where people with disabilities were 1.8 times more likely to face a difficulty compared to people with no disability.

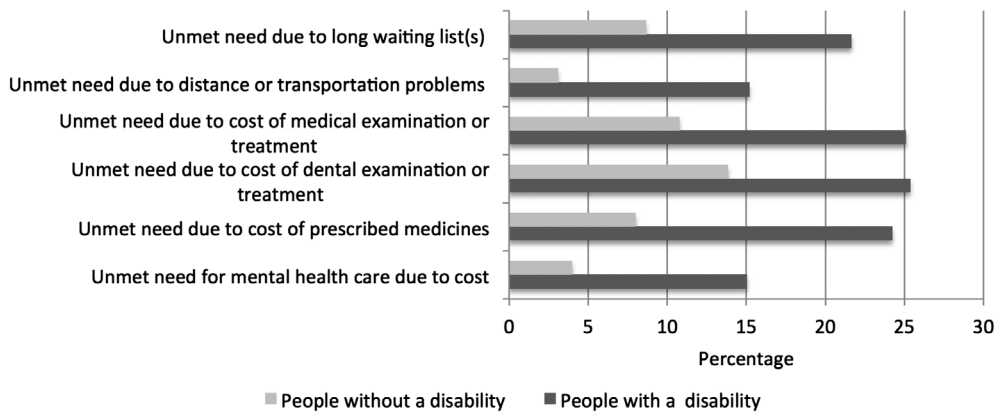
Table 3 shows the impact of *employment*, *education* and *income* on unmet health care needs for people with disabilities in Greece.

As can be seen from Table 3, unemployment, low educational level, and low income were positively associated with unmet health care needs for people with disabilities. Unemployed disabled people were 2.3 times more likely to have an unmet health care need due to long waiting lists or due to cost of medical examination or treatment, twice more likely to have an unmet need due to distance or transportation problems, and almost twice more likely to have an unmet need due to cost of dental examination/treatment or due to cost of prescribed medicines. Disabled people with primary education were twice as likely to have an unmet health care need due to distance or transportation problems, and 1.8 times more likely to have an unmet need due to cost of medical exam/treatment and due to cost of prescribed medicine, compared to disabled people with tertiary education. Disabled people in the first income quintile were 2.6 times more likely to have an unmet health care need due to cost of medical examination/treatment, 2.4 times more likely to have an unmet need due to cost of dental examination/

**Table 1.** Comparison of socio-economic and demographic characteristics between people with and without a disability in Greece.

Parameter	Without a disability (n = 2689)		With a disability (n = 2711)		p value	Strength of association
	n	%	n	%		
<i>Gender</i>						
Male (n = 2121)	1168	43.44	953	35.15	p < .0001	Cramer's V = .085
Female (n = 3279)	1521	56.56	1758	64.85		
<i>Age groups</i>						
15–29 (n = 586)	528	19.64	58	2.14	p < .0001	Cramer's V = .613
30–44 (n = 1210)	996	37.04	214	7.89		
45–59 (n = 1260)	775	28.82	485	17.89		
60–79 (n = 1704)	349	12.98	1355	49.98		
80+ (n = 640)	41	1.52	599	22.10		
<i>Urbanisation</i>						
Urban areas (n = 3206)	1840	68.43	1366	50.39	p < .0001	Cramer's V = .203
Semi-urban areas (n = 750)	360	13.39	390	14.39		
Rural areas (n = 1444)	489	18.19	955	35.23		
<i>Regions</i>						
Northern Greece (n = 1827)	901	33.51	926	34.16	p < .0001	Cramer's V = .069
Central Greece (n = 1455)	667	24.80	788	29.07		
Attiki (n = 1426)	786	29.23	640	23.61		
Aegean Islands, Crete (n = 692)	335	12.46	357	13.17		
<i>Civil status</i>						
Not married (n = 1092)	869	32.32	223	8.23	p < .0001	Cramer's V = .392
Married (n = 3090)	1580	58.76	1510	55.70		
Widowed (n = 1218)	240	8.93	978	36.08		
<i>Nationality</i>						
Greek (n = 5236)	2565	95.39	2671	98.52	p < .0001	Cramer's V = -.091
Not Greek (n = 164)	124	4.61	40	1.48		
<i>Employment</i>						
Employed (n = 1652)	1308	48.64	344	12.69	p < .0001	Cramer's V
Unemployed (n = 622)	462	17.18	160	5.90		
Inactive (n = 3126)	919	34.18	2207	81.41		
<i>Education</i>						
Pre-primary and primary (n = 2018)	350	13.02	1668	61.53	p < .0001	Cramer's V = .517
Secondary and post-secondary (n = 2270)	1475	54.85	795	29.32		
Tertiary (n = 1112)	864	32.13	248	9.15		
<i>Health self-assessment</i>						
Bad (n = 703)	4	.15	699	25.78	p < .0001	Cramer's V = .699
Average (n = 1338)	99	3.68	1239	45.70		
Good (n = 3359)	2586	96.17	773	28.51		
<i>Income quintiles</i>						
1st quintile (n = 1104)	588	21.87	516	19.03	p < .0001	Cramer's V = .161
2nd quintile (n = 1090)	496	18.45	594	21.91		
3rd quintile (n = 1124)	427	15.88	697	25.71		
4th quintile (n = 1047)	535	19.90	512	18.89		
5th quintile (n = 1035)	643	23.91	392	14.46		

treatment or due to cost of prescribed medicine, and 1.8 times more likely to have an unmet mental health care need due to cost, compared to disabled people who are in the fourth and fifth quintiles.



**Figure 1.** People with unmet health care needs (%).

**Table 2.** Unmet health care needs between people with and without a disability in Greece unadjusted, partially adjusted (socio-economic effects), and fully adjusted odds ratios.

Parameters	Unadjusted OR (95% C.I.)	Partially adjusted OR (95% C.I.)	Adjusted OR (95% C.I.)
<i>Unmet need due to long waiting list(s) (n = 5327)</i>			
People with a disability	2.86*** (2.44–3.37)	2.68*** (2.21–3.25)	2.09*** (1.65–2.65)
<i>Unmet need due to distance or transportation problems (n = 5400)</i>			
People with a disability	5.63*** (4.42–7.17)	3.10*** (2.34–4.09)	1.90*** (1.34–2.69)
<i>Unmet need due to cost of medical examination or treatment (n = 4536)</i>			
People with a disability	2.66*** (2.26–3.14)	2.66*** (2.18–3.25)	2.01*** (1.57–2.59)
<i>Unmet need due to cost of dental examination or treatment (n = 4645)</i>			
People with a disability	2.10*** (1.81–2.44)	2.11*** (1.75–2.53)	1.84*** (1.46–2.31)
<i>Unmet need due to cost of prescribed medicines (n = 4739)</i>			
People with a disability	3.55*** (2.96–4.25)	3.02*** (2.44–3.74)	2.21*** (1.70–2.88)
<i>Unmet need for mental health care due to cost (n = 2841)</i>			
People with a disability	4.10*** (3.03–5.53)	4.29*** (3.03–6.08)	2.58*** (1.66–4.03)

Reference: People without a disability.

\*\*\* $p < .001$ .

## Discussion

### *The construction of disparities in health care access*

The results show that people with disabilities in Greece report higher unmet health care needs, with cost, transportation and long waiting lists being significant barriers. Unemployment, low income and low education were important predictors of increased barriers to accessing health care. The results support the findings of a recent study which indicated that due to the economic crisis, 60% of chronically ill patients in Greece reported facing serious economic limitations or extended waiting lists in their effort to access health care services (Economou, Kaitelidou, Katsikas, Siskou, & Zafropoulou, 2014b). Low socio-economic status (SES) has been associated with larger barriers in accessing and utilising health care services for the general population (Fiscella & Williams, 2004; Geitona, Zavras, & Kyriopoulos, 2007), and people with disabilities in particular (Rotarou & Sakellariou, 2017a).

Financial crises can affect health equity through both direct (for example, increased cost of health care) and indirect mechanisms (for example, reforms in the labour market or cutbacks in welfare programmes) (Ruckert & Labonté, 2012). Kentikelenis (2017) identified three main pathways through which structural adjustment programmes can affect health: direct effects (for example, cuts in health care



**Table 3.** Selected determinants of unmet health care needs for people with disabilities in Greece, Adjusted odds ratios<sup>§</sup>.

	(1)	(2)	(3)	(4)	(5)	(6)
	OR (95% C.I.)	OR (95% C.I.)	OR (95% C.I.)	OR (95% C.I.)	OR (95% C.I.)	OR (95% C.I.)
<i>Employment</i> (ref.: employed)						
Unemployed	2.34*** (1.46–3.75)	1.97* (1.01–3.84)	2.27** (1.42–3.64)	1.85* (1.16–2.96)	1.87* (1.16–3.00)	1.46 (.71–3.01)
<i>Education</i> (ref.: pre-primary and primary)						
Secondary and post-secondary	.99 (.78–1.28)	.68* (.49–.94)	.94 (.73–1.21)	.75* (.57–.98)	.81 (.63–1.04)	.95 (.64–1.43)
Tertiary	1.02 (.69–1.51)	.50* (.26–.98)	.58* (.37–.91)	.65 (.42–1.02)	.56* (.36–.89)	.97 (.50–1.90)
<i>Income</i> (ref.: 1st quintile)						
2nd quintile	1.60** (1.19–2.16)	1.18 (.84–1.67)	.70* (.52–.93)	.78 (.58–1.05)	.94 (.72–1.24)	.64* (.42–.99)
3rd quintile	1.24 (.92–1.68)	1.23 (.88–1.72)	.58*** (.44–.77)	.70* (.52–.95)	.73* (.55–.96)	.52** (.33–.80)
4th quintile	1.23 (.89–1.70)	1.39 (.96–2.02)	.60*** (.44–.82)	.73 (.52–1.02)	.69* (.51–.94)	.82 (.52–1.31)
5th quintile	.96 (.66–1.39)	.73 (.44–1.21)	.39*** (.27–.57)	.42*** (.28–.62)	.41*** (.28–.61)	.56* (.32–.98)
Observations	2681	2711	2435	2155	2692	1504

Notes: (1) Unmet need due to long waiting list(s); (2) Unmet need due to distance or transportation problems; (3) Unmet need due to cost of medical exam or treatment; (4) Unmet need due to cost of dental examination or treatment; (5) Unmet need due to cost of prescribed medicines; (6) Unmet need for mental health care due to cost.

<sup>§</sup>Adjusted for age, sex and other variables presented in Table 1.

\* $p < .05$ ; \*\* $p < .01$ ; \*\*\* $p < .001$ .

budgets), indirect effects (for instance, scaling back of the public sector), and effects on social determinants (for example, informalisation of labour). These effects can have a disproportionate impact on the most vulnerable parts of the population, including people with disabilities, who have the least protection from health and financial risks.

Access to health care and subsequent unmet needs for people with disabilities are impacted by broader reforms that affect the general population. The combination of increased health care needs due to the presence of disability, the effects of austerity policies and a neoliberal discourse of responsibilisation, whereby access to health becomes a private matter, can lead to increased barriers to health care access for disabled people (see also Rotarou & Sakellariou, 2017a). People with disabilities are also affected by reforms that specifically target them, although not directly their access to health care. One example of this is Law 4387 (2016), stipulating a reduction of national pension proportionate to the severity of impairment.

The results of our study show that cost was generally a severe problem for disabled people, whether for access to general health care, dental care or mental health care. Disabled people have 2.2 higher odds of facing an unmet need due to the cost of prescribed medicines, compared to people with no disabilities. In this study, high cost of prescribed medicines was an issue for 8% of the people without disabilities and for 24% of the people with disabilities. In Greece, people belonging to some groups defined as vulnerable are entitled to free health care, including medication, irrespective of their diagnosis. These categories include disabled people in residential care and disabled people who both require hospitalisation or continued medication and are deemed as having incapacity of over 67%, as confirmed by a medical committee (Law 4368, clause 33, 2016; Ministerial Decree, 25132, clause 3).

The majority of disabled people, however, need to pay a 25% contribution towards the market price of any medication they may need, like the rest of the population (EOPPY, 2017). People who fall within certain diagnostic categories, including Parkinson's disease, myasthenia and Alzheimer's, pay a reduced contribution of 10%, while some other diagnostic categories entitle people to a null contribution; these diagnoses include multiple sclerosis, psychosis, all types of cancer, paraplegia and tetraplegia (Ministerial Decree, 104747). It is not clear how the separation into these two separate categories of reduced and null contribution was decided. Irrespective of category, the

reduced or null contribution only applies to medication prescribed specifically for the diagnosis that leads to the reduction. A person with multiple sclerosis, for example, will pay no contribution for medication prescribed specifically to address multiple sclerosis, but the full contribution of 25% will be required for all other medication.

The results also indicate that people with disabilities have 1.9 higher odds of having an unmet health care need due to distance or transportation problems. Currently, in Greece only people with double lower limb amputation or severe paraplegia (as per medical assessment) are eligible to a mobility benefit (Academic Network of European Disability [ANED], 2017). Therefore, the majority of people with disabilities need to find their own solutions, including private cars, taxis or public transportation, which – apart from the metro system in Athens – is largely inaccessible.

Regarding SES variables, that is, income, employment, and education, our study shows that people with disabilities who belong to a lower SES group have more unmet health care needs than people with disabilities from a higher SES group. Especially in times of economic crises, higher SES can better protect people against health adversities and can act as moderator of recession impacts on health (Kirsch & Ryff, 2016). Low SES contributes significantly to SES differences in health, and mortality, with people of higher SES living longer and having lower rates of most diseases (Charonis et al., 2017; Marmot, 2004). Low SES has also been associated with larger barriers in accessing and utilising health care services for the general population (Fiscella & Williams, 2004; Geitona et al., 2007), and people with disabilities in particular (Rotarou & Sakellariou, 2017a).

Disabled people with lower incomes are more likely to have unmet health care needs than disabled people with higher incomes. Low income is also positively associated with higher use of health services in the public sector, which in Greece, however, experiences shortages in material and human resources, thus leading to high waiting times (Kondilis et al., 2013). Wealthier individuals are generally more able to overcome barriers to health care services, since they can afford to pay for better health insurance (often, private) or make out-of-pocket payments to access health care.

With out-of-pocket expenditure accounting for 35.4% of total health expenditure in 2014, people in Greece are particularly vulnerable to catastrophic out-of-pocket payments (Grigorakis, Floros, Tsangari, & Tsoukatos, 2017). Furthermore, with a 45.3% decrease in total public health spending between 2009 and 2014 (European Observatory on Health Systems & Policies, 2014), one out of six people from low-income groups in Greece reported some unmet health care need due to financial or other reasons in 2013 (OECD, 2015). These findings are particularly worrying considering that data from 2015 indicate that the household poverty risk for disabled people aged 16–64 in Greece is 54.4%, while for non-disabled people it is 36.8 (ANED, 2017).

Unemployment can cause economic barriers but also barriers in access due to waiting lists, since unemployed people cannot access alternative health care services, such as private health care (Kyriopoulos et al., 2014). In Greece, waiting times to receive public health care outpatient services have increased by 200% (Economou et al., 2014b). The latest data on unemployment for disabled people in Greece are from 2011, when only 14.6% of people that had a basic activity difficulty and only 15.5% of people that had a work limitation due to long-standing health problem and/or a basic activity difficulty were employed (Eurostat, 2014). Due to the worsening socio-economic conditions in Greece and the increase in the general unemployment rate since then, it is reasonable to assume that unemployment of disabled people has increased even further. In our sample, only 12.7% of people with disabilities reported being in paid employment.

Perhaps one of the most concerning barriers is that of access to mental health care. Our findings showed that people with a disability were 2.6 times more likely to have an unmet need for mental health care due to cost. This happens in the context of increasing incidence of mental health problems and suicide attempts (Economou et al., 2014a; Simou & Koutsogeorgou, 2014) and funding cuts for mental health care services (Kentikelenis, Karanikolos, Reeves, McKee, & Stuckler, 2014).

## ***Austerity-driven reforms and the construction of long-lasting disadvantage***

De Vogli (2014, p. 5) argues that the financial crisis in Europe has 'produced differential health effects in different socioeconomic groups'. Studies have shown that financial crises and subsequent responses can negatively affect the health of groups that are already facing problems accessing health care services (see for example, Kentikelenis et al., 2015, on the increased infectious disease risks among migrant populations in Europe; and Foscolou et al., 2017, on the increased isolation, smoking, depressive symptoms and adoption of less healthy dietary habits by older people). Due to the global recession and the deterioration of the welfare state, neoliberal regulations are often adopted in the area of health, leading to the loss of the notion that health is a universal right. As such, we have seen the rise of the *health consumer* and of the notion of health as a choice, that is, a matter of personal responsibility (Ayo, 2012).

This individualisation of the right to health has led to a reconceptualisation of 'health care up as a private good for sale rather than a public good paid for with tax dollars' (McGregor, 2001, p. 84). Such notions and practices can have a detrimental effect on the health and access to health care services for groups that are already experiencing difficulties, such as children, the elderly, the poor, women, indigenous groups and people with disabilities. Evidence from Chile (Rotarou & Sakellariou, 2017a, 2017b), the first country where neoliberalism was adopted as the overall policy framework across all sectors, including health care, shows that neoliberal reforms have produced long-lasting, negative effects on health, disproportionately affecting the most vulnerable parts of the population.

Schrecker (2016) used the term *neoliberal epidemics* to refer to the material effects that this economic policy can produce. The impact of such reforms can be particularly severe when not combined with increased support mechanisms. Recent social protection mechanisms designed to ensure access to health care in Greece, such as a health voucher scheme, have not been very successful (Karanikolos & Kentikelenis, 2016). Reasons may include inadequate information regarding eligibility and, more importantly, the fragmented nature of such measures; if, for example, there is no accessible or affordable transportation to enable people with disabilities to even reach a health care facility, schemes such as the health voucher will not benefit the most vulnerable parts of the population.

Reforms currently being planned might lead to greater and long-lasting disadvantage for disabled people in Greece, directly targeting access to health care for this population. A particularly worrying clause is included in a new law, currently in draft form, which will guide the structural reforms in the Greek health care sector in the following years. Clause 9 of the law states that:

Individuals, whose test results at the time of the obligatory antenatal screening, were compatible with adult life incapacity of over 80% (genetic diseases), shall not have the right to health care coverage. (Greek Parliament, 2016)

The ethical and financial implications of the law are disturbing. By conceptualising people with disabilities as unwanted *costly bodies* (Rotarou & Sakellariou, 2017a) who use more health care than what they can pay for, this proposed law could be seen as the expression of a state form of eugenics. In a health care system that undergoes wide-ranging austerity-driven structural reforms, it makes sense to limit health care usage by controlling or excluding access to the system. The proposed law directly excludes people from health care through state intervention regarding which lives are worth to be lived and which are not. This has the potential of leading to either catastrophic out-of-pocket payments or abortions due to inability to make such payments. It is not clear who will be deemed as having an incapacity of 80%, how adult life will be defined, and the extent of the genetic conditions the law may apply to, taking into account progress in diagnostic techniques. Should it be voted in the Greek parliament, the implications of the law could be wide.

The findings of this study make a valuable contribution to the understanding of unmet health care needs for disabled people in Greece in particular, but also for disabled people in other countries facing austerity measures. These needs are 'an indicator of equity and accessibility to health care services' (Zavras et al., 2016, p. 2). This study brings to light the barriers in access to health care for disabled people in Greece leading to unmet health care needs, at a particularly difficult time for the country, when the main determinants of health care access, such as income, are deteriorating. Since disabled people generally have lower socio-economic status due to lower educational attainment and higher

unemployment, leading to lower income, this population can be particularly vulnerable to the effects of the financial crisis and austerity-driven structural reforms in the health care sector (Kyriopoulos et al., 2014).

## Study limitations

One of the limitations of the study is that we cannot make any causal inferences as to the reasons for the observed inequities in access to health care due to the cross-sectional nature of the data. Furthermore, the EHIS relies on self-reporting information, which leaves the instrument open to response bias. For example, self-assessed health is affected by several socio-economic, demographic, psychosocial and behavioural factors (Alexopoulos & Geitona, 2009). Another limitation is the way disability was defined, leading to a very high percentage of people with disability (50%). However, this offers an indication of the people who report both a long-standing condition and limitations. Furthermore, the definition of disability we used corresponds to established conceptualisations of disability (e.g. World Health Organisation, n.d.). Even in the original data-set (before our definition of disability and case-deletion), 55.8% of people answered that they suffer from an illness for at least six months, vs. 44.1% that said that they did not. This could be because in the Greek sample 65.7% of people were above 45 years of age, while 41% above 60. This may be related to the time of day data collection took place, with working-age people not being at home. It may also be related to increased emigration of young skilled Greeks who leave Greece to seek employment elsewhere (Labrianidis & Pratsinakis, 2016).

## Conclusions

This study explored unmet health care needs for people with disabilities in Greece, in the context of austerity reforms in the country. While the nature of the data does not support causal inferences, the findings do provide valuable information as to the current situation. People with disabilities in Greece report higher unmet health care needs compared to non-disabled people, with transportation, cost and long waiting lists being the main barriers; all of the barriers are positively associated with low socio-economic indicators, which are becoming worse in the ongoing financial crisis. This is alarming, as the combination of increased health care needs and lower socio-economic status renders this population particularly vulnerable to health risks.

Social policy measures should be implemented in order to address the extra barriers to health care for vulnerable groups, such as disabled people. Research indicates that 'social policies can decrease the unofficial hurdles towards health care take-up' (Israel, 2016, p. 1). However, successive Greek Governments have not implemented such strategies, in part due to the fiscal restrictions attached to the economic adjustment programmes (Matsaganis, 2013; Matsaganis et al., 2016), which are largely influenced by neoliberal principles and the responsabilisation discourse. Strategies to reduce income inequalities, improve the employment rate of people with disabilities and ensure a decent income are necessary, especially if we bear in mind that disparities in access to health care are largely based on disparities in wider health determinants, for instance, income, employment and education. Policies should also address other barriers that people with disabilities face in accessing health care, such as transportation. The existing Equality Law 3304 (2005) offers explicit protections for people with disabilities only in the area of employment and not more widely in their social participation (National Confederation of Disabled People, 2007). A comprehensive anti-discrimination legislation might help to address some of the barriers people with disabilities face, reduce their unmet health care needs, and protect them from potentially harmful, neoliberal austerity-driven measures implemented in an effort to ensure fiscal austerity.

## Note

1. The relative advantages of listwise deletion and imputation are debated; given that our missing data related to outcome variables only, and deletion left us with a sufficiently sampled data-set, we decided to use listwise deletion.

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