

## THE WELFARE STATE IN GREECE

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With the new enlargement the social situation in the European Union has changed dramatically and new challenges for social policy developments have been generated. Enlargement has raised the European Population reaching the level of more than 451 million European citizens but the GDP increased was only by 4.5%. The social and economic inequalities across the EU Member States are wider and new challenges for policy developments are documented at a National and European Level. There are large differences in living standards and life satisfaction among the European Citizens. In the “old” EU-15 countries around 88% of the population is satisfied with their lives whereas only 65% of the citizens in the New Member states report life satisfaction. The welfare reforms played a significant role in reducing the social risks and improving life expectancy and life satisfaction.

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Throughout the 1980s Greece had been in the phase of regulating the welfare system by introducing important legislative acts. After the reestablishment of democracy in 1974, the social objectives were redefined and new policies were introduced aiming at the expansion of social insurance coverage, improving the access to social services, balancing regional inequalities and reallocating resources towards the needy and the lower income classes. The objective of equity was very well expressed in many legislative acts introduced during the 1980s. However, despite the good intentions of the reformist, neither the public administration machinery, nor the economic climate was supportive for launching large scale social reforms. The civil services was not qualified enough to implement new public management techniques, and there has been a low incentive for productive and efficient utilization of public resources. The lack of qualified public managers in the civil service contributed to limited absorption of the European Structural Funds. Furthermore, in the 1980s, the sluggish economic growth, the high rate of inflation, combined with mismanagement lead to increasing public deficits and economic imbalances. At the same time the government confronted accumulated social demand for health and social reforms. Major reforms were introduced such as the establishment of a National Health Service System (Law Act 1397 in 1983), but these reforms were not accompanied by the necessary public management steps in order to ensure an efficient implementation of the stated objectives.

The 1990s brought a new era of skepticism and rethinking of social objectives. Equity was reconsidered by taking into account efficiency, effectiveness economic growth, and public satisfaction with the anticipated reforms. The party politics within the public sector were criticised and the launching of several privatization schemes were introduced. At the same time the European Commission demanded better utilisation of European Funds and the Government was asked to submit proposals for funding supported by rigorous economic feasibility studies. Hence the period of 1990-1997 is characterized by the introduction of a new concept of public efficiency based on a large scale monitoring and evaluation of the implemented reforms.

Similar developments in the social and economic spheres have been identified in Spain, Portugal and Italy. In the social science literature these developments have often been discussed and analyzed and because of many similarities among these Countries we often make reference to the so called Southern European Welfare Model.

In 2004 the Greek Government signed with the European Commission the Greek National Reform Programme (NRP) emphasizing the key challenges faced on fiscal consolidation, modernization of public administration, enhancing employment, education, innovation, and lifelong learning. The report calls upon Greece to ensure reforms in the areas of the National Health Sector by introducing an information system allowing better quality assessment, cost control

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and increasing use of public private partnerships. In the area of pensions important reforms are expected on early retirement, changing the pay as you go system by introducing a second pillar, and launching more sustainable measures to confront increasing ageing of the population and adequacy pension benefits.

The purpose of this paper is to discuss the evolution of the Greek Welfare system in conjunction with social policy developments in the European Union.

Section 1 presents the evolution of social expenditure in EU and Greece. Emphasis is given to the converging trends which have been witnessed in Greece after 1994. Section 2 focuses on poverty and social exclusion and analyses the relative position of Greece with respect to the rest of the European Member States. Section 3 discuss the organizational structure of the welfare state in Greece and provides a brief overview of the financing and distribution of social insurance expenditures. Section 4 briefly presents the health reforms and section 5 the pension reforms. Finally section 6 critically assesses the welfare policies and reforms launched during the period 1990-2007.

### SOCIAL PROTECTION IN EU AND GREECE

The evolution of social expenditure in the European Union during the last decades presents an irregular path of development. Examining the evolutionary process, we may witness both expansionary and stabilizing trends over time. Overall

the expenditure in social protection as percentage of GDP increased on the average, in all the EU-25 Members States (see diagramme 1). This increase is attributed to several factors:

- To a substantial rise in unemployment benefits.
- To an overall rise in public expenditure
- To supportive trends of economic growth.

The OECD, in its economic report, argued that social policies should not been implemented outside the reality of budget constraints and invited the Member States to:

- Redefine social priorities and social objectives
- Re-examine the evolutionary process of social expenditure
- Introduce more cost effectiveness thinking in order to increase efficiency
- Reallocate responsibilities and actions from the public to the private sector.

On the base of the above proposals the Governments of the European Union introduced several measures to control their social spending. The success in implementing cost –effectiveness in the social sector varies enormously among the European states.

A comparative view of the different paths of development of social expenditure is shown in diagramme 1.

In 2003 the social protection expenditure as percentage of GDP in the EU-25 was highly diverse. Total social spending amounted to 28 per cent of GDP in 2003. (see di-

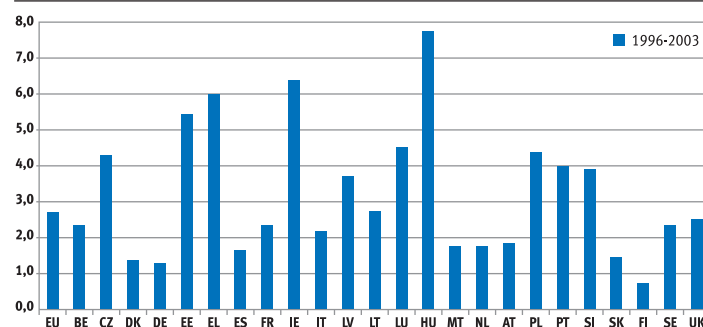
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agramme 2). Italy, Greece and Portugal representing the Southern European block of countries spend relatively less than the average EU-25 on social protection. Luxembourg, Denmark and the rest of Northern European countries, in comparison to Southern Member States, devote a much higher proportion of their GDP to social spending. (See diagramme 2.) Social spending is heavily involved in covering the pensions of the elderly, followed by expenditure on sickness and health care. (see diagramme 3). Large disparities are observed among the EU-25 States in the composition of social expen-

diture. Italy and Greece are among the EU-15 countries with the highest proportion of pensions to social expenditures. These disparities reflect differences in :

- Setting priorities to attain social objectives
- trends in the ageing of the population
- levels of socio-economic development,
- organizational structures between the welfare systems,
- unemployment rates
- effectiveness of the welfare system to accomplish social objectives.

**Diagramme 1** The Evolution of Social Expenditure in EU-25 over the period 1996 - 2003



**Diagramme 2** Percentage of GDP devoted to Social Spending in 2003

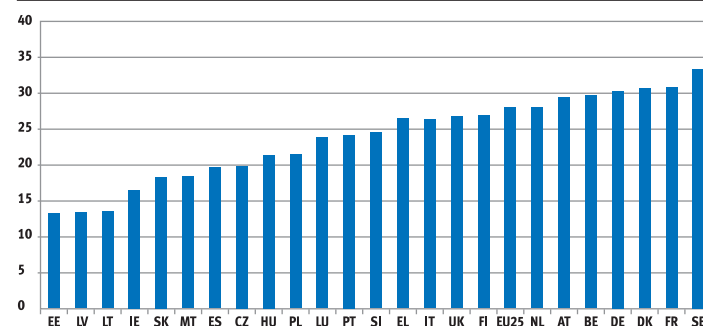
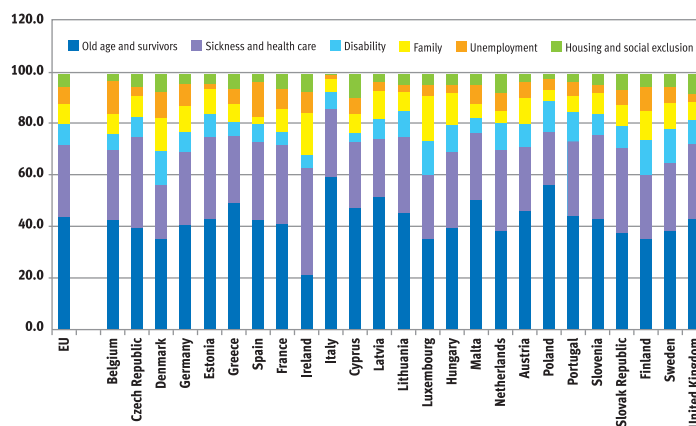


Diagramme 3 The Structure of Social Expenditure in the EU Member States



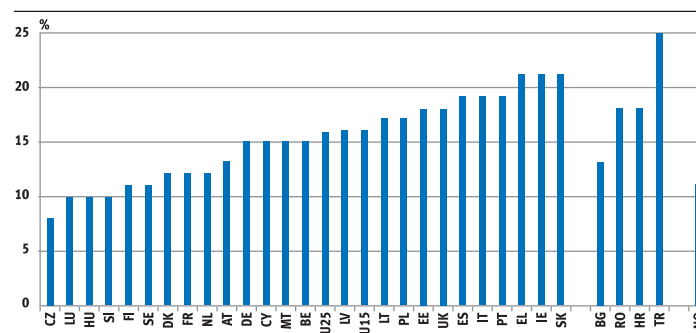
**POVERTY AND SOCIAL EXCLUSION**

The Nice Summit in December 2000, confirmed social policy as an integral part of the overall economic policies of the Union. However despite the good will of the European policy makers, as much as 17% of the European Citizens live below the poverty line defined as 60% of the national median income. (diagramme 4).

The EU social policy model makes extended demand for representative social indicators describing as

much as possible the great differences in the current social situation as well as the dynamic social trends across the EU Member States. At the Laeken Council in 2001, a set of primary and secondary indicators was proposed to measure several dimensions poverty and social exclusion. Income poverty and income inequality, health disparities, educational attainment, unemployment and worklessness were among the proposed indicators. Those who are “at risk of poverty” are defined in purely relative terms as falling

Diagramme 4 Percentage of Persons in Poverty at 60 % Median Equivalised Household Income 2003



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below a percentage of median income. The income threshold used to define the risk of poverty has been fixed at 60% of the national median disposable income per equivalent adult. On average in 2003 according to the Eurostat data 16% of the EC population were at risk of poverty. Poverty varies significantly among the Member States ranging from 24% in Portugal, and 21% in Greece and Ireland, to 10% in the Netherlands and Denmark (11%). These differences may be attributed to economic, political and cultural factors that have contributed to the evolution of the welfare states in Europe. In addition almost all European Countries (except Greece), have developed minimum income schemes to protect EU citizens from poverty and social deprivation. Some Governments, like the northern European and the Scandinavian have developed effective targeted social policies to combat poverty and social exclusion. In Greece, despite the evolution of the welfare services and the implemented reforms in the National Health Service system and the Social Insurance sector, there are some institutional and bureaucratic obstacles which prevent the effective redistribution of resources towards the poor and the socially excluded persons.

Following the proposal of the European Commission, each Member State undertook the responsibility to submit in September 2001, a National Action Plan to fight poverty and social exclusion. The Greek report presented some “stylised facts” indicating the social groups which are at a high risk of poverty and social exclusion:

- The elderly and the very old confront a high risk of poverty. This risk is much higher in Greece in comparison to EU average. In Greece the poverty rate for the age group 65 and above is 33%. The corresponding figure for the EU is 20%.
- The economic position of the pensioners seems to deteriorate up to 1994. Some positive improvements have been realized thereafter.
- Poverty is related to geographical areas and is more apparent in rural areas.
- Unemployment and access to labour market and social services appear to be the major factors contributing to poverty.
- The informal social networks and the “family” as a nucleus of the Greek society still play and important role in preventing poverty and social exclusion.

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The Welfare State in Greece is administered through a complex system of public and private institutions. According to the 2006 Social Budget more than 175 insurance agencies and institutions are functioning, supervised by six different Ministries with a multiplicity of social objectives and an overlapping of services. The Ministry of Employment and Social Protection is responsible for the organisation and administration of social insurance services. There are around 96 insurance agencies supervised by the Ministry of Employ-

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ment and Social Protection. The Ministry of Health and Social Solidarity deals with the primary health centres, the hospitals, the social centres for the children and the elderly as well as the regional distribution of health and welfare services. The Ministry of Defence is supervising 10 insurance units that provide health services and pensions schemes for the army personnel and their dependants.

The Ministry of Agriculture deals with the provision of health care to rural population. The Ministry of Merchant Navy supervises 7 insurance schemes that cover the seamen and their dependants. Finally the Ministry of Finance undertakes the role of financing the above services. In addition to above there are around 56 sickness and pension funds specialised to the provision of supplementary welfare services.

Approximately one hundred of the above institutions provide medical health care benefits and the remaining offer varying forms of pension schemes, unemployment

benefits and other types of insurance.

### Organizational and Administrative Structures

At present the largest insurance units which provide various forms of insurance benefits are the following:

- I.K.A (Institute of Social Insurance) Insurance coverage is provided to urban population-blue and white collared workers)
- O.G.A (Organisation of Agricultural Insurance) The rural population is covered under by a mean test system
- T.E.V.E. TAE (Insurance Fund for Merchants Manufacturers, and small trade Businessmen)
- Civil Servants
- O.T.E (Telecommunications personnel)
- D.E.H (Electricity personnel)
- BANKS' INSURANCE UNITS (Banking personnel)

Table 1 presents the number of direct and indirect insured under each of the above organisations.

**Table 1 Insured Population by Insurance Scheme**

INSURANCE FUND	DIRECTLY INSURED	INDIRECTLY INSURED	TOTAL	% OF TOTAL POPULATION
IKA	3,032,000	2,505,000	5,537,000	50.50%
OGA	1,578,000	452,000	2,030,000	18.50%
O.A.E.E.-TEVE	543,242	814,863	1,358,105	12.40%
O.A.E.E. TAE	156,100	265,300	421,400	3.80%
TSAY	82,000	92,022	174,022	1.60%
TSMED	93,704	58,094	151,798	1.40%
OTE	85,396	78,436	163,832	1.50%
Electricity DEH	58,728	68,041	126,769	1.20%
NAT- BANK	2,141	2,964	5,105	0.50%
<b>Total</b>	<b>5,634,395</b>	<b>4,338,820</b>	<b>9,973,215</b>	<b>100.00</b>
Total population of Greece (census 2001): 10,964,020				

Source: Social Budget 2006

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The majority of the Greek population is covered under IKA (50.35%), OGA (19.6%) and TEVE-TAE (14.3%).

In an attempt to describe the spectrum of services provided by the insurance organisations we portray in table 2 the insurance coverage for outpatient, hospital, pharmaceutical, dental, laboratory and other services.

In Diagramme 5 we present the organizational structure of the Greek Health Insurance Services. We follow the OECD approach to present the interaction between:

- Population
- Central Government
- Social insurance funds
- Private agents

Diagramme 5 describes the complexity of the Greek health services in the financing and delivery side.

Co-ordination is required among the insurance agencies in order to ensure a better organisation in the various insurance schemes, as well as, prevent people from heavy double or triple insurance coverage. As long as the co-ordination



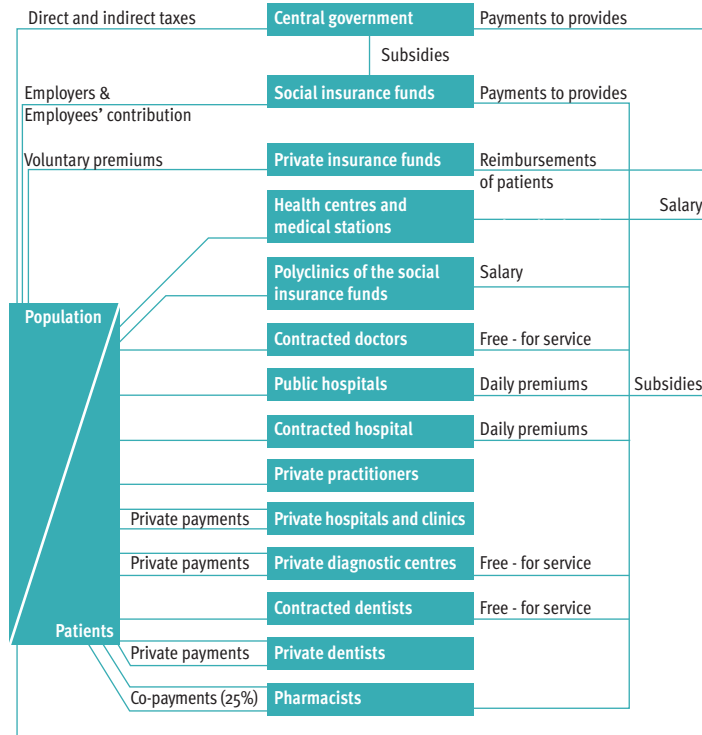
is not achieved, the injustice and the inequalities in the distribution should be done gradually by specifying common objectives and developing synchronised policies. A short-term objective which will be further discussed below is to develop harmonising policies which will lead to gradual integration of O.G.A, I.K.A., T.E.V.E. and other units under a unified insurance system. The cost of social insurance may be reduced due to economies of scale, as well as to possible reductions in the over-utilisation of services. New methods of management should be developed among the insurance agencies in order to control the increasing defect and develop rational cost-containment policies. The different insurance system schemes should be adequately administrated in order to obtain the best cost-benefit ratio.

**Table 2** Spectrum of Services provided by the Insurance Funds

INSURANCE FUND	OUT PATIENT	HOSPITAL	PHARMA-CEUTICAL	DENTAL	LABORATORY	OTHER
IKA	+	+	+	+	+	+
OGA	+	+	+	-	+	+
TEVE	+	+	+	-	+	+
TAE	+	+	+	-	-	+
OTE	+	+	+	+	+	+
DEH	+	+	+	+	+	+
BANKS	+	+	+	+	+	

Source: Social Budget 2006

Diagramme 5 THE GREEK SOCIAL INSURANCE SYSTEM



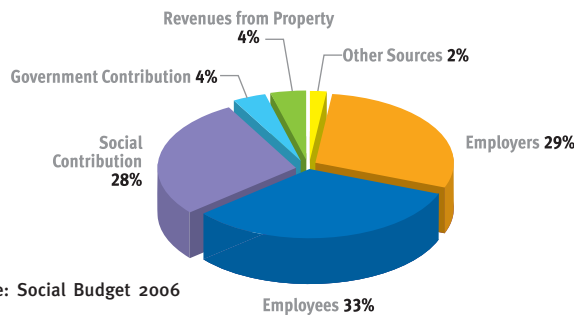
**Financing**

The main source of financing social insurance in Greece is the employers' and employees' contributions. The employers' contributions represent 29% of the total revenues whereas the corresponding figure for employees' contributions

reach a similar level of 33%. (Diagramme 6).

The figures for employees' contributions include the self employed. There are great disparities among the social insurance organisations in their contribution rates. The financing

Diagramme 6 Sources of Social Insurance Revenues 2006



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of IKA, TEVE, OTE, and the Banking insurance units are mainly out of employers and employees contributions. In the case of OGA, the State covers the total Budget through earmarked and community taxation. During the last decade there have been increasing pressures in the financing of social insurance services. The Government could not increase the contribution rates, and at the same time, the cost of social care has been escalating. The result has been the increasing deficits in the major insurance units, which brought a profound impact in the reduction of quality of provided services.

Furthermore, the level of minimum pension benefits were below the poverty limit. However, at the same time a relatively large proportion of people enjoyed pension benefits without fulfilling the age criterion (65 years). It has often been argued that the distribution of social benefits and pensions in particular have been influenced by “political and clientelistic” relationships. Recently, there have several attempts to re-consider the eligibility criteria for providing pensions. Despite the implemented policies, the burden of financing social services is still severe and there is no sign at least in the short run period to combat the deficit.

### **Social Expenditure**

As it was presented above, there are several Ministries involved in the provision of Social Services in Greece. The Ministry of Employment and Social Protection plays the leading role in the provision of benefits (both in cash and in kind), and in budgetary terms, it absorbs the highest percentage accounting more than 81% of the total funds devoted to the social sector. The rest of the

Ministries play a relatively minor role, and the funds devoted to them out of the Social Budget constitute only 13% for the Ministry of Finance, and 6% for the rest of the Ministries. Since the Ministry of Employment and Social Protection is the responsible administrative and political entity for providing social services, it is crucial to further examine the allocation of funds among the major social functions.

Pensions represent one of the largest functions of the modern welfare world. In all Members of the European Union the expenditure on pension are growing exponentially due to the ageing effects. Among all the E.U. Member States, Greece is the only Country with the highest share of social expenditure devoted to Pensions. As much as 66% of the Social budget goes for pensions (see. Diagramme 7). For this reason the Greek welfare system it was often argued that serves mainly one function, that for the elderly, leaving little space for the development of the rest of the Welfare Services.

Sickness is the second function absorbing 23 % of the Social Budget. It should be noted here that several reforms have been undertaken in the health sector which were explored at some length above. Despite the expansion in social coverage since the 1960's after the establishment of OGA, public expenditure on health have not shown a similar growth to those of other European countries which have undergone similar institutional changes. The fact that the expansion in social insurance has not been accompanied by a corresponding increase in public expenditure has resulted in a decline in the quality of services provided.

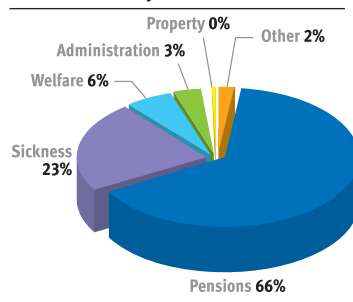
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In Greece, social expenditure have been devoted to various functions and services without taking into account the efficiency and the effectiveness aspects of the system. Very little economic analysis has undergone in the social field and the provision of social benefits is distributed without taking into account the alternative cost benefit options. Any proposal for reform should be accompanied with a detailed feasibility study highlighting the social cost and benefits of the proposed actions.

### HEALTH REFORMS

The Health system in Greece presents the features of the Southern European Models based on the mixture of the principles of Bismark and Beveridge principles. Health care is provided by a three party system i.e: i) the Public sector (NHS), ii) the Insurance Agencies and iii) the private sector. The Ministry of Health and Social Solidarity is responsible for the

**Diagramme 7 Social Expenditure by Function 2006**



Source: Social Budget 2006

overall organization, financing and delivery of health services. The Ministry of Employment and Social Protection finances the services provided by the insurance funds and the

private sector functions on a contracted base with the insurance funds and provides private hospital, consultation and diagnostic services. The health status in Greece in comparison to other European Countries is ranked at a high level with increasing life expectancy and declining infant mortality. The health gains observed over the last four to three decades may be attributed to improvements in living standards, Mediterranean diet, better access to health services and pharmaceutical therapies.

All the European Member States have faced over the last decade increasing demands for more and better quality services. Given the commitment of the European Health models to principles of equity and universality in the access to health services, several reforms have been introduced aiming at cost containment and efficiency in the utilization of services. The European Commission invited the Member States to:

*Contribute to improve the efficiency and effectiveness of health systems so that they achieve their objectives within available resources. To this end, ensure that medical knowledge and technology is used in the most effective way possible and strengthen co-operation between Member States on evaluation of policies and techniques.*

In order to achieve greater efficiency health reforms have been introduced aiming at the regionalisation and decentralization of services. Greater responsibilities have been given to regions to organize their hospitals and general practitioners. Greece has not been an exception to this rule. The legislative act 2889

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passed in March 21 established 17 Regional Health Authorities (PESY). Under this law hospitals and primary care centers have become decentralized units run by professional managers. Each PESY is responsible to develop an operational plan and to device priorities in order to allocate resources efficiently. In March 2004 the Conservative Government came in power and enacted the legislative Act 3329 passed in 4th April 2005. The regionalization of health services was maintained following the previous framework dividing Greece into 17 health regional authorities. (DYPE). Each DYPE is a public independent administrative health region managed by a Director and a health board appointed by the Minister of Health and Social Solidarity.

However, the anticipated control of health expenditure and the expected efficiency gains through regionalisation have not been achieved and in the 9<sup>th</sup> February 2007 a new legislation was enacted reducing the number of Regional Health Authorities (DYPE) from seventeen to seven. The area of Greece is divided into seven health authorities:

- First Health Authority of Attica (including previous DYPE A and B)
- Second Health Authority of Piraeus and Aegean Sea (including previous DYPE of Attica C, Northern Aegean DYPE and Southern A and B DYPES)
- Third Health Authority of Macedonia (including previous DYPE of Western Macedonia and B DYPE of Central Macedonia)
- Fourth Health Authority of Macedonia and Thrace (including previous A Dype of Central Mace-

donia and East-Macedonia Thrace DYPE)

- Fifth Health Authority of Thessaly and Central Greece ( including the previous DYPE of Thessaly and Central Greece)
- Sixth Health Authority of Peloponessos, Ionian Islands, Epirus, and Western Greece (including all the corresponding DYPE of Peloponessos Ionian Islands, Epirus, and Western Greece)
- Seventh Health Authority of Crete (including the previous DYPE of Crete)
- The purpose of reducing the excess number of previous 17 DYPE into 7 is to control the administrative cost, to initiate greater control and transparency over the budget public hospitals and to implement health reforms towards the introduction of the quasi-market philosophy. At the same time new initiatives in the public - private partnership are promoted.

### Public - Private Mix

Greece is undergoing new reforms aiming at the interaction between the public and the private sector within the National Health Service System. In the literature there are various forms of co-operation between the public and the private sector such as contracting out, vouchers, subsidies, grants, and formal agreements. Public Private Partnerships (PPPs) should not be confused with liberalization and privatization of the National Health Services. The reforms towards PPPs implementation arose in many European Countries because of the bureaucratization and the inefficiencies of the public sector to ensure high quality of services to a large

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segment of population at an affordable level of public budgets. Greece is in the process of implementing policies towards to PPPs. The experience of other European Countries, like United Kingdom, Sweden, Spain and Portugal with PPPs would provide valuable information in Greek authorities in implementing health policy reforms. By European standards, Greece is classified among the moderate to high spenders on health services. On the average (E.U.-15), around 9.1 percent of the European GDP goes for health expenditure. The corresponding figure in Greece is 9.5 percent of the GDP. Analyzing the evolutionary process of both public and private expenditure in Greece as percentage of GDP, over the period 1960 to 2005, we may distinguish both expansionary as well as cost containment periods.

In the early 1960s total health care expenditures in Greece were rather low by international standards. In 1970s, a marked increase is observed followed by further marginal increases in the early 1980s. This increase may be attributed to substantial funds devoted for the modernization of public hospital and the establishment of 180 primary health centres. It should be noted that during the 1980s and the first half of 1990s there have been no explicit policies by either Socialist or Conservative Governments to develop cost containment and cost control policies in public spending. The first decade after the introduction of the NHS the explicit goal of both Governments had been to increase public sector involvement in the finance and delivery of health services. The overall objective was to ensure equity at the cost of efficiency. The decade 1990-2005 is characterized by the expansionary

process of private initiatives in the health sector that contributed to further increase of private health expenditure. According to OECD estimates Greece is the only European Country with the greatest segment of private expenditure. At an EU-15 level public expenditure on health represent around 75 percent of the total expenditure. In Greece the corresponding figures amount to only 55 percent (see diagramme 8).

### Pharmaceutical Reforms

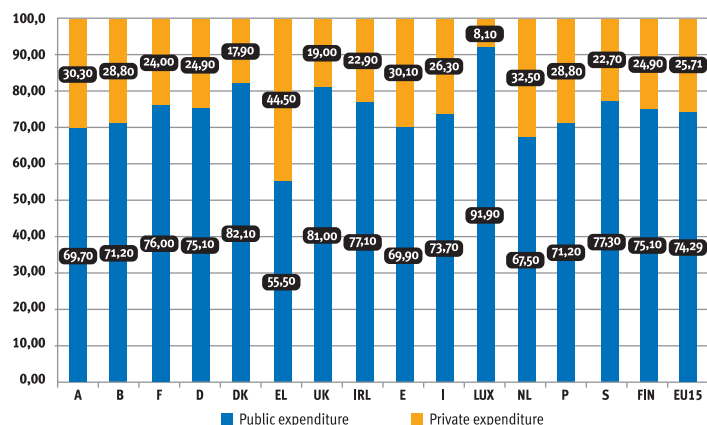
In the Pharmaceutical sector, the legislative act No 3457 was enacted, in May 8th 2006, aiming at a substantial reform of the pricing and reimbursement system. The aim of this legislation is to alter the focus of the pharmaceutical policy in Greece from the negative reimbursement list to a more pioneered method aiming at the control of pharmaceutical expenditure and reimbursement rates. More analytically, the new legislation claims to ensure equity in terms of access to medicines, improvements in citizens' quality of life, effective and efficient utilization of health resources, transparency in public management, protecting public health, and maintaining a long term financial viability of the insurance system. The innovative aspect of the new legislation is the establishment of a rebate system granting the National Insurance Funds a rebate rate paid by the pharmaceutical companies.

### PENSION REFORMS

The Greek Pension System was evolved since 1950s and like the health system is characterised by the historical, cultural, political and economic characteristics of the Southern European or the Mediterranean Welfare states. It is fragmented and it is

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Diagramme 8 Composition of Public and Private Expenditure in the EU –15 Countries

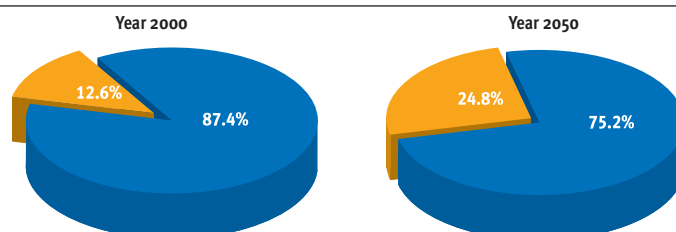


based on the corporatist tradition. The financing and the provision of pension benefits varies enormously among the occupational classes. Pensions are related to formal labour market arrangements and earnings histories. The largest pension insurance fund is IKA (Institute of Social Insurance) providing more than one third of pension benefits to private sector employees. In addition OGA (Organisation of Agricultural Insurance) provides mean tested pensions for the rural population of Greece and for those who have not sufficient earnings profiles to acquire a full pension. Given the lack of a social safety net or any other form of universal coverage, OGA plays the role of a minimum social assistance programme in covering all the elderly (65+ years of

age) in Greece and providing a minimum pension. In 1996, in an attempt to reduce poverty among the elderly, EKAS, a mean tested pension supplement was introduced to cover the needs of the pensioners over 65 years of age. Income and wealth criteria were used to grant EKAS to more than 350.000 pensioners across several insurance funds.

Pensions represent a substantial part of the Greek Social Security System since 66 percent of the Social budget and more than 12 percent of the Gross Domestic Product is devoted to pension benefits. Pensioners are expected to increase from 12.6% of the population at the turn of the century to 24.8% in 2050. (see Diagramme 9). This increase would cre-

Diagramme 9 Percentage of the elderly (65+ years of Age) to total population



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ate a profound impact in the overall macro-economic balance of Greece by raising pension expenditure from 12% of GDP in early 2000 to more than 20% by the year 2020.

In 1992 the legislative act No. 2084 was enacted aiming at the harmonisation of the pension system by introducing common criteria for all labour market entrants since January 1993, regardless of employment status or membership of social security fund. The system introduced the age limit of 65 for both men and women, tripartite financing by the State, the Employers and Employees contributions and maximum replacement rates at 60 per cent for primary and 20 percent for supplementary pensions. The new system was less generous but actuarial studies carried out by independent organisations supported the long term financial feasibility of the proposed pension system. During the 1990s and early 2000s the reform of the pension system became a “hot” political issue and increasing demands for cutting of “the Gordian Knot” of the pension system was proposed by the two major political parties. However the Pay as you Go System (PAYG) is based on an inter-generational solidarity among the age cohorts and is highly influenced by the ageing of the population. It should be noted that in 1974 the ratio of insurance contributors to pensioners was 3.58 (i.e 3.58 insurance contributors could finance the pension of an elderly person). In 2006 this ratio was reduced to 1.74 contributors per pensioner. Striking differences are observed among the insurance funds i.e: in IKA a reduction is calculated in the contributors / pensioner ratio from 4.02 in 1978 to 2.17 in 2005. In OGA the reduction in the ratio is from 2.84 in 1978 to 0.83

in 2005. A strict PAYG system is not financially sustainable in the long run and reforms towards a mixed system of both PAYG and partially funded pension reforms should be introduced. Several studies conducted in Greece have proposed the adoption of either a mixed system or one based on exclusively funded individual accounts. The arguments favour more the idea of a mixed system because of its gradual transition to a more efficient and more equitable provision of benefits ensuring at the same time a long term financial sustainability. In 1997, a “National Social Dialogue” was established between the Government, the Trade Unions, and the Industry dealing with employment and pensions issues without reaching a consensus among the parties. In June 2002 the passage of Law Act No. 3029 introduced new instruments for reforming the pension system and a new philosophy in establishing a second pillar pension schemes based on funded principles. The idea of a mixed pension system is legally reinforced by the passage of Law 3029 in 2002. The implementation of the 2002 pension reform is considered by the International Organisations like OECD and the European Commission as crucial in modernizing the system and strengthening the long term financial sustainability. In the second half of 2000s the Government of New Democracy re-launched the social dialogue and introduced reforms aiming at: i) the unification of the fragmented pension system, ii) increasing employment rates, and iii) fighting tax evasion and curbing social insurance contributions. The implemented measures point out to the right direction for satisfying the needs of the elderly for a sustainable and adequate pension system.