their claims, the latest available data from the Hellenic Centre for Disease Control show that tuberculosis incidence is rising (appendix),[2] including in people of Greek origin.[2] Second, they contend that rising HIV infections are "almost entirely" driven by intravenous drug users; we also noted the importance of this group but also the near tripling of infections without a transmission mode classification between 2010 and 2012, suggesting possible miscoding across other categories. Third, they cite preliminary estimates of suicide rates[3] suggesting that there was a significant decrease in 2012. The official data by the Hellenic Statistical Authority show a 6·5% increase compared with 2011.[4] Fourth, we agree that the important issue is not the magnitude of the cut to health-care spending per se but its effect on health-care access and quality. For example, we have previously noted that budget reductions have been accompanied by a 47% increase in unmet health-care needs. Indeed, in a recent speech in the Greek Parliament,[5] the Minister of Health conceded that between 2 million and 3 million people—ie, 18–27% of the Greek population—now lack health insurance.

Fifth, the authors suggest that childhood poverty did not rise substantially, but overlook Eurostat data revealing that both severe material deprivation rates in children younger than age 6 years and prevalence of households reporting an inability to afford nutritious food for their children more than doubled between 2008 and 2012 (appendix).

Turning to infant mortality rates, we cite WHO data demonstrating that long-term decreases in infant mortality rates reversed in 2009. Fountoulakis and Theodorakis contend that this increase was due to perinatal disorders and congenital malformations. Their observation is surely sufficient justification for concern about access to health services.

Vlachadis and colleagues argue that we used "fragmentary selective measures", and propose comparing the 4 years before crisis with the same period since its onset. However, taking a simple average of crisis years can mask year-to-year changes as socioeconomic conditions have worsened. In their own analysis of the same indicators, they still find that the indicators we used are "temporarily or partly associated with austerity".

Konstantopoulos falsely attributes statements to our team. We agree that the Greek health system suffered inefficiencies before the crisis and called for expanding access to generic medicines. However, as we note, the scale and speed of change made it difficult for hospitals to adapt appropriately to changing circumstances.

Finally, Kontodimopoulos and colleagues question our optimism concerning the health voucher programme and recent collaborations between the Greek Ministry of Health and WHO. At the time of writing, it was too early to ascertain their effects. However, this supports our call to monitor closely the situation of vulnerable groups and the untested policy experiments taking place on the health of the Greek population.

AK was invited, as part of an expert team, to provide technical advice to WHO on the issue of health-care provision to those without insurance in Greece. The other authors declare that they have no competing interests.

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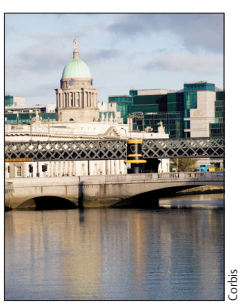
See **Online** for appendix

## The Irish health-care system and austerity: sharing the pain



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As Ireland exits its bailout, the experience of the Irish health system provides valuable insights into the opportunities and pitfalls of managing austerity. Ireland is being held up for prudent adjustment and austerity. Yet 6 years into the crisis, Ireland's economy is only just emerging from its second bout of recession, its debt to GDP ratio stands at about 120%, and its fiscal deficit, although falling, is still above the 3% European Union guideline.[1] It is revealing to sift through the evidence and see how the Irish health system has adjusted to this macroeconomic environment, providing lessons for those who must embrace austerity.

The Irish health system has endured radical resource cuts. From 2009 to 2013 financing of the Health Service Executive fell by 22%, which amounted to almost €3·3 billion less in public funding.[2] Staffing of public services has also fallen by 12 200 whole time equivalents or 10% of total staffing from its peak in 2007.[2] A major concern at the beginning of the crisis was that the Irish health-care system would not be able to sustain cuts and maintain services and quality. Nevertheless, many indicators of performance suggest better outputs with fewer resources. There are now more day cases in the hospital sector, more attendances and admissions at

For the **Eurostat database** see http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database

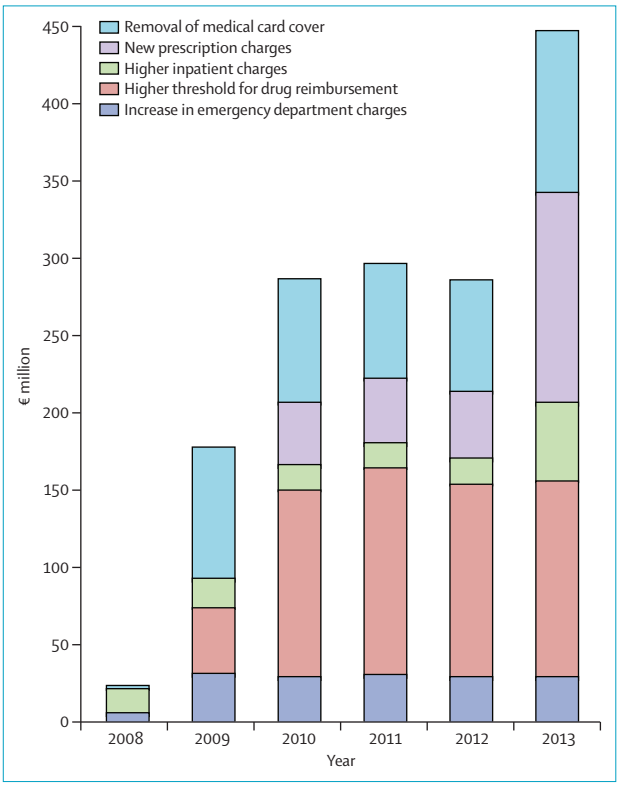


***Figure:*** **Estimates of cost-shifting from the government to households, 2008–13**
We used data from Health Sevice Executive Performance reports,[2,3] Primary Care Reimbursement Services Annual reports, and government budgets.

For the **Primary Care Reimbursement Services Annual reports** see http://www.hse.ie/eng/staff/PCRS/PCRS_Publications/

For the **government budgets** see http://budget.gov.ie/budgets/2013/Documents/Expenditure%20Report%202013%20Part%20I.pdf

emergency departments, and slightly lower average lengths of stay.[3]

Were the only message more productivity and improved efficiency —then a mild and brief austerity programme might be the boot camp needed for a lagging health system. Nevertheless, the prolongation of austerity, coupled with other less appealing adjustment policies, has yielded increased rationing. First, despite increased efficiencies, waiting lists are rising. Whereas, there were some improvements in reducing wait times for elective public hospital care between 2011 and 2012, these were lost in the first 9 months of 2013. Designated numbers of public hospital beds fell by about 900, or around 10%, between 2008 and 2012 and not surprisingly the system is now showing strain. Also other cutbacks in services relate to home-help hours, which are projected to be 18% lower in 2013 than in 2008. This is despite a policy to care for more people in their homes in the community, keeping older and sicker people out of hospitals.

Nevertheless, Ireland has provided substantial financial protection for the worst off in the health sector through the crisis bailout period. More people than ever before have medical cards (which ensures free family doctor and hospital care and medications at low charge) due to higher unemployment rates and decreasing incomes. Yet, there has also been considerable but quiet cost-shifting by government back onto households. Ireland, despite being a tax-based system, had user charges at all levels of care even before the crisis.[4] Now, increasingly the costs of care are being transferred onto patients (figure). Throughout the austerity period, tariffs have risen (in terms of inpatient day charges, emergency department attendance charges, and the introduction and escalation of prescription charges, even for those with medical cards) and eligibility for subsidies has been eroded (the threshold for reimbursement of drug payments has increased) or been revoked for some groups (no longer automatic free care for people older than 70 years). In 2013, such cost-shifting meant that every person in Ireland was on average paying about €100 in additional costs for accessing care and prescribed drugs. More specifically the burden is on sick and old people. All this is happening when the government's policy is to achieve universalisation by extending free access to family doctor care and introducing universal health insurance. Yet that policy, hampered by the recession, is only just beginning with the promise of free family doctor access for children younger than 5 years in 2014.

Austerity has forced the Irish Government to scrutinise all health-care activities and costs. This is not a bad thing. However, the depth of cuts needed means that easy cost-saving measures have now been exhausted. Structural reform is required to manage costs down further, such as moving much of the care for chronic disease out of hospitals and into primary-care settings. Yet this takes time and the governance capacity to do this is absorbed with trying to hold the system together and transition to universal care. Although austerity can produce windfall gains through reducing costs and galvanising change, its benefits dissipate over time. Conversely, the risks of genuine harm increase through loss of entitlements, cutting of services, and increased burden on already struggling households.

We declare that we have no competing interests.

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## Economic recession and maternal and child health in Italy

Greece's dramatic downward trend in livebirth rates has been decribed as a component effect of the ongoing economic crisis.[1] This pattern has been noted in other European countries,[2] especially in Italy—where the recent economic recession has worsened social conditions and further increased unemployment.

Increased poverty and youth unemployment (42·3% of individuals younger than 25 years are