



## **ANED country report on the implementation of policies supporting independent living for disabled people**

**Country:** Greece

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The information contained in this report was compiled by the Academic Network of European Disability experts (ANED) in May 2009.



## **PART 1: EXECUTIVE SUMMARY AND CONCLUSIONS**

The key features of the community support system in Greece for people with disability are financial empowerment through disability benefits and pensions (the earliest intervention), and the provision of state-funded community-based or short-term residential rehabilitation services (L2072/1992). Local support started to appear in the form of small pilot projects with Help at Home in 1997 (L5814/1997), and developed through local social services departments and networks of support centres across the country only after 2003 (L3106/03).

The late development of community-based support, which includes information, counselling, training, after-care rehabilitation and home help services, means that they are not yet fully activated, despite increased investment by the state in comparison with state funding of institutions over the last decade (Social Budget, 2008). The Inspection Body of Health and Social Services (2006) reports that key tasks in various local social services departments have not been carried out, due to lack of staff, while support centres for people with disability have not developed training and independent living programs due to lack of policy on internal regulation.

Importantly, there is lack of data on the population using social services and on local needs, as well as a lack of evaluation of the effectiveness of services even though regional authorities (L3329/2005), as well as the National Observatory of Disabled People (L3106/03) and the Institute for Social Protection and Solidarity (L3370/2005) are legally responsible for this. The omission is a significant barrier in planning effective services from the point of view of the users of services.

There are moreover problems inherent in the system of assessment and service provision, which impede individually tailored and self-directed support. This is most evident in relation to home help programs, the “de-institutionalisation” benefit, and provision of assistive equipment. All of these have a direct impact on daily life activities at home. Common shortcomings are: eligibility criteria are based on diagnosis (a medical model) rather than support needs; access and use depend on available resources (except for the benefit) and they are inadequate in terms of the nature, amount and range of support they offer.

Overall, Greece lags behind in comparison with many European countries in developing independent living schemes based on principles of choice and control over one’s support. There has been a move towards community services but self-directed support is completely absent from discourse in policy and future strategies. Implementation would require a wholesale restructuring of the current system of assessment and provision, moving from the medical model to one that took self-defined support needs into account.



## PART 2: LEGAL AND POLICY CONTEXT

The policy context around community support for disabled people in Greece involves health/rehabilitation service provision and disability benefits/ pensions (which are provided through social security or social welfare for those uninsured); and social support services which only started developing on a local level from 2003 (L. 3106/03).

### **Social Security Legislation:**

Disability benefits were legislated separately for different impairments, starting in chronological order with benefits for blind people (L.1904/1951), people with hearing impairment (Ministerial Decision D3b/423/1973), people with paraplegia and tetraplegia (Ministerial Decision 115750/3006/1981), people with learning disability (Ministerial Decision C4/1930/1982) and people with cerebral palsy (Ministerial Decision C4a/1434/1984). In 1989, a Ministerial Decision made benefits available to all other categories of disability not already covered, and who were regarded as being over 67% disabled. (Please see more details on benefits, in Report for Social Inclusion and Protection). It is worth noting that all benefits, except those given to blind people, require that recipients do not stay in welfare state-funded institutions for longer than 3 months.

In 1998, important modifications were made to the benefit given to people with paraplegia and tetraplegia, (Law 2646/1998) in that support from a third person was included. Eligibility was extended to people with 67% disability, people with paraplegia or tetraplegia or similar, caused by any impairment to nervous and muscular system (previously restricted to paralysis), to people with amputation on any limb (previously restricted to people with double amputation), people with myasthenia and multiple sclerosis, as well as to family members in instances where the entitled person lacked legal capacity. An additional modification made was that only half the amount of the benefit was given to people living in institutional settings.

Disability pensions are legislated for by different social security bodies, who have differing eligibility criteria, mainly in terms of insured working days. The minimum threshold for disability pensions for all social security bodies is 50% disability (as assessed by the health commission of each social security body). Disability pensions of the social security body for private sector employees under the Ministry of Employment and Social Protection are coordinated on the basis of Law 612/1977 and 1902/1990, those of the agricultural social security body under N.2458/1997, and those of public sector employees under Law 2227/1994 and 3620 /2007, which entitles people with disability to a full pension if they have completed 15 years of work.

In 2004, Law 3232 (applicable to all main social security bodies under Ministry of Employment and Social Protection) allowed early retirement for mothers and spouses of people with disability with 80% or over, after 25 working years, regardless of age. The law also established that people with severe disability are entitled to their parent's pension after their death. (Please see more details on provisions and eligibility criteria for disability pensions, in Report for Social Inclusion and Protection)

### **Basic legislation for health and social care services:**

Law 2072/1992 first laid out regulations for establishing centres for institutional and community based rehabilitation service provision to people with disability. Expenses for rehabilitation are covered by social security and social welfare, through contracting with the Ministry of Social Welfare and Social Security (now named Ministry of Health and Social Solidarity).

A further Ministerial Decision in 1998 set out conditions, prerequisites, processes, staff and resources for establishing "Housing for supported living" in the community for people with disability, with view to de-institutionalization and independent living.



A similar move to de-institutionalization has been made in the field of mental health service provision. Law 2716/1999 enabled the creation of long or short term housing and support for children and adults with mental health problems in protected hostels or flats, by either public bodies (including hospitals) or private (profit or non-profit) organizations, It also established regulations for Limited-Liability Social Enterprises.

Law 3106/03 *Readjustment of National System of Social Care and other Regulations* marked for the first time the de-centralization of the Social Welfare system. Regional Systems of Health (founded through Law N 2889/01) now also acquired responsibility for providing local social support services, and for implementing measures for de-institutionalization, rehabilitation and social inclusion of people with disability. The legislation provided indicative examples, such as the creation of residential hostels and flats in the community, as well as the creation of sheltered employment and training centres. Importantly, the Law also foresaw capacity for contracting between local authority and other public, private and non-governmental bodies for the creation of services. In addition, the law created the National Observatory for People with Disability, and set out a research plan with regard to all aspects of disabled people's lives, including employment, education, equal access to services and coordination of policy and practice.

Law 3329/2005 *National System of Health and Social Solidarity and other Regulations* regulates in detail the internal organization, staffing, role and responsibilities of regional health and social care units, with regards to planning and implementing local measures for social protection and inclusion. Social Care units became public sector bodies with their own budgets, regulations and tax numbers. Article 21 and 22 of the law concern services for "de-institutionalization, rehabilitation and social inclusion" of people with disability. These may be provided by public social care units, private bodies or NGO's, subject to further regulations for acquiring a license. Independent living is conceived of again only in terms of community flats, with no more than four residents.

Law 3370/2005 *"Organization and Function of Health Services and Other Regulations"* refined the role of the "National Council of Social Welfare", which was renamed the "Institute for Social Protection and Solidarity". Duties included proposing, developing and implementing measures for social support and protection. Particular responsibilities of the Institute, which reports to the Ministry of Health and Social Solidarity, are to maintain a national record of people with disability who need social services, to support, supervise and coordinate social welfare workers, to develop innovative programs in social support and disseminate best practice, as well as to manage 5% of lottery funds for scientific research in the field of social welfare.

Parallel to the de-centralization of welfare and the creation of local social support services, the "Help at Home" program was increasingly run by municipalities across the country with 3<sup>rd</sup> Community Framework EU co-funding. It was first piloted in two municipalities in Athens in 1997 (Law 5814/1997). "Help at home" was restricted to elderly people (as a separate target group of beneficiaries from disabled people), and it was not until 2006 that it was modified to include people with disability who need help at home. (Ministerial decision 110941/12.4.2006)

In 2008, a new policy for management, evaluation, monitoring and inspection of Help at Home and other social welfare programs allocated national funding for the continuation of the program (Ministerial Decision 60292/2158/ 2008).

Other measures that can be argued to indirectly assist community living through financial relief are: (please note all apply only to people with 67% disability or over):



- Housing loan benefit (1 year)<sup>1</sup>, rent benefit (1 year)<sup>2</sup> and housing adaptations (only for houses older than 20 years old)<sup>3</sup>:all three applicable for disability pensioners only
- Revenue Tax relief<sup>4</sup>
- Motor tax relief<sup>5</sup>
- Free travel within city (buses, underground) and 50% reductions for coach and train travel<sup>6</sup>.
- Social Tourism funding<sup>7</sup>
- Free access to cultural sites<sup>8</sup>

Policies for community support have been planned on the basis of modernisation and de-centralisation of social welfare, with an underlying aim of moving away from institutionalisation and towards local, community-based structures of support. Reference to independent living is more apparent in policies regulating specific programs such as home help and sheltered housing, rather than those reforming social welfare. The issue of individualised and self-directed support does not feature yet in Greek social policy. Overall, although policy shows recognition of disabled people's right to live and participate in the community, it does not necessarily make the leap-conceptually and practically- to recognising that disabled people are competent to organise and control their own support.

"ESAMEA", (National Federation of People with Disability) is a key lobbying disability organisation involved in the development of the policy framework over the last decade.

Established by Law 2430/1996 as an official social partner for disability matters, it submits a detailed yearly report proposing measures for dealing with disability issues. The organisation is representative of the disability movement in Greece, and aims to promote policies that enable full participation of disabled people in social, economic and cultural life ([www.esaea.gr](http://www.esaea.gr)).

In regard to a national plan for de-institutionalisation, in 2005 ESAEA submitted a report, based on research in 2000 in 33 institutions carried out, to the chair of parliament. This report noted persisting issues in institutional care for people with disability, including basic problems of institutional care, isolation and living conditions in institutional settings, and also problems with isolation within one's own home, due to ineffective community support. The authors found that problems recorded in 2000 persisted in 2005, despite programs for de-institutionalisation and funding for the modernization of institutional structures.

<sup>1</sup> Law 2736/99(Official Journal of Government 172A')

<sup>2</sup> Law 1849/89 (Official Journal of Government 113A') and Ministerial Decision 2000 number 50262

<sup>3</sup> Law 2224/94 and N.2736/99

<sup>4</sup> Law 2238/1994 (Official Journal of Government 151A') and L 3522/2006 (O.J.G 276A')

<sup>5</sup> Law 490/1976 (O.J.G. 331A') and L. 3156/03 (O.J.G. 157 A')

<sup>6</sup> Law 2072/92 (O.J.G 125/A')

<sup>7</sup> Law 2224/94

<sup>8</sup> Ministerial Decision E/22240, 2003 (O.J.G. 1705/B')



### **PART 3: PROGRESS TOWARDS INDEPENDENT COMMUNITY LIVING**

Legislation has provided adequate grounds for the development of social support services in the community, particularly with the reformation of the welfare system (L3106/2003), and this is reflected in the steadily increasing regular state expenditure for health and social welfare since 2003 (3,904,791,000€), reaching in 2008 (6,077,537,000€). (General Secretariat of Social Security, Social Budget, 2008)

For 2008, expenditure by the Ministry of Health and Social Solidarity for Social Welfare exclusively (i.e community-based services, institutional care and benefits for those uninsured) reached in total 873,789,000€ in comparison with 714,080,000€ in 2007 (Social Budget 2007).

The bulk of the state budget for Social Welfare is directed to Regional Systems of Health and Social Support, out of which 600,000,000€ was spent in 2008 for health provision and social welfare benefits, compared to 560,000,000€ in 2007. Social welfare institutions absorbed 23,200,000.00€, in 2008 compared with 27,575,000€, in 2007, indicating decreasing investment in institutional settings at a local level.

Direct expenditure by the Ministry of Health and Social Solidarity in 2008 for community-based social services amounted to 89,580,000€, in comparison with funding of 28,420,000€ for welfare institutions. The respective figures for 2007 were 80,101,000€ and 27,575,000€, again showing increased investment in community services, although direct/central state funding for institutions remained at a fairly similar level.

In 2008, the Ministry of Health and Regional Authorities spent a total of 41,895,877€ on institutions for people with disability and elderly people in particular. It is important to note that only 27,12% of the total income of institutions came from state funding. 16,64% came from donations, 17,80% from the institutions' own income, 10,59% from tax, 11,39% from assets, and 16,46% from other sources (unidentified) (Social Budget 2008).

Progress in terms of legislation and investment does not however automatically result in improvements to the lived experience and quality of life of disabled people, in terms of independence, free choice and control over one's life. This depends on the nature, scope and effectiveness of community services provided, and the number of people it reaches. Unfortunately, there is no empirical research to provide this information across municipalities. The State acknowledges that, there is a general failure to evaluate services and to use current social services effectively to further the social participation of disabled people (National Action Plan for Welfare Development 2007-2013).

In particular, there is lack of data regarding:

- recording of the population of disabled people using different social services
- recording of population living in institutions: The European project "Included in Society" (2003) makes some figures available, although these are only indicative, as only 3 out of 16 identified Greek institutions gave data on the number of residents. In total the number of residents was 589, while the number of residents in each institution ranged from 35 to 454.
- recording and understanding of support needs at a local level, rather than impairment per se
- internal and external evaluation of community based social support services
- planning of social support services with involvement of users

In terms of creation and activation of community structures, progress has also been slow in the following respects:



Supported housing/ sheltered flats for independent living in the community have not been developed for people with physical disability (in contrast with progress in mental health and intellectual disability). De-institutionalization in this respect has only involved a few small-scale pilot projects, implemented by large-scale institutions for their own residents (National Strategy Report for Social Protection and Social Inclusion 2008-2010, please see also ANED Greece Country Report regarding Update on National Strategy for Social Protection and Social Inclusion).

By contrast, in the field of mental health (including also groups with intellectual or learning disability) law 2716/99 effected change in the model of service provision from institutions to community- based support units. Between 2003 and 2005, 130 community units were created in the form of hostels, protected flats, day centres and mobile units to support people with mental health as well as people with intellectual or learning disability. Furthermore, within the period 2000 and 2006, 12 limited liability social enterprises were set up, active for instance in selling small craft, gardening, or running a restaurant, constituting therapeutic centres at the same time as providing training/sheltered employment for people with mental health and learning disability.

It is estimated that the above measures benefited 1150 people with mental health problems previously in long term institutions and 1400 people within the community and the quality of service provision was greatly improved. (National Strategy Report for Social Protection and Social Inclusion 2006-2008).

However in November 2008, the National Committee of Ex-Users and Survivors of Psychiatry issued a Press Announcement denouncing these findings, a measure that attracted wide controversy at the time, due to the funding insecurity of the operational program for mental health reform. They maintained that there had been no real reform of models of service provision and that the logic of psychiatric institutions continues to dominate in community-based units. The Committee struggles for legal measures against practice of violence and sedation, real change in the attitudes and treatment of people with mental health problems in the community and for complete user involvement in services on a collective and individual level.

The Network of Social Support and Training Centres (L. 3329/2005) still lack regulation which in many cases translates to under- functioning and under-staffing. The majority of Centres have not been able to develop community-based training and independent living programs, nor build short-term supported flats intended for service users who live far from the Support and Training Centre (Inspection Body for Health and Social Welfare, 2006).

Social support departments of municipalities and regional authorities are found to work at a satisfactory level; however they still face issues in terms of accessibility of buildings and implementation of benefits policy, due to the complexity of the legal context. In many cases under-staffing means that the work of key personnel such as social workers or legal support workers has not developed. In addition, local social departments have failed so far to collect information on local needs that could better inform the planning of services (Inspection Body for Health and Social Welfare, 2006).

Home help programs, have experienced funding insecurity (although now secured with national resources in 2008), and thus have not been able to develop adequately to cover more needs and more population (Inspection Body for Health and Social Welfare, 2006).





## PART 4: TYPES OF SUPPORT FOR INDEPENDENT LIVING IN THE COMMUNITY

Community care (short and long term) mainly consists of provision of local community-based social, training and rehabilitation services and financial support with social security benefits in cash and in kind (assistive equipment).

In relation to accessible housing it is important to note that funding is not available for adaptations / equipment, (such as stair lifts), and for personal assistance (see sections 4.1 and 4.2)

Community-based services that have developed in the last decade in the move away from institutionalisation (L. 2646/1998, L 3106/03), mainly provide support with diagnosis, information and counselling, training, including lifelong learning, sheltered employment programs, day centres and physical rehabilitation services (such as physiotherapy, occupational therapy and speech therapy). These are provided through social support departments of regional/municipal authorities. They include: the “Supportive Social Services Network” (KEKYKAMEA) in 93 municipalities all over Greece, the National Network for the Social Support and Training of people with disabilities (24 across Greece), the National Centre for Social Solidarity (15 structures in Attica and 3 in Thessaloniki) and the After-Care Centres for Physical and Social Rehabilitation (Ministry of Internal Affairs and Decentralisation, 2006). All people with disability are entitled to access and use these services in principle and they are managed by the respective administration at a local level. However, use of services such as day centres or training also depends on availability of resources and the capacity of each service (Ministerial Decision P2b/14957/2001).

Although these services enhance community living and social inclusion, they do not provide support with daily life activities at home. The only exception is the Help at Home program of which there are now almost 1200 all over the country (National Strategy Report for Social Inclusion 2008-2010). However, it is worth noting that the overwhelming majority of beneficiaries are elderly people (seen as a different target group from disabled people). Even though disabled people have also been eligible for home help since 2006, there are basic reasons why this is far from adequate support for independent living:

- Hours of support are decided by the respective social worker of the department on the basis of resources/staff available, rather on the basis of needs assessment.
- Eligibility depends on annual income, meaning that certain groups are excluded altogether (Ministerial Decision 60292/2158/ 2008)
- There is a limited range of tasks that can be performed. These include personal care, housing and shopping. In addition, assistance can only be provided at home, i.e. there is no assistance available for education, work or social activities.
- There is a limit to the amount/ intensity of support performed, due to inadequate resources/ staff availability. Thus, a person with daily support needs with personal care cannot be covered by the program.
- No choice over staff/ hours
- No support is available to family members/ informal carers

In terms of monitoring of community services, law 2920/2001 established the Inspection Body of Health and Social Services under the administration and financial management of the Ministry of Health and Social Solidarity, as an independent inspection unit.

It inspects all central and decentralized agents run under the Ministry of Health and Social Solidarity, all health and social welfare services and structures in regional and municipal municipalities, as well as in the private sector. The Inspection Body came in force in 2002, and since this time two reports have been made available, in 2004 and 2006.





#### 4.1: PERSONAL ASSISTANCE SERVICES

Personal assistance schemes do not feature per se in Greek social policy, in the sense that this has been defined by the independent living movement across Europe (involving choice and control over who provides support; where, how and when assistance is provided). There is no discourse on the role of self-directed support in social policy in independent living, and consequently no provision or planning with regards to individually tailored service provision or direct payments for support with daily life activities within the community. Importantly, the current system of assessment and provision, which is overwhelmingly based on a medical model rather than support needs, impedes the inclusion of personal assistance schemes in the current system of social support.

The only available measures that indirectly enhance the ability of an individual to purchase personal assistance are disability benefits. In only one instance, exclusively for people with physical disability such as/ similar to paraplegia and tetraplegia, this benefit is intended for people who live in the community and who need assistance from a third person. In essence, however, this benefit does not differ from other benefits given to other disability categories, such as people with hearing or sight impairments, learning difficulties and so on, as part of policy programs for financial empowerment of people with disability.

In particular:

- a. The benefit is given exclusively to people with 67% disability or over, with the following impairments: people with paraplegia or tetraplegia, myastheneia, multiple sclerosis, and amputation (either one or more limbs).
- b. The monthly amount of the benefit equals 20 times the daily rate of unskilled worker at any given time, currently standing at 673€ (2009), with a 7% yearly rise from 2008 (629€) and thereafter until 2011, when it is foreseen it will reach 771€ (Ministerial Decision P.3a/18/63731/2008)

The inadequacy of this “de-institutionalization” benefit is due to the following issues:

- The benefit is limited to certain categories of disability, based exclusively on diagnosis rather than support needs
- The benefit is provided at a fixed rate for all eligible individuals, without regard to different levels of need
- The amount of the benefit is inadequate to employ personal assistance for people with high level of needs (minimum wage in Greece is 680,59 €, for 48 hours per week - Eurostat, 2008). In reality, for many people this benefit constitutes their primary source of income and this is insufficient to cover the additional cost of personal assistance.

In any case, benefit policy cannot substitute for a framework of policy measures needed to create the conditions for self-directed support. These would include: legislation and regulations for direct payments based on individualised needs assessment, a network of public services for personal assistance, and the creation of independent living centres for peer support and training of employers, which are altogether lacking in Greece.



## 4.2: ASSISTIVE EQUIPMENT AND ADAPTATIONS

Provision of assistive equipment is managed through social security bodies, which set their own regulations in terms of eligibility, range of equipment and cost ceilings. The following information applies to the two main bodies of social security, that of the public sector, OPAD, ([www.opad.gr](http://www.opad.gr)) and that of the private sector, IKA, run by the Ministry of Employment, ([www.ika.gr](http://www.ika.gr)), which provide the largest range of equipment.

In all cases, social security bodies provide only rehabilitative equipment. Therefore, the cost of assistive equipment such as home adaptations and assistive technology for access to Information and Communication Technology, which are arguably vital for independence and social participation of disabled people, is not covered by the state. The only kind of home adjustment that is covered by all main social security bodies (private, public and agricultural sector) is raised toilet seats.

Equipment for sensory disabilities is limited to basic technical aids, such as hearing aids, speech aids, glasses and walking sticks (provided by all social security bodies). For physical disability, the range of assistive equipment includes:

- a. (Provided by all social security bodies): electric and manual wheelchairs, orthopaedic products, air mattresses and wheelchair cushion for protection against pressure sores, walking aids, artificial body parts/ prosthetics, and expendable medical supplies such as catheters, or ventilators.
- b. (Provided only by IKA and OPAD): electric beds, hoists, physiotherapy bicycles (passive and active exercise), orthostatic equipment, electric stimulators, and commodes.

There are limits to the cost covered for equipment, which vary according to the type. For instance, under IKA (2009), the cost met for a simple, manual wheelchair is 269€, for an enhanced light weight manual wheelchair 1800€, for a child's wheelchair 1743€, while for a simple electric wheelchair it is 3.850€, and 5.810€ for a powered electric wheelchair. In comparison, the social security body for those insured in the public sector provides up to 400€ for a simple manual wheelchair, 1100€ for a light weight manual, and 4000€ for a powered electric wheelchair (OPAD, 2005)

Similarly, eligibility also depends on the type of equipment. For instance, under IKA an electric wheelchair is funded only for people with tetraplegia, and only under specific circumstances in cases of paraplegia (e.g. increased body weight, or a long distance between work and home). OPAD is a bit more flexible with eligibility on the basis of impairment, as people with any neurological condition that causes similar impairment to paraplegia or tetraplegia (with 80% or over disability) are entitled to equipment such as manual or electric wheelchairs. All eligible individuals pay 25% contribution, except in cases of paraplegia and tetraplegia, for whom the social security bodies pay full cost (this applies to both IKA and OPAD).

Despite differences between social security bodies in terms of eligibility, range of equipment and cost ceilings, there are two strands in common. Firstly, social security bodies cover part of the cost of equipment, i.e. provision is in cash, rather than in kind. Therefore, people are free to choose and buy equipment from the private market as it suits their needs and preferences. It also means that there are no restrictions with regards to moving across the country, as equipment is owned by disabled people themselves.



Secondly, the process of assessment is similar in all social security bodies: eligible people require certification of their impairment from two people: a specialised doctor who is contracted with the respective social security body, and a social security doctor or health commissioner designated for provision of equipment. In all cases, the certification of impairment has to be an exact match with the conditions and prerequisites of the social security body. This is the strongest critique against this system of provision; assessment is based on diagnosis, rather than need. For instance, a person with mobility problems but not with complete paraplegia will have to privately fund a wheelchair. The strict medical model used means that many people with mobility problems are excluded and have to bear the extra costs of impairment in living independently in the community.

There are no publicly available figures on the number of people receiving equipment. An approximate estimation could be made from looking at state expenditure. Health-related provision through social security in cash (i.e. equipment) and kind (e.g. physiotherapy, occupational therapy) amounts to 21,91%, in relation to 68,19% for pensions and 6,38% welfare (benefits) (Social Budget 2008).



## **PART 5: EVIDENCE OF GOOD PRACTICE IN THE INVOLVEMENT OF DISABLED PEOPLE**

Evidence of involvement of disabled people in the shaping of matters that directly concern them exists only on a collective level, through the legal role of ESAMEA as social partner for consultation on disability policies. Evidence of individuals' involvement in assessment and use of services, is not available.

Apart from direct consultation to the parliament, ESAMEA is involved with the following organizations:

- Monitoring Commission of the 3<sup>rd</sup> Community Framework program 2000-2006
  - Monitoring Commissions of Central and Regional Operational Programs
  - Special Education Department of the Educational Institute
  - Institute of Social Protection and Solidarity
  - National Council of Administration Reform
  - In primary and secondary Health Commissions of Law 2643/1998 (regarding employment of people with disability in public and private sectors)
  - Managing Boards of Rehabilitation Centres
  - Commissions and Working Groups in Ministries, which are relevant to disability
- ([www.esaea.gr](http://www.esaea.gr))

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Ministerial Decision C4/1930/1982 *Benefit for people with learning disability*

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