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Quality of Long-Term Care in an LTC Outlier: Insights from the Greek Case

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Abstract. Population ageing, within an evolving socioeconomic and technological landscape, has brought renewed attention to the quality of Long-Term Care (LTC), a multidimensional concept encompassing, inter alia, regulatory design, monitoring capacity, service delivery structures, user engagement and workforce conditions. Yet, substantial cross-national variation in the definition and operationalisation of 'LTC quality' – including the absence of any definition in some national legislations – hinders comparative understanding and system-wide improvement. Greece represents a particularly instructive case. Despite having one of the fastest-ageing populations in Europe and the EU's lowest public expenditure on LTC, the LTC sector in this country remains characterised by fragmented governance, minimal public investment, heavy reliance on informal and migrant carers, and the near absence of palliative care, dementia services and quality-assurance mechanisms. Against this background, this exploratory article examines how key stakeholders conceptualise LTC quality, the challenges they identify, and the pathways they consider necessary for improvement.

Drawing on 15 semi-structured interviews with academics/LTC policy experts, public officials, senior administrators/managers of LTC units, as well as formal and informal carers, the qualitative thematic analysis utilised identifies six interlinked themes: conceptual ambiguities and legislative gaps; the absence of comprehensive quality standards; data deficiencies and weak monitoring infrastructures; minimal quality-assurance mechanisms; limited user involvement and persistent unmet needs; and workforce constraints that undermine LTC quality. These themes cluster around the three dimensions that dominate international debates on LTC quality: conceptual and regulatory foundations; monitoring and accountability; and care experience and delivery.

The findings reveal severe weaknesses but also highlight opportunities for reform, including the establishment of measurable quality standards, development of interoperable data systems, and construction of a coherent quality-assurance architecture. The analysis ultimately suggests that improving LTC quality requires not only a legislative reform, but also sustained political commitment, meaningful stakeholder engagement and everyday practices grounded in the lived realities of care.

Keywords: LTC, LTC quality, Greece, ageing and demographic changes, welfare state sustainability.

Introduction

Amid profound demographic, socioeconomic, and technological change, including the rapid acceleration of population ageing – *Long-Term Care* (LTC), encompassing services for individuals requiring assistance with activities of daily living and/or ongoing

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nursing care, with the aim of enabling those experiencing, or at a risk of, significant loss of intrinsic capacity to retain functional ability – has risen on both supranational and national policy agendas (Thissen & Mach, 2023; World Health Organization [WHO], 2024a). Within this evolving landscape, viewed in conjunction with the effects of the COVID-19 pandemic, which exposed preventable mortality in LTC settings and drew attention to long-standing deficiencies across quality dimensions (Arlotti & Neri, 2023; Estévez-Abe & Ranci, 2024), the term 'LTC quality' has gained increasing prominence.

That said, given cross-national variation in LTC definitions, the meaning and operationalisation of 'LTC quality' also differ considerably, with some national legislations offering no definition at all. Yet, the WHO conceptualises LTC quality as equitable, person-centred care which respects user preferences and diverse needs, while advancing outcomes consistent with human rights, autonomy, safety, and dignity for both users and workers (WHO, 2024a). It should be noted that this broad framing has expanded scholarly attention to under-examined LTC dimensions, including user engagement, systematic needs assessment, and working conditions of both formal and informal carers, as well as to the contribution of informal care relationships to the sustainability of LTC systems (Ghailani, Peña-Casas, & Spasova, 2024). International research consistently identifies moreover three broad sets of factors deemed to undermine what may be perceived as LTC quality: weaknesses in conceptual and regulatory foundations, including unclear definitions and fragmented legislation (Gonzalez-Aquines et al., 2024); deficiencies in monitoring and accountability mechanisms, including limited data, inadequate indicators, and weak oversight (WHO, 2024a; European Commission, 2024); and care-delivery-level pressures, such as insufficient user engagement, unmet needs, workforce shortages, poor working conditions, and heavy reliance on informal and migrant care (OECD, 2023; European Commission, 2025).

This article seeks to contribute to the relevant literature by examining Greece – a country widely recognised as an LTC outlier and a country where policy development remains, inter alia, highly underfunded and fragmented (Kasimatis, 2022; Xiarchi et al., 2024). Illustrative of the exceptional nature of the Greek case is the fact that, whereas, by 2050, Greece is expected to have the EU's second-highest old-age dependency ratio (62.6%)[1], in 2023, public LTC expenditure stood at 0.16% of GDP, i.e., it was the lowest in the EU-27 and well below the EU average of 1.71%[2]. The LTC system in Greece lacks infrastructures capable of ensuring universal coverage, whereas services remain narrowly targeted and shaped by prevailing financing mechanisms. Publicly available provision is largely limited to home- and community-based services, supplemented by comparatively few publicly funded residential facilities (Tinios, 2017). System limitations are compounded by the near absence of palliative care and dementia services and by comparatively low LTC bed availability (OECD, 2023; WHO, 2024b). Minimal public investment has entrenched reliance on unpaid family support in the provision of LTC

[1] https://ec.europa.eu/eurostat/databrowser/view/proj_19ndbi/default/table?lang=en.
[2] https://ec.europa.eu/eurostat/databrowser/view/tps00214__custom_15068507/default/table?lang=en.

services and on migrant domestic carers working outside formal regulatory frameworks. Around 34% of the population, i.e., more than 3.6 million people, are estimated to engage in caregiving[3].

Furthermore, the number of actors involved in the LTC field is a sign of high fragmentation. Established in 2023, the Ministry of Social Cohesion and Family Affairs holds primary responsibility for LTC, while the Ministry of Health oversees LTC services with health and nursing components. Prefectures license residential providers, and municipalities deliver a wide range of services, though with considerable local variation. At the same time, private provision, especially in residential care, remains insufficient to meet the growing demand, and for-profit, non-profit, and Church-affiliated providers coexist within a heterogeneous, unevenly regulated environment (WHO, 2024b). Overall, the Greek LTC model is therefore best characterised as 'mixed', combining public and private provision with a persistent centrality of family care (Tinios, 2017).

Segmented governance and extensive reliance on informal care, amid workforce shortages and low pay in the case of formal carers (Tinios, Valvis, & Georgiadis, 2022), are amongst the features underscored in the relevant literature, whereas 'quality' considerations – with only limited exceptions (Stavropoulou et al., 2022) – have been largely absent from the Greek LTC policy landscape, until recently. However, within a context of LTC reforms that places quality-related factors at the forefront, ranging from service expansion in Bulgaria to Italy's legislated nominal increases in public LTC expenditure (European Commission, 2024), Greece has recently begun to take steps in a similar direction. Milestones are the 2024 National Strategic Framework for LTC, accompanied by a nationwide sector mapping (Ministry of Social Cohesion and Family Affairs, 2024), as well as the 2025 launch by the Ministry of Health – in collaboration with WHO and the Agency for Quality Assurance in Health S.A., a governmental agency under the Ministry of Health, established in 2020 (ODIPY) – of the First National Strategy for Quality of Care and Patient Safety 2025–2030. These developments may signal movement toward system transformation, though their effectiveness depends on implementation.

Against this background, this exploratory article examines how key stakeholders in Greece conceptualise LTC quality, a concept which is increasingly recognised as emerging from the interaction of regulatory design, monitoring capacity, service delivery structures, user engagement, and workforce conditions (WHO, 2024a); as well as what factors they identify as enabling or constraining the achievement of high-quality LTC, and how challenges might be addressed. Hence, the article arguably sheds light on underlying 'inputs' that enable or constrain LTC quality rather than 'outputs' in the form of measurable care outcomes. Following this short introduction, the next section outlines the methodology used, the third section presents the findings, and the fourth section discusses these findings and concludes on the key points of this paper.

[3] https://eurocarers.org/country-profiles/greece/.

Methodology

This article draws on empirical findings from 15 semi-structured interviews conducted between September and November 2024 with key stakeholders in the Greek LTC sector. Participant recruitment followed purposeful sampling, which is a well-established qualitative approach designed to identify information-rich cases relevant to the research questions (Stratton, 2024), with participants selected on the basis of their professional expertise, role in the LTC sector, and direct, hands-on experience in care provision across a range of settings, as well as policy involvement. Participants were invited to participate via e-mail. Additionally, the article was informed by literature on the interplay between governance structures, user experiences and workforce conditions which emphasises the need to integrate diverse institutional and professional perspectives (Leichsenring, Billings, & Nies, 2013; Damant et al., 2023).

The following table (Table 1) presents the main characteristics of the research participants, who are identified by using anonymised codes reflecting their professional role:

Table 1. **Main characteristics of the research participants**

Code	Category	Description	Gender	Region
AC1	Academic / LTC policy expert	Academic / LTC policy expert	Female	Athens (the capital of Greece)
AC2	Academic / LTC policy expert	Academic / LTC policy expert	Male	Athens
AC3	Academic / LTC policy expert	Academic / LTC policy expert	Female	Athens
N1	Nurse	Nurse in an intensive care unit in a public hospital	Female	Athens
N2	Nurse	Nurse in a public hospital, also volunteering in a Church-affiliated elderly care unit	Female	Athens
N3	Nurse	Nurse in ‘Help at Home’ programme, i.e., the largest community-based LTC programme in Greece	Male	Attica (i.e., the region encompassing the Athens metropolitan area)
SW1	Social worker	Social worker in ‘Help at Home’ programme	Female	Central Macedonia (in Northern Greece)
SW2	Social worker	Social worker in Department of Social Solidarity, also serving as a social consultant inspecting LTC facilities	Female	Eastern Macedonia and Thrace (in the Northeast of the country)

Code	Category	Description	Gender	Region
MO1	Municipal official	Head of department at an 'Open Care Centre for the Elderly' (KAPI)	Female	Attica
GO1	Government official	Representative from the Ministry of the Interior	Female	Athens
M1	Manager	Senior administrator/manager in elderly care units	Male	Athens
M2	Manager	Senior administrator/manager in Alzheimer units	Male	Athens
IC1	Informal carer	54-year-old woman caring for her partner with dementia symptoms	Female	Athens
IC2	Informal carer	65-year-old woman caring for a friend's mother	Female	Attica
IC3	Informal carer	59-year-old woman from the former Soviet Union caring for a 90-year-old woman with dementia	Female	Athens

Data were collected through a semi-structured interview guide designed by the author, which allowed the interviewees to articulate their experiences freely, while ensuring systematic exploration of the core topics. The guide covered three broad domains: understandings of the LTC quality and relevant legislation; perceived challenges to achieving high-quality LTC; and proposals for improvement. Examples of questions included: "How do you understand the concept of LTC quality?"; "Are you aware of any legislation on quality assurance in LTC?"; and "Where do you believe the most significant problems lie, and why?" Follow-up prompts were used to encourage elaboration.

The participants[4] were informed that their anonymity would be rigorously protected. Interviews lasted 45–90 minutes, were audio-recorded, and were transcribed verbatim by the author. Most interviews were conducted online, with a small number carried out face-to-face. Coding was undertaken manually, following a thematic approach. That said, qualitative thematic analysis was used to identify recurring patterns and organise them into coherent analytical themes. Although broadly aligned with major themes dominating the relevant literature – such as conceptual clarity (Gonzalez-Aquines et al., 2024), regulatory oversight (Thissen & Mach, 2023), data and monitoring systems (WHO, 2024a), user involvement (Hutchinson et al., 2023), and workforce determinants (OECD, 2023; European Commission, 2025) – which is consistent with qualitative exploratory designs – the analytical themes presented in the *Findings* section were not predetermined. They emerged inductively from interview data and were subsequently inter-

[4] No participants declined to take part in the study. Furthermore, it should be noted that, in accordance with Greek legislation, formal ethical approval is required only in specific cases and was therefore not necessary for the present study.

preted in dialogue with the broader literature (Braun & Clarke, 2021). That said, during the analysis, the six inductively derived themes (conceptual ambiguities and legislative gaps regarding LTC quality; absence of comprehensive quality standards and a coherent regulatory framework; data deficiencies and the development of indicators and data systems for quality monitoring; minimal quality assurance mechanisms; limited user involvement and persistent unmet needs as barriers to LTC quality; workforce-related factors undermining LTC quality) were found to cluster around three overarching dimensions widely highlighted in the relevant literature: conceptual and regulatory foundations; system-level monitoring and accountability mechanisms; and care experience and delivery factors (OECD, 2023; Gonzalez-Aquines et al., 2024; WHO, 2024a). However, for the sake of analytical clarity, the six themes are presented separately in the *Findings* section.

Findings

Conceptual Ambiguities and Legislative Gaps Regarding LTC Quality

The interviewees articulated diverse – and at times overlapping – understandings of what constitutes LTC quality, as this is reflected in the broad range of factors identified as key components of quality, including staff working conditions and the overall well-being and quality of life of care users. Furthermore, among the interviewees, academics/LTC policy experts, public administration officials and senior administrators/managers of LTC units demonstrated the clearest understanding of the legislation governing the LTC sector, while simultaneously acknowledging that the legislative framework regulating LTC in Greece does not provide an explicit definition of 'LTC quality'. As one policy expert (AC3) observed, *'the problem begins from the fact that even LTC is not clearly identified in the legislation, let alone LTC quality and core principles commonly associated with the concept of quality in the relevant literature and policy reports, such as equity, integration, person-centredness, safety, efficiency, and timeliness'*. This legislative 'silence' was broadly acknowledged to further complicate efforts to articulate and operationalise the already multidimensional nature of LTC quality, making it more vulnerable to subjective interpretation and, ultimately, undermining 'quality' per se.

Against this backdrop, the interviewees unanimously stressed the need to adopt a clear, operational definition of LTC quality, beginning with a precise delineation of what constitutes LTC itself, which is also perceived as being absent from the Greek legislation. Most interviewees – especially academics/LTC policy experts and senior administrators/managers of LTC units – also emphasised that this process should be informed by international standards and practices. As one of the managers of LTC units (M2) noted, *'drawing on frameworks developed by the WHO and European institutions, while also incorporating the perspectives of a broad range of stakeholders involved in care provision, policymaking, and service use, is the only and the right way to proceed'*.

Absence of Comprehensive Quality Standards and a Coherent Regulatory Framework

The majority of interviewees agreed that the absence of comprehensive quality standards for LTC – irrespective, moreover, of different care settings or service types – in conjunction with the lack of agreed-upon statements defining what constitutes high-quality care, enshrined in guidelines, legislation, or other regulatory frameworks, are factors posing severe obstacles to the pursuit of LTC quality. As one social worker involved in the inspection of LTC units (SW2) explained, *'the absence of comprehensive quality standards and a coherent regulatory framework in LTC in Greece should be viewed alongside the fact that regulatory oversight is largely confined to ensuring compliance with minimum operational requirements... these primarily concern technical and structural specifications such as facility size and staff composition, and much less issues such as appropriate medication management and the provision of adequate nutrition'*. The interviews, on top of that, indicated that these regulatory provisions – frequently neglected in practice – are dispersed across multiple legislative sources and vary according to the facility type and ownership.

Within this context, all interviewees highlighted the urgency of establishing a comprehensive and substantive set of quality standards, extending beyond compliance with the minimum operational requirements. These standards, they argued, should encompass a wide range of quality dimensions, with an emphasis on user safety, effectiveness (including cost-efficiency), accessibility, availability, and person- and need-centred care. Several interviewees – particularly academics/LTC policy experts – also underscored the importance of linking compliance with such standards to the allocation of state funding for LTC, especially for not-for-profit providers. In the words of one of the managers of LTC units (M1) interviewed, *'the absence of a mechanism for this purpose has exacerbated disparities between for-profit and not-for-profit actors within the Greek LTC sector. In my view, LTC providers failing to meet established quality benchmarks should be rendered ineligible for reimbursement by the National Organisation for the Provision of Health Services (EOPYY)'*. At the same time, interviewees – particularly those managing LTC units – stressed that any quality standards introduced must be realistic and therefore tailored to the institutional and resource constraints faced by LTC providers.

Data Deficiencies and the Development of Indicators and Data Systems for Quality Monitoring

During the interviews, data deficiencies and the essential absence of LTC monitoring were consistently identified as additional major obstacles to any pursuit of 'quality' in LTC. All interviewees agreed that data collection – even in the case of what they viewed as 'basic' indicators, such as the number and characteristics of individuals requiring or receiving LTC or the incidence of pressure ulcers – remains fragmented, unsystematic, and highly variable across providers. A notable illustration is the prevailing situation in

the community-based '*Help at Home*' programme. According to the nurses and social workers interviewed, who were directly involved in the programme, data collection and the application of care protocols depend largely on the discretion of local administrative authorities and frontline professionals. As one social worker (SW1) remarked, *'annual performance reports submitted to prefectures and municipalities vary substantially in content and level of detail… such limitations render the available data unfit for meaningful quality monitoring'*.

These weaknesses need to be considered alongside significant gaps in data on privately delivered LTC services. As one of the senior administrators/managers of LTC units (M1) explained, *'the Hellenic Statistical Authority (broadly known as ELSTAT) restricts its data collection to public providers, thereby excluding a considerable share of LTC actors… There is also continued reliance on paper-based records by many providers, which further undermines efforts toward data standardisation… which should be viewed alongside the fact that interoperability between health information systems and the LTC system is either severely constrained or entirely absent. Overall, these deficiencies pose substantial barriers to the systematic assessment of service performance and impede the implementation of evidence-informed improvements… posing, moreover, severe obstacles to any pursuit of 'quality"*.

In light of these challenges, the interviewees underscored the need for a systematic approach to data collection as an inextricable part of building strong foundations for LTC quality. Their recommendations included leveraging existing administrative infrastructures – such as the national social security registry (broadly known as AMKA) – to track LTC beneficiaries, and cautiously incorporating data from a wide range of providers, including community centres and local social services. However, these efforts, they argued, should be supported by a centralised and interoperable data system capable of linking LTC and healthcare services. Additionally, some interviewees – particularly academics/LTC policy experts – stressed the importance of expanding data collection to under-researched domains such as palliative care, as well as to informal carers. In the words of one of the policy experts (AC2) interviewed *'the contributions of informal carers are central to the LTC system… yet they are typically omitted from national household surveys'*. This latter recommendation aligns with the complaints voiced by all the informal carers interviewed, who noted that they feel invisible to the system.

Finally, most interviewees emphasised the need to introduce mandatory LTC quality monitoring, initially through the development of a small core set of 'quality' indicators. As one policy expert stated (AC1), *'these indicators should be context-sensitive and appropriately weighted to account for variables such as age, health status, and the type of LTC service provided… and should gradually evolve into a comprehensive and robust quality monitoring framework… otherwise the quest of quality in LTC will remain an illusion'*.

Minimal Quality Assurance Mechanisms

All interviewees agreed that the absence of a national authority with an explicit mandate to oversee quality in the LTC sector severely undermines any effort to pursue quality LTC. As one policy expert (AC1) explained, *'the ODIPY, which operates under the Ministry of Health and is partly modelled on the United Kingdom's Care Quality Commission, is responsible for monitoring the quality of publicly provided and publicly funded healthcare services – including primary and hospital care, as well as private providers contracted by the EOPYY. However, ODIPY's mandate does not extend to LTC services, even in cases where medical care constitutes a core component of those services'*. Another policy expert (AC2) added that *'ODIPY may lack the institutional and financial capacity to address the specific requirements of the LTC sector'*.

Regarding current inspection practices in residential LTC facilities – aimed at ensuring compliance with the limited (and frequently violated) operational requirements set out in legislation (e.g., square footage per resident, staff-to-resident ratios, basic nutritional guidelines) – the interviewees unanimously agreed that these practices bear little relation to quality assurance. The capacity to evaluate and ensure high-quality LTC provision beyond mere compliance remains severely limited. This challenge is compounded by the chronic understaffing of the social services departments of the prefectures, which are responsible for inspections. As one of the social workers interviewed (SW2) explained, *'Responsibility for verifying compliance lies with the social services departments which conduct routine biannual inspections supplemented by ad hoc visits when necessary. These inspections are typically carried out by designated "social consultants" (usually qualified social workers), who submit written reports based on their observations. However, the lack of personnel often leads to the temporary reassignment of staff from unrelated agencies to conduct inspections – a practice that undermines the inspection process and, apparently, the LTC quality'*.

Interviewees involved in managing LTC units also observed that the current system provides minimal – if any – incentives for continuous quality improvement. Against this backdrop, all interviewees emphasised the need to develop and institutionalise a robust, comprehensive quality assurance framework, applicable to all LTC programmes and facilities. Such a framework, they argued, should include mechanisms for systematic coordination, monitoring, and evaluation.

Limited User Involvement and Persistent Unmet Needs as Barriers to LTC Quality

The interviews indicated that user engagement and needs assessment are perceived as crucial foundations for LTC quality. Instead, both remain extremely underdeveloped, if not entirely absent. As one nurse (N2) remarked, '*LTC users are not involved in the planning, monitoring, or evaluation of the services they receive, nor are their preferences and expectations – or those of their families – integrated into the service design and imple-*

mentation'. Similarly, as one policy expert (AC2) noted, *'Needs assessment, understood as the formal evaluation of an individual's care requirements arising from functional decline – whether due to mental and/or physical conditions – combined with personal preferences, values, and socioeconomic circumstances, as measured against formally recognised eligibility criteria, is absent… essentially there is no standardised process for assessing individual care needs and determining eligibility for LTC services'.* These deficiencies raise serious concerns, also because, as all interviewees agreed, the demand significantly exceeds the system's current capacity, especially in cases involving neuropsychiatric conditions such as dementia or the need for palliative care. As noted by an informal carer providing care to her partner with dementia (IF1), *'the state has recently introduced a Personal Assistant programme aimed at supporting individuals with substantial care needs. However, the programme remains in a pilot phase and is not yet widely accessible'*.

Furthermore, the interviews indicated that even when services are available, the users' needs are not necessarily met in a consistent, timely, or adequate manner. The '*Help at Home*' programme is a telling example. As a nurse employed in this community-based programme (N3) explained, *'Help at Home operates only during weekday daytime hours, leaving significant gaps in service coverage during evenings and weekends. As a result, programme users – largely older adults and persons with disabilities – are often left with no alternative but to rely on arrangements outside the scope of the formal LTC system. These may include support from family members, neighbours, or privately paid carers during non-operational hours'.*

In light of these shortcomings, the interviewees emphasised the need for changes targeted at strengthening user engagement and addressing unmet needs in the LTC system. That said, a key recommendation concerned the development of a comprehensive and systematic framework for identifying and categorising user needs, based on criteria such as age, medical condition, and the level of dependency. Even the government and municipal officials (GO1 and MO1) interviewed acknowledged that the complexity and breadth of LTC needs may warrant greater involvement of the private sector – particularly compared with other areas of social protection. Yet, as the government official (GO1) remarked, *'such expansion must be accompanied by robust regulatory oversight to safeguard quality in service provision'.*

Workforce-Related Factors Undermining the LTC Quality

Recognising the critical role of workforce-related factors in determining LTC quality, most interviewees identified deficiencies in the education, training, and skills of care workers –particularly those employed in not-for-profit facilities – as a key obstacle to quality. One striking example, mentioned by an interviewee with extensive experience as a nurse in both health and LTC units, concerned an LTC facility affiliated with the Greek Orthodox Church. As she (N2) observed, *'In the LTC facility where I volunteer, caregiving responsibilities had been assigned to a cleaner and a cook'*. Although interviewees

agreed on the need for updated training in clinical guidelines, care techniques, and condition-specific protocols for formal carers, deficiencies in education, training, and skills were perceived as significantly more pronounced among informal carers – who are often family members. As one nurse (N3) explained, *'The absence of structured training for this group is severely impairing their ability to provide appropriate and effective care to individuals with complex needs, while also raising concerns about user safety and care quality more broadly'.* That said, only one of the informal carers interviewed had relevant technical training, acquired as a nurse in the former Soviet Union and Greece since the early 1990s.

In addition, the interviewees – particularly the senior administrators/managers of LTC units interviewed – expressed concern about the disproportionate reliance of Greece on informal carers and the predominance of family-based care, especially compared with other European countries. As one of the managers interviewed (M1) noted, *'In cases where informal carers are not family members, they are frequently foreign nationals with limited proficiency in Greek – which is an obstacle to effective communication and the development of meaningful relationships with care recipients. In addition, these individuals typically lack formal certification and fall outside recognised professional labour frameworks, leaving them without clear employment rights. Within this context, talking about quality does not sound very realistic'.*

The majority of the interviewees – especially care workers – also highlighted demanding and often exploitative working conditions within the LTC sector as a further obstacle to pursuing quality. These include extended night shifts, inadequate remuneration, and a general absence of policy measures aimed at improving the job quality of care workers. In the words of one nurse (N2), *'I regret not leaving Greece for a foreign country after the 2008–2009 economic crisis… things are going from bad to worse, and there seems to be no hope'*. As one policy expert noted, *'The difficult working conditions faced by the staff involved in the LTC sector act as significant deterrents to the recruitment and retention of qualified personnel in the sector'*. Furthermore, as one interviewee with managerial responsibilities for LTC units (M1) observed, *'there is currently a need for between 2,000 and 3,000 additional health and social care professionals – including nurses, care assistants, and specialised staff such as physiotherapists – in elderly care units across the country'*. Chronic understaffing, coupled with underfunding, has further contributed to fragmented service delivery, as reflected in the inconsistent implementation of the "*Help at Home*" programme discussed elsewhere in this article.

Overall, although the interviewees with direct, day-to-day experience – particularly nurses and social workers – offered the most critical assessments of the current system, there was consensus across all stakeholder categories that persistent workforce-related challenges compromise the rights of LTC users and care providers, including those of both formal and informal carers, seriously undermining any effort to pursue LTC quality. To address these challenges, the interviewees proposed a series of policy interventions. These included the development of structured training programmes for all LTC stakeholders, designed and overseen by universities, hospitals, and care organisations. Addi-

tional measures focused on facilitating the legal employment of third-country nationals as care workers – specifically, through streamlined visa and work permit procedures, as well as language training. Increasing staffing levels and offering competitive wages were also regarded as *sine qua non* for improving the quality of the LTC services provided.

Discussion and Conclusion

This article has offered empirical insights into a markedly under-researched field: LTC quality in Greece, a multidimensional notion increasingly central to debates on ageing, care, and social protection, as well as welfare sustainability in general. By shedding light on the perceptions and views of key stakeholders regarding LTC quality, the article also identified the principal challenges undermining quality, alongside the pathways through which improvement may be pursued. Examples of challenges are the lack of a legislative definition of LTC quality, the absence of a dedicated quality assurance authority, significant gaps in data collection and monitoring, and adverse working conditions for carers. These same deficits also create opportunities for a reform, including the establishment of clear and measurable quality standards, the development of comprehensive and interoperable data systems, and the construction of a coherent quality assurance architecture capable of supporting continuous improvement.

Overall, while a high degree of convergence emerged among stakeholders regarding the main factors undermining the quality of LTC in Greece, some differences in emphasis were also evident. The participants who were directly involved in care provision, including nurses, social workers and informal carers, tended to foreground the everyday constraints shaping care delivery, such as workload pressures, limited resources and the challenges of meeting complex care needs. By contrast, academics and actors operating at the policy or administrative levels placed greater emphasis on structural and institutional shortcomings, including fragmentation, the absence of a coherent regulatory framework along with insufficient strategic planning. These differences reflect the distinct positions and roles of stakeholders within the LTC system, while also pointing to a shared recognition of the need for systemic improvements to enhance care quality.

The findings contribute to the quite limited literature on LTC in Greece (e.g., Stavropoulou et al., 2022; see Karamessini, 2025, for a very recent contribution), but also broader comparative debates on how LTC quality is conceptualised and operationalised. Although centred on the Greek case, the analysis resonates with wider scholarly work emphasising that the pursuit and attainment of LTC quality depends on a combination of a series of diverse but inter-related factors, as exemplified by conceptual and regulatory clarity, robust monitoring and accountability structures, and supportive organisational and workforce conditions (WHO, 2024a). Furthermore, the findings presented in this article are broadly consistent with relevant research in Southern Europe (Lopes & Dias, 2018; Mangili et al., 2023; Santini et al., 2023) and beyond (Damant at al., 2023; Hutchinson et al., 2023), indicating that, despite its specificities, Greece offers an in-

structive lens through which to examine the factors that are deemed to shape LTC quality across diverse LTC systems.

That said, many of the challenges identified during the interviews mirror the patterns observed in other countries, including unmet care needs and workforce shortages, highlighting the broader pressures faced by contemporary LTC systems and underlining the need to expand and strengthen responses to such challenges, so as to enhance LTC quality (Thissen & Mach, 2023; WHO, 2024a). Specifically, the concerns raised by the interviewees map closely onto the salience of the three dimensions/clusters of parameters that dominate international debates regarding quality LTC – that is conceptual and regulatory foundations, monitoring and accountability, and parameters shaping care experiences and delivery – and therefore reinforce the wider relevance of the findings presented here. Additionally – and albeit the absence of LTC users among the interviewees constitutes a limitation that the author will address in forthcoming research – stakeholders' accounts correspond with comparative evidence showing that Greece is among the few OECD countries where more than three-quarters of the population express concern about access to good-quality LTC (OECD, 2023).

Currently, Greece, as mentioned in the introductory section, is arguably at a 'developmental crossroads', since recent initiatives, such as the 2024 National Strategic Framework for LTC and the First National Strategy for Quality of Care and Patient Safety 2025–2030, might signal a potential shift towards a more quality-oriented LTC system. Realising such a transition will require nonetheless sustained political commitment that will bridge rhetoric with implementation. As Ranci and Arlotti (2019) observe, the central challenge lies not in articulating aspirations for change but in ensuring their implementation. Embedding the insights of key stakeholders within a participatory, evidence-informed policy process – as opposed to the tendency to impose top-down policies without listening to the views of those with hands-on experience – is crucial if rhetorical commitments are to be translated into concrete improvements. The narrative adopted in this article rests on this acknowledgement: the LTC reform depends on meaningfully engaging with the lived realities of LTC and thereby with the knowledge and perspectives of those actively involved in the LTC field. In this sense, the Greek case may illustrate that LTC quality cannot emerge from a legislative reform alone – but that it must be cultivated through everyday practices and inclusive governance targeted at embedding quality across the system. Hence, greater coordination across all levels of governance and more systematic engagement with frontline professionals and informal carers are essential to ensure effective and responsive policy interventions, pointing to the need for more proactive and sustained action to promote a more quality-oriented LTC system.

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