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**The influence of the medical profession on the National  
Health Service of Greece, 1983-2001**

**Athanasios Nikolentzos**

**London School of Hygiene and Tropical Medicine**

**Thesis submitted to the University of London for the degree of Doctor of Philosophy**

**March 2008**

*.....this thesis is dedicated to my parents, Aspasia and Christos*

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## **Abstract**

Greece has experienced three major Health Care Reforms since 1974, in 1983, 1992 and 2001. The common characteristic of all three has been that they have still not realized their aims and objectives. One explanation for the puzzling failure may lie in the way structural institutions shape and are being shaped by the main actors in the health arena in Greece. Furthermore, this study argues that health policy-making is dependent on broader policy making and on decisions or non decisions that have already been made in the past. Within this context, there are several embedded interests, such as the medical profession and its trade unions, civil servants and social insurance funds, which benefit from the failure of any reform, and are in favour of the preservation of the status quo, ignoring the dissatisfaction of the Greek citizens with the health services they receive.

The aim of this study is to reveal the influence of the main actors in the system, with particular reference to the medical profession, through careful and in-depth analysis of the series of reforms. The strongest focus will be on the most recent reforms of 2001. Documentary collection and interviews with key informants (participants and representatives of organizations/interests) in the Greek Health Care System, were undertaken and analyzed, using the most suitable framework derived from historical institutionalism.

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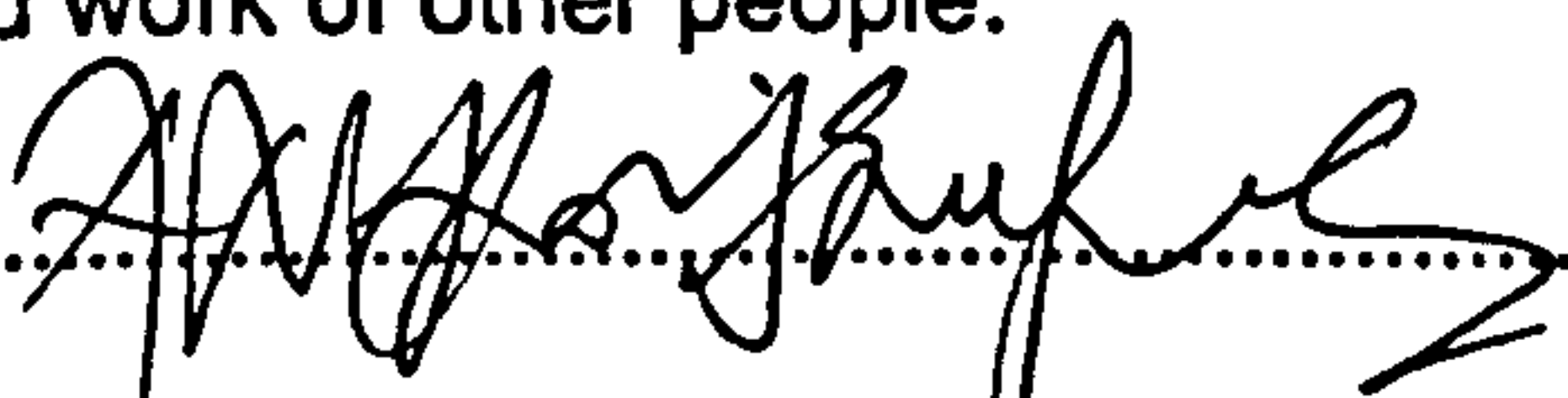
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### **Common Abbreviations used in the text**

**ADEDY: Confederation of Public Servants**

**CMP: capitalist mode of production**

**DEH: Public Power Corporation**

**EDA: Union of the Democratic Left**

**EEC: European Economic Community**

**EINAP: Association of Hospital Doctors Of Athens and Piraeus**

**EKAB: National Centre for Emergency Care**

**EOF: National Drug Organisation**

**EOM: National Transplant Organisation**

**ERE: National Radical Union**

**ESYE: National Statistical Service of Greece**

**EU: European Union**

**EKKE: National Centre for Social Research**

**GDP: Gross Domestic Product**

**GNHS: Greek National Health System**

**GP: General Practitioner**

**GSEE: Greek General Confederation of Labour**

**HI: Historical Institutionalism**

**IKA: Social Insurance Institute**

**ISA: Athens Medical Association**

**KEEL: Centre for Communicable Disease Control**

**KEPE: Centre for Planning and Economic Research**

**LSE: London School of Economics and Political Science**

**MoH: Ministry of Health**

**MP: Member of the Parliament**

**NAT: Naval Veteran Fund**

**NATO: North-Atlantic Treaty Organisation**

**NHS: National Health System**

**ND: New Democracy**

**NWE: North Western European**  
**OAE: Social Security Organization for the Self-Employed**  
**ODIPY: Organization for the Management of Health Funding**  
**OECD: Organisation for Economic Co-operation and Development**  
**OGA: Agricultural Insurance Organization**  
**OENGE: Confederation of Unions of Greek Hospital Doctors**  
**OKANA: Organisation Against Drugs**  
**OPAD: Civil Servants' Health Insurance Fund**  
**PASOK: Pan-Hellenic Socialist Movement**  
**PHC: Primary Health Care**  
**PIS: Pan-Hellenic Medical Association**  
**POEDHN: Pan-Hellenic Federation of Public Hospital Workers**  
**POSEYPIKA: Pan-Hellenic Federation of Health Scientists of Social Insurance Institute**  
**RAWP: Resource Allocation Working Party**  
**RHS: Regional Health Systems**  
**SEV: Federation of Greek Industries**  
**SEYPIKA Athens-Piraeus: Health Scientists of Social Insurance Institute in Athens-Piraeus**  
**SHI: Social Health Insurance**  
**TEVE: Greek Fund for Craftsmen & Small Traders**  
**TSAY: Insurance Fund for the Health Workers**  
**USA: United States of America**  
**WHO: World Health Organisation**  
**WWI: World War I**  
**WWII: World War II**

## Chapter 1: Introduction

### 1.1 Greek Health Care Arena: A unique puzzle?

Greece first attempted to establish a universal health care system, free at the point of use, in 1983, when the Socialist government (PASOK) introduced Law 1397/1983. The goals of the reform were an equitable and efficient health system. Although three major reforms have taken place since 1983 (1992, 1997 and 2001), the overall objectives of the reformed Greek National Health System (GNHS) have not been realized in the face of sustained opposition to most of the major changes proposed (Mossialos 1997).

Law	Year	MoH	Main Features
1397	1983	Avgerinos (PASOK) <sup>1</sup>	<ul style="list-style-type: none"> <li>• Universal and equal access to health care, free at the point of use</li> <li>• Expansion of public sector provision of primary and secondary health care services</li> <li>• Prohibition of private hospitals</li> <li>• Primary health care development</li> <li>• Doctors had to choose between full employment in the NHS or private practice</li> <li>• Decentralization</li> <li>• Improvements of health sector management</li> <li>• Promotion of active community participation</li> </ul>
2071	1992	Sioufas (ND) <sup>2</sup>	<ul style="list-style-type: none"> <li>• State acts as a guarantor of the citizen's right to preventive and curative care, according to principles of freedom of choice and respect for human dignity</li> <li>• Freedom of choice of doctor and hospital</li> <li>• Hospitalized patients have rights according to the European Charter of Patients' Rights</li> <li>• Doctors became free to choose full or part-time employment within the NHS</li> <li>• Restrictions concerning the establishment and development of private hospitals and clinics are withdrawn</li> </ul>

<sup>1</sup> Greek Socialists → Panhellenic Socialist Movement (ΠΑΣΟΚ in Greek).

<sup>2</sup> Greek Conservatives → New Democracy (Νέα Δημοκρατία in Greek).

			<ul style="list-style-type: none"> <li>• Increase in hospital per diem reimbursement rates</li> <li>• Insurance funds can contract with private clinics and diagnostic centres</li> <li>• Co-payments and fees are introduced, i.e. drugs and outpatient visits and inpatient admissions</li> </ul>
2519	1997	Gitonas (PASOK)	<ul style="list-style-type: none"> <li>• Issues of rationing and cost containment</li> <li>• Introduction of management personnel in hospitals</li> <li>• Development of urban health care centres</li> <li>• Review of the way hospital budgets are constructed</li> </ul>
2889	2001	Papadopoulos (PASOK)	<ul style="list-style-type: none"> <li>• Decentralization and regional organization of the system</li> <li>• Splitting between purchasers and providers, and creation of an internal market</li> <li>• Effective management of hospitals</li> <li>• Establishment of collaborative relationship between the public and private sectors</li> </ul>

The characteristics of the current health care system include: over-centralization, fragmentation of coverage (with 30 funds that distribute costs and benefits unevenly across groups in the population), regressive financing including extensive user charges and informal payments, inefficient allocation of resources based on history rather than needs, perverse incentives for providers and a heavy reliance on unnecessarily expensive inputs (Davaki and Mossialos 2005). As a result, the public is generally dissatisfied with the health care system (Mossialos 1997) and many of the major players in reforms, in particular the medical profession, succeed in turning successive more or less well organized reform efforts into failures in order to protect their vested interests. This thesis focuses on unravelling the *puzzle* of how the medical profession is consistently able to resist and dilute Greek reforms and why the Greek medical profession has not been challenged to the same extent as doctors in Western European or North American countries. Thus, this thesis examines the role of the medical profession and its patterns of influence within the health system reforms in Greece taking into consideration the bigger

picture of how the newly formed Greek State was established and its particular founding institutional arrangements, and their intriguing relationship with various interest groups.

Puzzle solving according to Grofman (2001:1) is *“a key task of empirical oriented social scientists in their attempt to find interesting features of the world and try to tell us something insightful that will help us explain them/understand them better”*. A researcher who attempts to solve a *puzzle* based on his/her empirical observation, can, on the one hand, be very attentive to real-world phenomena, and, on the other hand, can be led to a more ideographical perspective by looking beyond facts, to their theoretical grounding. In other words, unraveling the *puzzle* of the Greek health system requires going beyond acknowledging the particularities of the health system, to take into account theory in order to understand and explain these particularities, and to see if these particularities are responsible for the outcome of the Greek health system (Grofman 2001).

Understanding the failure of the reforms means answering fundamental questions such as: why do governments decide to undertake health reform (particularly when strong resistance is known to be highly likely) and how are initial decisions and subsequent implementation shaped? The weakness of the Greek State and the complexity of Greece's Welfare State, combined with the constraints afforded by political institutions, and the resultant influence of the major actors in the health care system (the medical profession, health insurance funds and trade unions) together offer the most fruitful potential explanation for recent and past failures of reform. An early version of the explanation of the Greek health care reform failures was written before the researcher completed and analysed any of the interview data (Nikolentzos and Mays 2008). The article was drafted by the researcher with the assistance of Prof. Nicholas Mays who provided comments and critique, prompting revisions. This thesis will attempt to justify and refine this explanation.

Social science research on Greece has made much progress during the last two decades, but in general terms it is underdeveloped. The reason behind this underdevelopment is mainly the lack of financial and human resources, and the lack of State support and guidance for people carrying out research. It was only after 1974<sup>3</sup> and when Greece entered the European Economic Community, that various scholars began to

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<sup>3</sup> Restoration of Democracy

examine the birth and development of the institutions of the Greek State and society, either in the form of monographs or in European comparative studies. Within this period we can identify a variety of works on modern Greek society, politics and economics that have been landmarks in their field (Mouzelis 1978; Diamandouros 1983; Clogg 1993; Sotiropoulos 1996).

However, it seems that until recently (up to the 1990s), there has been very little research interest in public policy, public administration or health policy issues. During the 1990s researchers started to gain interest in health policy reforms. (Tsalikis 1988; Kyriopoulos and Tsalikis 1993; Kyriopoulos 1995; Sissouras, Karokis et al. 1995; Liaropoulos and Kaitelidou 1998; Matsaganis 1998; Tragakes and Polyzos 1998; Sissouras, Karokis et al. 1999; Liaropoulos 2001; Tountas, Karnaki et al. 2002). Scholars such as Venieris (Venieris 1997b) and Mossialos (Mossialos and Davaki 2002; Oliver and Mossialos 2005) have examined the development of the Greek National Health System in general, and have provided important insights on Greek Health Care services provision and funding in relation to core reforms of the Greek Health Care System (1983-2001). Nevertheless, there is no single study that specifically examines the role of the medical profession, and more importantly its influence on the State Health Care System.

Finally, Carlos (2001) and Guillen (2002) adopted a Southern European comparative perspective in their effort to answer the question why countries like Italy, Spain, Portugal and Greece decided to implement National Health Service Systems during the 1980s. They argued that the role of the medical profession was crucial in the implementation of health care reforms, but they did not justify their analysis with empirical data. Their comparative studies are based on already published accounts and are not the result of extensive fieldwork.

All the aforementioned studies have one salient characteristic in common. They all relate the peculiarities or the characteristics of the underdevelopment of Southern European countries (e.g. Greece) (Tsoukalas 1987; Malefakis 1992; Castles 1993; Clogg 1993; Diamandouros 1994; Ferrera 1996; Katrougalos 1996; Petmesidou 1996; Mavrogordatos 1997; Diamandouros and Larrabee 1999; Argyriades 2001; Carlos 2001; Sotiropoulos 2004b), to the way their health care systems have evolved. On the other

hand, they do not constitute a thorough account of the influence of the Greek medical profession and/or other interests on the State apparatus.

## **1.2 Research Questions, Aims and Objectives**

The aim of this thesis is to examine the influence of the medical profession through its organizations on the State Health Care System of Greece, over the last twenty years, and specifically within the three major reforms that Greece has experienced in 1983, 1992 and 2001.

In doing so, the study attempts to address the following questions:

### **Research Questions**

- 1) What influence have organized medicine and related medical interest groups exercised in the health care arena, concerning decision making on the one hand, and policy implementation on the other, in relation to the three major reforms of 1983, 1992 and 2001?
- 2) How has this influence been exercised, and what strategies have been adopted?
- 3) Which, if any, of the existing overarching theories of the role/influence of organized medical interests best explains the role/influence of organized medical interests in the recent health care reforms of 1983, 1992 and 2001 in Greece?
- 4) To what extent can the influence of the medical profession and its strategies be explained by reference to the specific historical, cultural and institutional context of Greece (i.e. the Southern European Welfare State model)?
- 5) What is the evolving role of government and Health Care System Institutions in recasting the relationship between the medical profession and the State?



- a) Has the relationship between the medical profession and the State altered appreciably since any of the major reform attempts?
- b) What are the implications of any change for the prospects of future health care reform?

### **Objectives**

1. To describe the origins and nature of organizations representing medical interests in Greece.
2. To explain the basis of the position of doctors as the main entrenched interest group that resists implementation of health reform.
3. To investigate how broader public policy-making is carried out in Greece, within the historical, cultural and institutional, formal and informal context of the Greek State.
4. To reveal the failure of the main interests to achieve a stable coalition supporting the 3 major reforms (1983, 1992 and 2001).

### **1.3 Current theories of health care reform**

The international health reform literature has shown the importance of the relationship between the State and the medical profession as well as other interest groups for the implementation of health care reform (Immergut 1991; Freidson 1994; Tuohy 1999). It is thus crucial for researchers of any health care reform to acknowledge, describe and interpret the relationship between the State and the medical profession as well as other interest groups. For this reason I use three theoretical frameworks from sociology and political science, which are likely to be relevant: sociological theory of the professions, historical institutionalism and structural interest theory.

#### **1.3.1 Theory of Professions**

During the last forty years, several theories of the professional power of physicians have been developed, mainly to explain the pivotal role of physicians in

modern societies. Many scholars argue that the medical profession has a dominant role not just in delivering services, but also in the process of policy making, affecting the health care system more widely. They argue that this dominance is derived from the expertise and the esoteric knowledge that only doctors control. As health policy directly affects their income, working conditions, ability to use their knowledge, power and prestige, it is obvious why they are involved in health politics. Freidson argues that doctors have been dominant and will remain so in the future, despite the external structural changes in the organization of the profession (Freidson 1988; Freidson 1994). Other theorists argue that medicine was once dominant in health and health care, but is now fundamentally challenged (McKinlay and Arches 1985; Colombotos and Fakiolas 1993; Coburn and Willis 2003). Coburn and Willis (2003) especially argue that recent changes in health systems reveal that, far from being unique, medicine is a normal occupation, subject to the same processes of industrialization, bureaucratization, corporatization and rationalization as other occupations. These processes are challenging doctors.

The main conclusion to draw from the contemporary debate among theorists of the professions is that whatever the origins of doctors' professional autonomy - technical expertise, market monopoly or broader cultural factors - once professional autonomy has been established, the medical profession is uniquely well positioned as a political lobby group to protect its position even when it is being challenged (Immergut 1992).

### **1.3.2 Historical Institutionalism (HI)**

Historical institutionalists offer explanations as to how, in conflicts between rival groups for scarce resources, institutions (formal or informal procedures, routines, norms and conventions embedded in the organizational structure of the polity and the political economy) favour some interests and disadvantage others. Contrary to the behavioralists who dominated political science in the 1950s and 1960s, historical institutionalists believe that the organization of the political economy (analysis of the fundamental issues arising from the accumulation and distribution of the surplus product in capitalism) is the predominant factor structuring the outcomes of inter-group conflict. Behavioralists, on the other hand, argued that social, psychological or cultural traits of individuals structured behaviour and drove outcomes (Rothstein 1996). Historical institutionalists examine how

institutions distribute power unevenly across social groups. In particular, they focus on identifying how institutions have a tendency to give some groups or interests disproportionate access to decision-making, and how these groups win and the others lose. This idea stands in contrast to the idea of freely contracting individuals whose actions will lead eventually to everyone being better off (Steinmo, Thelen et al. 1992).

HI is closely associated with a historical developmental perspective on public policy and the State. Its scholars have argued that policy change is heavily 'path-dependent'; that is that 'given' institutions constrain the evolution of policy to specific paths. Previous decisions and events play an important role in determining the later development of institutions and policies (Hacker 2002). Path dependency is enhanced by certain conditions, such as: a. when policies implemented have created large institutions with substantial set up costs (so that the cost of future efforts to switch to another policy is high) (Pierson 1994); b. when institutions benefit important organized interest groups, that can either influence decision making through Parliamentary means (i.e. through veto points, mainly in Western European countries) (Immergut 1992), or can influence subsequent policy implementation; c. when institutions embody long term commitments ; d. when institutions reflect the broader cultural and economic values of the society; and e. when conditions put barriers in the path of change, that no one expects or desires (Hacker 2002; Oliver and Mossialos 2005).

However, Historical Institutionalists do not argue that major policy change can never happen. Radical change can occur, but only if a major exogenous event - technological development, demographic change, change in the political climate, unusually dynamic policy actors, or exogenous crisis (e.g. the oil crisis during the 1970s) - affects the balance within the dominant interests. This situation is characterized in a variety of institutional studies as a 'critical conjuncture' (Berins-Collier and Collier 1991; Lavdas 1995; Guillen 2002). In other words, political development is punctuated by critical moments or junctures that shape the basic contours of social life for long periods afterwards. HI is important for contemporary political science for three reasons: first, HI offers answers to big questions that are of concern to broad publics; secondly, it develops explanatory arguments about important outcomes or puzzles, taking into serious consideration time, meaning that it tries to specify and trace sequences of events; and

finally, it tries to take account of the macro-context of policy, in particular, the combined effects of institutions and customary policy processes on policy outcomes. As a result, Historical Institutionalists tend to be interested in comparative studies of policy processes either through time or between countries (Pierson and Skopcol 2002). HI has been used to analyse health politics and health care reform in particular (Immergut 1992; Wilsford 1995; Tuohy 1999).

### **1.3.3 Structural Interest Theory**

The theory of structural interests (Alford 1975) argues that the health care field and its dynamics are defined by conflicts between fundamental, structural interests. They can be classified as dominant (the medical profession), challenging (the 'corporate rationalizers', mostly managers) and repressed (the community and patients). New structural interests can be created through the process of 'corporate rationalization'. Causes of this could be changing technology, changes in the division of labour in health care distribution and production, and an attempt to shift rewards to different social groups and classes.

Hospital administrators, government health planners, and public health agencies have a common structural interest in breaking the professional monopoly of physicians over the production and distribution of health care. So, these 'corporate rationalizers' contradict and challenge the fundamental interests of professional monopolisers. These conflicts occur in an institutional framework that generally prevents the corporate rationalizers from generating enough social power fully to integrate and coordinate health care in the way they would want.

It is worth commenting on the category of repressed interests. These are the structural interests of the community population. Not only are the interests of the community population generally not strongly represented in the health care system, it is argued that they are generally not organized as a structural interest group. As a result, their autonomous demands are not heard.

## **1.4 Organization of the Thesis**

The outline of the thesis is as follows. Chapter 2 provides a general overview of professional power through the lens of sociological theory of the professions. It also discusses the main characteristics of the professions, which is professional autonomy, and how if established, the medical profession is positioned as an important political lobby. Chapter 3 introduces interest group theories specifically applied to health systems and health care dynamics. A particular focus of this chapter is Alford's Structural Interest Theory, and its core characteristics. In Chapter 4, Historical Institutionalism is discussed, which in essence fills in the gaps and builds on theory of professions and Alford's Structural Interest Theory.

Following Chapter 4 and before a full description of the three main reforms is provided, the thesis briefly refers to the current Greek Welfare State and within it, the Greek Health Care System. Chapter 5 is dedicated to the historical, political and societal factors of the Greek case, and whether Greece represents a particular case, or is part of the so called Southern European Welfare Model. These characteristics are directly associated with the rise of the influence of the medical profession. An account of the current features of the Greek Health Care System, such as health care expenditure, health services provision and delivery, and institutional organization is also offered. Following that, information is provided on the health and social insurance system before 1974, and from 1974 to 1983, before the National Health Service System was established.

Chapter 6 offers a detailed account of the characteristics of the Greek medical profession. Key factors include reimbursement, workforce allocation and features of professional organizations, societies and trade unions.

Chapter 7 elaborates the methods used for this thesis, starting with a description of the data collection methods, including archives, Parliamentary minutes, articles from daily newspapers and semi-structured interviews with key informants. Later on it is argued that the case study has received a lot of criticism as a research method, and that there are misconceptions about the usefulness of it as a research tool. This chapter is completed, by offering details on how Historical Institutionalism, as the main methodological theoretical framework, can deal with the notion of change.

Chapter 8, Chapter 9, and Chapter 10 are a detailed account of the three reforms using Parliamentary minutes, daily newspaper articles and doctors' trade unions and societies' announcements. Chapters 8, 9 and 10 include a thorough account of the major stakeholders of the Greek Health Care Arena, and their interrelation with the State. In addition to this, examples of the medical profession's patterns of influence at various levels and in different areas are identified.

Chapter 11 focuses on findings from an extensive range of interviews with participants in the reforms. The analysis is thematic and the important role of the Hospital Doctors, University Doctors and Health Insurance Funds is revealed. It is also argued that the failure of the reforms after 1983 can be explained as an example of path dependency, and, in particular, the persistence of pre-1983 institutional patterns in the Greek health system that are supported by the medical profession.

The final discussion in Chapter 12 places the Greek findings on the influence of the Greek medical profession in an international perspective. Following this, Chapter 12 provides an account of the advantages and disadvantages of the three theoretical frameworks and methods used and their contribution to the thesis. In addition to this, the importance and the contribution of this thesis are highlighted, on the grounds of the research that other scholars have already done. The last part is dedicated to the perspective of change, in particular, the extent to which the Greek health care system has changed since 1983 despite the 'failure' of the successive reforms. This thesis concludes that the evolution of the Greek health care system is very strongly path-dependent. Its development till now does not support recent suggestions of institutionalists that small successive scale changes can occur via 'displacement', 'layering', 'drift', 'conversion' and 'exhaustion' (Streeck and Thelen 2005). Finally, the thesis offers insights on possible institutional change according to the theoretical frameworks of *power* and *legitimation*.

## **Chapter 2: Professions – Sociological Perspectives on the Medical Profession**

### **2.1 Introduction**

The medical profession has evolved throughout the last two hundred years, and this evolution has certainly not been restricted to specific countries. On the contrary, scholars usually refer to this as an international trend. In a worldwide perspective, the role of the physician has little to do with the traditional healer, as today's healers face different uncertainties than their predecessors did. These uncertainties are formed out of the various revolutions in science, technology, politics and society, and could have a serious impact on the future of medicine as a profession. Aspects of medicine such as the nature of medical autonomy, structure of patient-doctor and doctor-State relationships, and transformation of collegial relationships are part of the everyday agenda of health care policy; the crucial debates concerning the quality of health care, rising costs, cost containment and the role of medicine in delivering health care are examples of this (Hafferty and McKinlay 1993). Medicine has been considered a prototypic profession, used to advance their knowledge about the nature of professions. Hence, the power of the medical profession is explained through the analytical tools of theories of professions in general (Coburn and Willis 2003).

### **2.2 Theoretical Framework of Professions**

A conventional history of professions starts with 'trait' theories, which attribute to professions particular characteristics such as esoteric knowledge, a code of ethics, and an altruistic orientation (Carr-Saunders and Wilson 1933). Parsons (1951), who represented the functionalist approach to professions, presented an idealized model of the physician-patient relationship based on the premise that an 'implicit contract' had been signed between society and the professions, with the latter given autonomy in exchange for self-regulation. The next step in the analysis of professions was the move towards the deconstruction of the positive 'traits' attributed to the medical profession, such as rigorous self-regulation or medical ethics, and the production of medical dominance theory. Founders of this perspective were representatives of the Chicago School of Sociology like Everret C. Hughes, Howard Becker and more recently Eliot Freidson (1970). Freidson eschewed Parsons' functionalist vision and argued that medicine has

achieved the legally sanctioned status of a special occupation by controlling the work of others and by making itself immune to external assessment. Most of his studies focused on medical dominance issues and were undertaken during the 1960 and 1970s, the so-called golden age<sup>4</sup> of medicine. By the late 1970s the field of health care had changed and other researchers such as Haug (1975) and McKinlay (McKinlay and Arches 1985) drew different conclusions from Freidson, and described what they saw as a deprofessionalisation and proletarianization of the medical profession. More recently, Coburn (1999) argued, that Freidson's theory lacks empirical support. He suggested that the power of doctors can be traced by describing the profession through its role within health systems and the social basis of its power. For Coburn, as far as health systems are concerned, their common trait is industrialization. In terms of social theories of power, he regarded doctors not as unique, but as a normal occupation that is subjected to the same processes as other occupations. Additional processes to deprofessionalization and proletarianization, such as rationalization, corporatisation, bureaucratization, are now challenging doctors.

The whole discussion of medical professionalism, and whether or not physicians have lost part of their autonomy due to managerialism (Harrison and Schulz 1986) has proved to be crucial in worldwide debates on health policy making. Table 2.1 briefly presents the six important power theories of professions.

<b>Authors</b>	<b>Perspective</b>	<b>Underlying Structure</b>	<b>Focus</b>	<b>Type of Power</b>
(Parsons 1951; Parsons 1963)	Altruistic/ Functionalistic	Normative Consensus	Professional Role	United Body
(Freidson 1970; Freidson 1985; Freidson 1994)	Neo-Weberian	Professional Knowledge	Medical Work	Professional Dominance

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<sup>4</sup> A term used by Paul Starr (1982)



(Larson 1977)	Neo-Weberian	Industrial Society and Rationalization	Marketplace, Professional Projects	Unified Body due to Professional closure and Sheltered Markets
(Navarro 1976; Hafferty and McKinlay 1993)	Neo-Marxist	Capitalist Economy	Corporate Structure of Health Care	Corporate control of health care- 'Proletarianization' of Physicians
(Witz 1992; Lorber 1993)	Feminist	Patriarchy/Gendered Issues	Gendered Organization of Health Care	Gender Professional Projects
(Foucault 1973; Fox 1992; Turner 1992)	Post Modern/ Social Constructionist	Discourses	Discursive Strategies	United vs. Fragmented Character of Power
Elements of Parsons-Larson (1977) on the nature of medical work, while the view on medical power is Pluralist	Segmentation Theory	Industrialization of Medicine	Internal differentiation into segments	Fragmentation of Power (The power of the medical profession is fragmented, yet it might be the case that the profession enjoys a common shelter, but as far as collectivity is considered, it is just a myth that national medical associations have tried to keep alive.) (Klein 1993; Riska 1998)

Source: Table adapted from (Riska 1998), p.100

There are six major theoretical sociological perspectives that try to explain and predict the power and the influence of the medical profession. The independence of the medical profession (i.e. professional autonomy) is viewed as a key feature of the privileged position of physicians, yet each theory analyses the sources of this autonomy differently.

Talcott Parsons was one of the first scholars to view the traits of professionalism - special training, codes of ethics, supervision only by professional colleagues - as a

necessity arising out of a social need. The Parsonian view of the medical profession dominated most of the writings on the power of doctors as an occupational group until 1970. In his view, the service of professionals is "*altruistic, oriented towards community service and regulated by professional ethics*" (Parsons 1991:xxii). Furthermore, he argued that the medical profession has developed effective norms that define and guarantee the profession's role and behaviour. As a result, a '*social contract*' between the society and the profession exists in which the latter is given autonomy in exchange for self-regulation. This 'enables' doctors deliver quality care to those who need it (Coburn and Willis 2003).

The Parsonian functionalist, altruistic view was challenged by '*power-based*' approaches (Weberian, Neo-Weberian, Marxist and Feminist). Freidson (1994) was the first to question whether all the socially necessary occupations were granted the same autonomy and privileges as doctors. In his '*Grand Theory*' about professional dominance he suggested that medicine is dominant in health and health care. That is to say that medical professionals control medical work, clients and other health care professions, but also, most importantly, the context within which medical care is delivered (i.e. health policy). Domination of medicine is enhanced by its social and cultural authority and its clinical autonomy. Freidson considered that medical knowledge is untainted by social factors. Yet the application of medical knowledge reflected the profession's interests in restricting competition, raising salaries and increasing its control over health and health care.

What Freidson (1970) achieved was to redirect attention from the focus on the '*socialization*' of doctors and the functions of doctors' behaviour, to a new structural perspective. Functionalistic approaches from the '*socialization*' school indicated that physician behavior was a consequence of how they had been trained and socialized into the role of 'doctor'. On the contrary, structuralists argue that physician behaviour and control over work is more a function of the structure of the situation in which doctors practise, and in addition, "*it is political in character, involving the aid of the state in establishing and maintaining the profession's preeminence*" (Freidson 1988:23). In that sense Freidson concluded that the medical profession's autonomy is something that the State has granted, under the occupation's attempts to direct the efforts of the State

towards its desired policies. Furthermore, it is the interaction between the State and the medical profession (with its formal representation by either their collective bodies or individuals) which is responsible for establishing and shaping the medical profession's control over its work. An example comes from the fact that only doctors are recognized as capable of judging technical aspects of medical work. Technical autonomy, however, had not always been assured. Physicians had to campaign to prove to governments that the medical profession needed specialized training and licensing.

Professional dominance theory was challenged by Marie Haug. She argued that service professions and especially medical professionals had by the 1990s forfeited their monopoly on esoteric knowledge, clinical knowledge and authority to other health professions and lay persons. The result of this process was a gradual but steady challenge or even revolt against the care givers by a substantial minority of citizens, a process that Haug characterized as the deprofessionalization of the medical profession (Haug 1975).

During the 1980s and 1990s, Freidson attempted to rebut Haug's argument, based again on professional dominance theory, but slightly modified. He argued that the medical profession had adapted to changing external circumstances by altering its internal structure. Three main divisions were recognizable within the profession: 1) the producers, 2) the knowledge elite, and 3) the administrative elite. The administrative elite exerted economic and administrative power, and the knowledge elite dominated the technical and cognitive power of the profession (Freidson 1985; Freidson 1986).

Friedson's influence can be seen on Larson (1977) who also argues that medicine is a united entity, primarily organized to protect its self-interest. Larson focuses on how professional autonomy is achieved. She believes that professional autonomy is achieved when doctors monopolize the market, and not by their technical expertise (as Freidson argued). Doctors as a status group develop a 'sheltered' market or a market that it is not open to everyone (Closure Theory). At this point of argument she agrees with Freidson about the importance of political skill and historical luck, as the profession uses its monopoly to increase its income and social status (Immergut 1991)

Another power theory that challenged Freidson was proposed by Neo-Marxists (Hafferty and McKinlay 1993). Neo-Marxists criticized Freidson for not referring to the class basis of the relationships between the professions and the capitalist State. On the

contrary, Navarro directly related the power of the medical profession to the capitalist economy and corporate power. Furthermore, McKinlay (very much based on the US experience) predicted that doctors are becoming in large part employees of large corporate structures in health care, a process that will '*proletarianize*' doctors in the future (Navarro 1976; McKinlay and Arches 1985).

Neo-Weberian and Neo-Marxist power theories have been the most influential theories concerning the power of the medical profession. However, it is worth referring to two alternative views that challenged Weberians and Marxists.

Feminists argue that the majority of the healers before the eighteenth century had been women. This changed during the eighteenth and nineteenth century when men took over women's traditional healing role. Witz argued that the majority of theories of the professions were gender-blind (Witz 1992), and that the medical profession is part of the patriarchal or gendered structure of the society. In addition, feminists view medicine as one vehicle through which embedded patriarchal modes of control in laws, statutes or societal norms are produced and reproduced. However, for feminists, "*medical work is characterized by segmentation by gender while the profession is male dominated and united*" (Riska 1998:101).

Post-Modernists locate the power of the medical profession in the discourse of medicine. Foucault's view on power of the medical profession is two fold. He stresses that power enables, and, at the same time, constrains doctors, but also that power and knowledge are inextricably intertwined to the point that theorizing about medicine means constructing it and gaining power over it (Coburn and Willis 2003). Thus, through the exercise of power, the medical profession has succeeded in establishing its own knowledge as the only reputable and legitimate form. The establishment of knowledge through power led to medical dominance supported by the State's regulations and criteria. For Foucault this knowledge forms the 'biomedical model', a form of discourse, which in essence is a particular way of constructing our understanding of disease. The emergence of the biomedical discourse explains medical dominance through what Foucault's followers called the 'medicalisation' of our society, which aims to monitor and administer the bodies of the citizens in an effort to regulate and maintain social order (Turner 1992).

According to the Foucauldian view, the medical profession appears to be united in the process of exercising power and creating its own knowledge as the only reputable and legitimate form (Foucault 1973), while another scholar influenced by Foucault's work on discourse analysis, Fox (1992), argues that the medical profession is fragmented and not united as the emerging specialties develop and define their domain of work by discursive strategies. Physicians theorize their area of specialty by constructing it and finally gaining power over it.

Recently, scholars have generally been in favour of the view that the medical profession is not united. They argue that it is a differentiated body divided into autonomous segments that pursue their own interests. Segmentation theory supports the idea that the fragmentation of the medical profession is caused by the development of medical science and the demands for the differentiation of medical work (Riska 1998). However, Freidson suggests that the differentiation of the medical profession in specialties and segments provides the essential characteristics for understanding “ *the kind of influence claimed by doctors who invoke technocracy and the power of technique in shaping public policy, as well as those asserting professional hegemony and monopoly of discourse in shaping public consciousness* ” (Freidson 1993:58). In other words, the generic source of power for a profession comes from its ability and knowledge to carry out particular work. This means that different theories and practices advanced by formal specialties or informal segments or schools within the profession do not necessarily damage the power of a profession. In the end, what really matters is that different members of the medical profession still remain bona fide members of the profession, promoting the same intellectual orientation and authority of knowledge. It may be true that the autonomy of individual physicians could be reduced by new forms of specialisation, however the profession's power as a whole remains intact, and in several cases has increased (Freidson 1993; Wolinsky 1993).

The main conclusion is that whatever the origins of doctors' professional autonomy might be - technical expertise, market monopoly or broader cultural factors - the implication of all these studies is that once professional autonomy has been established, the medical profession is uniquely positioned as a political lobby group to defend it (Immergut 1992).

Nevertheless, comparative studies carried out in countries such as France, Sweden and Switzerland (Immergut 1992) have concluded that although their medical professions have similar characteristics of professional autonomy, their health care systems have evolved differently and thus the medical profession exercises different types and levels of influence over these systems. In order to explain the different impact of the national medical associations on policy decisions and systems, we need to look beyond the general professional dominance of doctors over their working conditions, clinical autonomy, and division of labour (sociological theories of professions) to focus on the role of institutions and major stakeholders on changes in health care policy (Immergut 1991). Theories of the professions are necessary, but not sufficient, to explain the medical profession's influence over health system reforms in specific country contexts.

## **Chapter 3: Interest Group Theories of Health Policy and System Dynamics**

### **3.1 Introduction**

Chapter 3 provides a brief description of interest group theories that try to analyze the dynamics of the health care policy arena. No theory has been proved to be adequate on its own; that is to say that only a combination of them can provide a sound understanding of all the aspects in health care policy making. These basic interest group theoretical approaches to health dynamics are: Pluralism; Marxism; and Structuralism. Within the three dominant theoretical approaches particular emphasis is given to Alford's Structural Interest Theory since it was developed specifically to help understand the dynamics of the health policy arena.

### **3.2 Pluralist Approaches**

The essence of the pluralist theory of power and decision making is that the resources which contribute to power are widely distributed among different groups in society. No group is dominant, each one exercises a degree of influence, and power is shared between official groups in governmental agencies and outside interests which exert pressure on government agencies. This means that there is no consistent bias in the allocation of values, although groups vary in their ability to influence these agencies. Developments in health services and policy are explained in terms of the interplay between interest groups. Since there is no dominant interest, pluralists examine who wins and who loses through the detailed analysis of the preferences of the different interests and the outcomes of different decisions. The question 'who has the power?' has to be answered, as far as pluralists are concerned, through case studies of particular policy areas. A range of factors may be important, including party manifestos, key individuals, official reports and the activities of pressure groups, but their relative influence must be studied in specific cases. Pluralist research studies tend to show that final decisions emerge through a series of compromises between interests (Eckstein 1959; Eckstein 1960).

The advantages of Pluralism are that it is sophisticated as far as the analysis of individual, group and organisational influences on policy processes. What it does not

provide, is an adequate theory of power. For example, the consistent strength of the producer groups and the relative weakness of consumer groups in health systems cast doubt on the pluralist argument that any group can make itself heard effectively at some stage in the decision process, and that no group is dominant (Ham 1999).

### 3.3 Marxist Approaches

Another theoretical approach in analyzing the distribution of power within health care systems comes from Marxists. Marxist theorists argue that the various inequalities in health and health services depend on who controls these services and who is responsible for the allocation of resources (Ham 1999). Medical services are seen as part of the capitalist mode of production (CMP). The dominant class is the owner of the means of production to whom the proletariat sell their wage labour. This mode is the one that gives rise to class relations of production. The economically dominant class is always the politically dominant one. The State is seen as an actor in favour of the bourgeoisie (owners of capital), and performs a number of functions (Navarro 1976).

The State involvement in the provision of health services occurs for two reasons:

- a. action by bourgeoisie to reduce the cost of labour power and to prevent social unrest; and
- b. action by the proletariat through the class struggle to win concessions from the bourgeoisie.

A possible fiscal crisis will result in cuts to the health care budget, and for the Marxists this would be a case of an attack on the interests of the proletariat, although health services are also a form of social control. Health inequalities in provision are explained in terms of the lack of productivity of groups such as the mentally ill, other people with health difficulties, and the elderly. They do not make profit, so they will receive a lower quality of service. In addition, social class inequalities in health show the continuing influence of economic factors on health and the persistence of class divisions within the society. Therefore, “ *the distribution of benefits within health services is explained by reference to class conflict and the dominance of the bourgeoisie*” (Ham 1999:204).



### 3.4 Structural Approaches

David Mechanic (1972) argued that the health care problems of the poor in the US were a product of the larger socio-political system and of the more general organisation of health care services. So the crisis of health care, as Alford (1975:xi) characterized “*the high and rising costs, inadequate numbers of medical and paramedical personnel, a higher infant mortality rate in 1969 than in other thirteen countries*”, in the United States, is not a result of the necessary competition of diverse interest groups and providers in a pluralistic and competitive health economy, nor is it a result of bureaucratic inefficiencies to be corrected by yet more layers of administration established by government policy. It is the result of the conflicts between the professional monopolists, who seek to erect barriers to protect their control over research, teaching and care, and the corporate rationalizers, who seek to extend their control over the organisation of services. Alford (1975) argues that these conflicts come from a fundamental contradiction between the character of the technology of health care and the private appropriation of the power and resources involved (i.e. by the professional monopolists). The integration of health care would require the defeat or consolidation of the social power of various social groups that preserves existing allocations of social values and resources. According to David Mechanic “*...medical care involves a variety of interest groups that tend to prioritize from their own particular perspectives and interest, and it is enormously difficult to achieve a consensus. Groups are usually reluctant to yield rights and privileges that they have already exercised and will resist significant restructuring unless it appears that there is something in it for them (or maybe that it is not enough for them)...(Mechanic 1972:6)*”.

That was an important recognition that Alford took into account when offering an account of the ‘politics’ of the various interest groups in the health sector (e.g. conflicts about control over appointments, recruitment, attempts to influence politicians, party politics, etc.) (Alford 1975).

Structuralists, like Alford, argue that the constant and permanent crisis in health care is usually created by interest groups seeking political capital out of a situation that existed for many years and will exist after the crisis is out of the public eye. For example,

Alford argues that "*advertisements of crisis (i.e. mass media attempts to discredit political leaders because crises are news, studies that continuously stress the crises, thus, the studies themselves become part of the system and part of the barriers to significant change) serve as political weapons in the hands of interest groups, inside and outside the government, which divert resources and services from one program to another, one social group or class to another*" (1975:xii-xiii). This suggests that there are powerful and strategically located interests at stake in the present system which effectively resist change.

There are two types of significant reformers identified by Alford. The first are '*market reformers*', who blame bureaucratic interference for the defects of the system and demand restoration of market competition and pluralism to health care institutions. *Market reformers* believe that the expansion of the available facilities, the increase in the number of physicians, and an increase in the quality and quantity of private insurance will increase market competition, which will abolish expensive and duplicate health services. Furthermore, *market reformers* argue that control over physicians' labour relations is essential for the success of the reform.

The second are '*bureaucratic reformers*'. They blame market competition for the defects of the system, and demand more administrative regulation, government funding and control of health care. They perceive the hospital as a key location and organizer of the health services. They recognize the important role of the doctor in the system, but they suggest that doctors should be placed under the supervision of hospital administrators, hospital medical boards and committees. They are seen as increasingly powerful bureaucratic organisations and the main challengers of the professional monopolists.

The two types of reforms examined by Alford, '*market*' and '*bureaucratic*' are ideologies that analyse from a different perspective the nature and power of the medical profession, the role of the hospital and the role of the patient (i.e. the community demanding better health services or passively receiving what it given).

Alford's contribution lies firstly, in the insight that both, '*market*' and '*bureaucratic*' reformers fail to understand the interdependence of the defects they identify, and secondly, in his suggestion of a new way of understanding reform processes

in terms of the interplay of '*structural interests*'. The '*structural interest*' perspective offers a better way to understand the complexity and the interrelation of bureaucratic agencies, market - oriented physicians, clinics and hospitals, because these "*Powerful interests benefit from the health care system as it is - with its ineffective layers of bureaucratic planning and administration and its uncoordinated separate organisational and professional components responding to demands by the sick of care.....these interests do not have to exert power to influence particular decisions except to block proposals*" (Alford 1975:6).

Alford (1975:13-14) makes a distinction between "*the organized action of a group to represent its interests*", which he calls an '*interest group*', and "*those interests that are served or not served by the way they fit into the basic logic and principles by which the institutions of a society operate*", which he calls '*structural interests*'. In other words, structural interests are something "*more than potential interest groups, which merely wait for the opportunity or the necessity of organizing their present demands or grievances to the appropriate authorities. Rather structural interests either do not have to be organised in order to have their interests served or cannot be organised without great difficulty*" (1975:13-14).

Structural Interests can be classified as Dominant, Challenging and Repressed. Dominant are the ones served by the structure of social, economic and political institutions that exist at any given time. As a result, they do not have to organise themselves and actively defend their interests, as institutions do that for them. Challenging structural interests are produced by the changing structure of society, and, finally, Repressed structural interests are the opposite of the Dominant structural interests. In the case of Repressed structural interests, existing institutions make sure that these interests are not served, unless "*extraordinary political energies are mobilized*" (Alford 1975:14).

Whether health care institutions are fragmented and pluralistic, or monolithic, according to Alford (1975), they must be understood in terms of the continuing struggle between major structural interests operating within the context of a market society:

- Professional monopolists controlling the health resources;

- Corporate rationalizers challenging their power; and
- The community population seeking better health care via the actions of equal health advocates.

Battles may occur between segments of those who possess such a monopoly (i.e. among professional monopolists distributing and producing health services), but these are conflicts between interest groups within a dominant structural interest, and none of these conflicts challenge the principle of professional monopoly. They only determine which segment of the medical profession is going to exercise the monopoly. Technological development, division of labour in the production and distribution of health services and shifting rewards to social groups and classes, may create new structural interests (*corporate rationalization*). Hospital administrators, medical schools, government health planners, public health agencies and others constitute interest groups which share a common relationship to the underlying changes in the technology and organisation of health care. This common relationship constitutes their developing structural interest in breaking the professional monopoly of physicians over the production and distribution of health care.

So, *structural interests* in corporate rationalization contradict and challenge the fundamental interests of professional monopolists. These conflicts occur in an institutional framework that prevents *corporate rationalization* from generating enough social power to integrate and coordinate health care. The structural interest of *corporate rationalization* comprises people like senior health administrators or medical school directors. Their ideology stresses a rational, efficient, cost conscious and coordinated health care delivery system. These managers have many incentives to expand the size and resources of their organizations or institutions. An interesting perspective offered by Alford is a possible alliance between corporate rationalisers and professional monopolists, within their own institutions, as a way of gathering more financial resources and legitimacy, and as a way of bringing more and more care units under their control.

*Repressed interests* are structural interests of the community population (white rural and urban poor, ghetto blacks, lower middle class etc.). They are repressed because no social institution or political mechanism in the society makes sure that these interests are served. In the pluralist literature this distinction is not made as there is a tendency to

assume that there is a societal consensus that allows power and privileges of particular groups to continue. This may be the product of the high esteem that the society has towards physicians that freed them to influence the content of legislation, the composition of administrative boards etc. This is similar to Freidson's argument. Freidson said that professional dominance comes from the autonomy of the profession and that physicians in order to keep their autonomy must keep alive the public's trust in the independence of the professions - in other words, manipulate public opinion.

Alford on the other hand, says something different: the doctors' power generates the societal consensus, or, in other words, the existence of specific political, legal, and economic institutions guarantees that certain dominant interests will be served and taken for granted as legitimate, rather than the fact that people believe in doctors, explaining why they give them power (Alford 1975). In other words, it was the medical profession using its power and status granted by the formal institutions of the society (imprinted in a network of economic, legal and political institutions), which led to a societal consensus (rules of the game, norms and values) that promotes the structural interests of privileged groups (medical profession is included), and enables them to reproduce and continue to manipulate repressed structural interests.

Incentives of status, income, power which motivate persons in various organisational and professional roles to behave as they do, stem from the structural and cultural milieu in which they find themselves. Ideology is formulated from continuous attempts by groups and organizations to construct symbolic representations of their legitimate role, and, by extension, the legitimate organization of the health care organization of the health institutions within which their role is defined. Alford then suggests that the main concern should not be in changing a doctor's human nature or the communicative abilities of the administrators, but instead in changing the structure of health institutions which creates specific rewards and sanctions.

Alford's Structural Interest theory supports the existence of different perspectives on health care reform, and is based on the competing theories of the causes of the crises in health care in the 1970s. Based on his research in New York, and understanding of the USA health care system in the 1970s, Alford points out that many periodic crises have been precipitated by the corporate rationalisers, as a way of advancing their goals. As for

the future, *“given the institutionalized power of both Dominant and Challenging Structural Interests and the ease with which equal-health advocates can be co-opted, the most likely changes are an expansion of health-care-providing units at the bottom of the system and the elaboration of bureaucratic and planning machinery at the top”* (Alford 1975:250). The consequences of compromises between the two most important structural interests (Dominant & Challenging) will seriously affect the interest of the society. Therefore the population will have to put up with increasing costs, increasing problems in access to hospital services, expanding governmental agencies, and reduced ability to influence health policy decision-making (Alford 1975).

## **Chapter 4: New Institutionalism-Historical Institutionalism**

### **4.1 Introduction**

Historical Institutionalism (HI) is the last of the three theoretical approaches to understanding the distinction of power in health politics and systems examined in this thesis. Although this thesis argues that there is no such thing as perfect theory, HI offers explanations to overcome the deterministic nature of Alford's Structural Theory, and explains how countries with similar characteristics of professional autonomy, have evolved their health systems differently, a phenomenon that sociological theories of the professions struggle to explain. For Historical Institutionalists the answer lies on the role of institutions.

This chapter describes Historical Institutionalism, as part of New Institutionalism, and particularly focuses on its core concepts, main scholars and strengths and weaknesses.

### **4.2 Historical Institutionalism**

New institutionalism consists of three different schools: historical institutionalism, rational choice institutionalism and sociological institutionalism (Hall and Taylor 1996). Historical institutionalism developed as a response to interest group theories of politics and structuralism (see Chapter 3) - and also to functionalism, which had been applied in political science during the 1960s and 1970s. Historical institutionalists offer explanations as to how, in conflicts between rival groups for scarce resources, institutions (formal or informal procedures, routines, norms and conventions embedded in the organizational structure of the polity and political economy) favour some interests and disadvantage others. Contrary to the behavioralists that dominated political science in the 1950s and 1960s, historical institutionalists believe that the institutional organization of the political economy is the predominant factor structuring the outcomes of inter-group conflict. Behavioralists on the other hand argued that the social, psychological or cultural traits of individuals structured their behaviour and drove outcomes (Oliver and Mossialos 2005).

Hall and Taylor (1996) divide Historical Institutionalism (HI) into two approaches, according to the relationship between institutions and individual behaviour: the calculus and cultural approaches. The calculus approach assumes that individuals seek to maximize the attainment of a set of goals in a strategic way by reducing uncertainty in a specific institutional framework that may advantage some groups more than others. Uncertainty of individuals is reduced as institutions provide information about the present or future behaviour of other actors. In the end, institutions persist because people, at least those who are powerful, think that to deviate from them would make them worse off.

On the other hand, the cultural approach assumes that the behaviour of individuals is not fully strategic, yet determined by established routines or familiar patterns. Individuals are seen as satisfiers, and not utility maximizers. As a result, most of the time their behaviour is the outcome of their interpretation of a situation rather than the outcome of strategic planning. Institutions offer the means to individuals for interpretation or action. Individuals are seen as deeply involved in a world of institutional scripts, routines and symbols that provide filters for interpretation of a situation or another individual, and may result in constructing a course of action. That way institutions provide useful information and affect the identities, self-images and preferences of the actors (Hall and Taylor 1996).

The existence of different approaches within Historical Institutionalism, makes the supporters of historical institutionalism eclectic. They use different approaches depending on what suits their case and how they want to specify the relationship between institutions and actions. In addition to that, another aspect of HI is the importance historical institutionalists ascribe to power, and especially asymmetrical relations of power. As all institutional analyses have a direct bearing on power relations, historical institutionalists focus on revealing the second and third dimensions of power identified by Steven Lukes in the early 1970s (1974).

The first dimension of power *“involves a focus on behaviour in the making of decisions on issues over which there is an observable conflict of interests, seen as expressed policy preferences, revealed by political participation”* (Lukes 1974:15). The second dimension of power *“involves a qualified critique of the behavioural focus of the*



*one dimensional view, because it is believed that non decision-making is a form of decision making and it allows for consideration of the ways in which decisions are prevented from being taken on the potential issues over which there is an observable conflict of interest, seen as embodied in express policy preferences” (Lukes 1974:20).* Finally, the third dimension of power entails a thorough and ongoing critique of the behavioural aspects of the previous two definitions of power. The critique focuses on the fact that they are too individualistic, and leads to a consideration of all the issues left out of politics because of the operation of social forces and institutional practices or individuals’ decisions. This could happen even if no conflict is observed on the basis though that there could be fertile ground for potential conflict. This potential conflict, if realized, would consist of the contradiction of interests between the interests of those exercising power and the interests of those they exclude (Lukes 1974).

Historical institutionalists especially focus on the second and third dimensions of power and examine how institutions distribute power unevenly across social groups. In particular, they focus on how institutions give some groups or interests disproportionate access to decision making, and how these groups win and the others lose, rather than the idea of free-contracting individuals whose actions will lead everyone eventually to a better-off situation (Steinmo, Thelen et al. 1992).

Historical Institutionalism is closely associated with a historical, developmental perspective on public policy. Its scholars have argued that social causation is ‘path-dependent’ i.e. that institutions push policy along specific paths, where earlier decisions, choices or events play an important role in determining the later development of institutions and policies (Pierson 2001). Rothstein (1996) argues that institutions are built up layer by layer over periods of time, and that individuals do not have the luxury of choosing the institutions that they work within. If choice is possible, then we have to look also at the sequence of choices and events, in order to determine the implications each of them will have for future decision-making. The same choices in different sequences would affect decision-making in a totally different way.

Hacker argues that ‘path-dependency’ is enhanced by certain conditions, such as: a. when policies implemented have already created large institutions with substantial set-up costs (so that the cost of future efforts to switch to another policy is high); b. when

institutions benefit important organized interest groups, that can either influence decision making through Parliamentary means (i.e. creating veto points, mainly in Western European countries) (Immergut 1992), or can influence policy implementation; c. when institutions embody long term commitments; d. when institutions reflect the broader cultural and economic values of the society; and e. when conditions erect barriers to change, that no one expects or desires (Hacker 2002) cited in (Oliver and Mossialos 2005).

However, historical institutionalists do not hold that major policy change can never happen, but this can only happen if a major event - technological development, demographic change, change in the political climate, unusually dynamic policy actors, or exogenous crisis (e.g. the oil crisis during the 1970s) - affects the balance within the dominant interests. This situation is characterized in a variety of institutional studies as a 'critical conjuncture' (Wilsford 1994; Lavdas 1995; Tuohy 1999; Guillen 2002). In other words, political development is punctuated by critical moments or junctures that shape the basic contours of social life and propel policy onto a fresh path.

In her analysis of '*Accidental Logics*' in the health care arena of the USA, Canada and the UK, Tuohy (1999) stresses the importance of 'policy episodes'-quite rare and periodic incidents - that occur when a coincidence of external forces is strong enough to overcome the resistance of interests to change within the arena. Tuohy uses Historical and Rational Institutionalism in order to provide a thorough account of policy processes and outcomes. Then she uses the concept of path dependency to evaluate the degree to which policy actions have become institutionalized, and under which conditions change may occur. According to her three case studies, the policy processes of Britain during the 1940s, and the 1950s and the 1960s in the United States of America and Canada, led to the establishment of specific health care systems with distinctive inherent logics, and similar logics have shaped health system reforms all over the world during the 1990s. She analyzes change in health systems according to a conceptual framework based on distinctive structural and institutional patterns involved in the policy processes of each country. The policy processes of each country are established according to the extent balance between the following institutional instruments in the health sector: *hierarchy, market and collegiality* (Tuohy 1999). The balance of these three institutional instruments

is directly affected by the power and influence of the key structural interests in the health system: the State; the medical profession; and the market. The distinctive 'logic' of each of the health systems of the three countries was established according to the balance of these institutional and structural characteristics. As a result, the dominant institutional patterns within Britain, the United States and Canada, are characterized by *hierarchy, market and collegiality*, respectively. In addition to this, "*once established, the institutional mix and the structural balance of these systems intersect to generate a distinctive logic that governs the behaviour of participants and the ongoing dynamics of change*" (Tuohy 1999:6).

According to this conceptual framework, the reason that the market orientated mechanisms introduced during the 1990s in the British NHS (internal market) had a limited effect was because of the hierarchical corporatism that characterises the system. In the case of the United States, doctors' collegial power and influence were diminished by the introduction of market mechanisms, which, in turn, proved to be resistant to government's further involvement (Starr 1982; Stevens 1998). Change did occur in 1990s America, because of financial pressures on the system. That is when the hierarchical arrangements of the system gained a greater role, within the limited space left by the market. In Canada's case, the establishment and the evolution of the health system was based on the accommodation between the State and the medical profession up until the 1990s. After that, although the medical profession maintained its clinical autonomy, in contrast to the budgetary controls that the Canadian system has experienced, it lost part of its power in terms of its entrepreneurial ability.

Tuohy argues that her version of Historical Institutionalism "*emphasizes the importance of decisions taken at crucial points in time, decisions that become crystallized in the formal and informal rules governing behaviour, and that establish the context in which subsequent decisions will be made. Historical Institutionalism, however, is a house with many mansions: it allows for a variety of emphases regarding the factors that bring about critical moments of decision-making and that shape decisions at those moments*" (Tuohy 1999:107). These factors include:

- ***Political Institutions***, which are important for explaining the outcome of government's policy making. Different institutional structures in different countries are responsible for variation in the degree of success or failure of policies, such as health, education or social security. Institutions, could be seen to shape both the form and the content of policy by affecting the stage of the policy process in which influence is brought to bear by various interests. The resulting different policies and degree of their success are related to the ways in which institutional structures channel the representation of interests.
- ***Policy Legacies***, which become institutionalized policy arenas (path dependency). A typical example of path dependency comes from the failure of the Clinton initiative to reform the US health system. His initiative in the 1990s failed because it was not part of the Social Security 'policy legacy' established by Medicare in the 1960s.
- ***Public Opinion and Cultural Understandings***, which means that popular demands, needs and perceptions have to be taken into account. How public opinion develops in each country is an important factor influencing the timing of episodes of policy change, and the different policy outcomes in each country. For example, health policy makers in post-WWII Britain were constrained by the 'socially shared understandings' of the public, which already existed in Britain during the 1940s (Jacobs 1993).
- ***Political Culture and Parties***, which is "*another version of the argument that public opinion creates the conditions for policy change, establishes the parameters for policy options, looks to broad strains in national political cultures, and in particular their manifestation in party systems, in order to explain cross-national differences in health care policy*" (Tuohy 1999:115). For example, the absence of a social democratic party in the United States could be related to the absence of a national health insurance based system.
- ***Organized Interests***, which according to their power and influence, determine the outcome of each country's health policy. For example, a national health insurance based system was not feasible in the US during the 1930s and the 1960s, because of the strong opposition of organized medicine, the insurance industry and the

business community. These interests succeeded in opposing a possible change through the institutional structure of US Congress, and the ideological complexion of the political culture of that era.

- *Strategic Judgement*, which stresses the importance of judgements made by individuals and groups of actors, and the possible impact that they may have in the subsequent evolution of an institutional structure, within which judgements would have to be made in the future. Examples of strategic judgements come all from three countries that Tuohy examined.

In conclusion, Tuohy argues that in order to explain policy outcomes, a framework where all these factors' intersection can be understood, needs to be built. Her framework emphasizes the following characteristics:

1. The timing of policy episodes: when these occur is very important.
2. The set of political actors when these policy episodes occur must have the political authority to conduct the change and the political will to secure the resources for the change in the health care arena.
3. Different political institutions establish different degrees of constraint on the ability of the actors to consolidate authority, and as a result some countries have policy episodes of change more rarely than others.
4. Once these necessary conditions have been established the resulting change is crystallized by the, combination and influence of the aforementioned factors- "*the partisan complexion of the dominant set of political actors; the prevailing climate of policy ideas; the constellation of interests in the arena; and the strategic judgements made by both proponents and the opponents of change*" (Tuohy 1999:123).
5. Lastly, given that these factors are not stable, what really accounts for any possible change is the timing of the possible opening of 'windows of opportunity'. Forces of the broader political arena have periodically opened 'windows of opportunity' for major policy change in the health care arena of each of the three countries that Tuohy studied. The systems that came out of this process demonstrate the functioning of the 'accidental logics' that drive the dynamics of change. The systems that resulted were largely, if not entirely,

accidents of the timing of their birth. Had windows been opened at different times, the systems might have looked quite different. Decision-making systems which are established during particular episodes of policy change develop distinctive logics that condition future changes. Between these policy episodes, the systems are shaped by their own internal logics.

Despite its different approaches, historical institutionalism is important for contemporary political science for three reasons. First, historical institutionalism offers answers to big, substantive questions that are of concern to broad publics (*“origins, variety, and dynamics of national systems of economic regulation and social provision, revolutions, state-building, democratization, the construction of welfare States”* (Pierson and Skopcol 2002:5)). Secondly, it develops explanatory arguments about important outcomes or puzzles, taking into serious consideration the time factor, meaning that it tries to specify sequences and trace sequences, according to varying scale and temporality. Thirdly, it aims to undertake macro-analyses of different contexts and of the combined effects of institutions and processes. That is to say that historical institutionalists are not interested in examining a single institution at a single period of time, but rather undertaking comparisons over space and/or time (Pierson and Skopcol 2002).

#### **4.3 Rational Choice versus Historical Institutionalism**

The second branch of New Institutionalism is Rational Choice Institutionalism, and although many of its representatives, such as North (1990) or Shepsle (1986) share the same interest with historical institutionalists, such as Hall and Taylor (1996) and Skopcol (1992), in how institutions shape political strategies and influence political outcomes, there are important differences between the two. Rational choice scholars argue that *“institutions are important as features of a strategic context, imposing constraints on self-interested behaviour”* (Thelen and Steinmo 1992:7). On the other hand, historical institutionalists argue that the *“idea that institutions provide the context in which political actors define their strategies and pursue their interests, is unproblematic”* (Thelen and Steinmo 1992:7), and suggest that institutions play a much greater role in shaping politics and political history than rational choice institutionalism.

Furthermore, historical institutionalists find rational choice assumptions too strict and overconfining. For example, they usually disagree with the concept that all actors are rational utility maximizers. Historical institutionalists argue that people tend to be 'satisfiers' (DiMaggio and Powell 1991).

Another central disagreement between the two branches of New Institutionalism is the way preference is formed. Rational choice supporters claim that actors act strategically in order to maximize their self-interest, whereas historical institutionalism claims that not just strategies but also the goals that actors pursue are shaped by the institutional framework. A typical example of this difference is the way class interests are analyzed. Historical institutionalists would say that class interests are more a function of class position, reinforced or mitigated by the State or social institutions (political parties or union structures), while rational choice institutionalists would say that class position is largely an individual choice.

The need to analyze goals, strategies, and preferences enables historical institutionalists to show that unless something is already known about the specific context, then broad assumptions about self-interested behaviour are flawed. That is why they prefer a historical analysis to explain the aim of maximizing preference and what goals are pursued against others. As Thelen and Steinmo (1992:9) argue, "*taking preference as problematical rather than given, it then also follows that alliance formation is more than a lining up of groups with compatible (pre-existing and unambiguous) self-interests. Where groups have multiple, often conflicting interests, it is necessary to examine the political processes out of which particular coalitions are formed*". For example, new ideas can make groups rethink their interests, which means that the ways policies are 'packaged' can offer a fertile ground for the formation of specific coalitions and hinder others (Weir 1992a). Rothstein (1992) argues that leadership plays an important role in this process. The historical analysis of these processes, and how they occur, is part of the core of the historical institutionalist approach.

#### **4.4 Historical Institutionalism and Explanation of Change**

Historical Institutionalism theory has received severe criticism for its explanation of change. For example, Peters argues that although positive feedback mechanisms (self-reinforcing mechanisms which dictate that when a step has been taken in a particular

direction, it becomes more difficult to reverse this course) offer an adequate explanation of the persistence of institutional settings, New Institutionalism and more specifically Historical Institutionalism have difficulties in explaining change (Peters 2000). However, insights derived from Krasner (1984) emphasize the existence of change in the theoretical framework of 'path-dependence' and historical institutionalism. According to specific paths chosen in the past, other trajectories, that might be considered to be more appropriate for the solution of contemporary problems, are turned down. As a result, institutions allow for short bursts of rapid institutional change followed by long periods of stasis, that Krasner calls 'punctuated equilibrium', and which was first mentioned in a set of arguments made by Stephen Jay Gould and Niles Eldredge, who wanted to attack Darwinian Evolutionary theory. According to Krasner (1984:242), Darwin argued that "*the evolutionary process is a slow, continuous process of change in which entire species slowly adapt to environmental conditions*". On the contrary, Gould and Eldredge (1972) have argued that change tends to take place rapidly in geographically isolated groups which may then displace their ancestral populations. In continuation of the previous argument, Gould places the debate of gradual or punctuated change in the general context about the nature of change. "*Is our world (to construct a ridiculously oversimplified dichotomy) primarily one of constant change (with structure as a mere incarnation of the moment), or is structure primary and constraining, and as a result change is a 'difficult' phenomenon, usually accomplished rapidly when a stable structure is stressed beyond its buffering capacity to resist and absorb?*"(Gould 1982:383). The evolutionary theory adapted by Gould, can be applied by analogy in social and political science, with 'punctuated equilibrium' being the explanation of why institutions once established persist for a long period of time.

However, this long persistence of institutions can be disturbed by the appearance of what Hall and Taylor (1996) call 'critical junctures'. According to Mahoney (2000) and Thelen (2003) 'critical junctures' have three characteristics: First, they are contingent events, and according to Thelen, the contingency is caused by an exogenous factor (e.g. an international oil crisis, WWI or WWII, etc). Second, they should involve the choice between two or three alternatives, otherwise they tend again to 'path dependency', and third they should alter the situation established by the persistence of the previous



institutional arrangements, which means that they should stop the positive feedback mechanisms of the previous institutions (Thelen 1999).

Mahoney's explanatory typology sets out the range of ways of disrupting the positive feedback mechanisms according to each theoretical framework of the main explanations of change in historical institutionalism.

**Table 4.1-Typology of 'Path Dependent' explanations of institutional reproduction**

	<i>Utilitarian Explanation</i>	<i>Functional Explanation</i>	<i>Power Explanation</i>	<i>Legitimation Explanation</i>
<i>Mechanism of Reproduction</i>	Institution is reproduced through the rational cost-benefit assessments of actors	Institution reproduced because it serves a function for an overall system	Institution is reproduced because it is supported by an elite group of actors	Institution is reproduced because actors believe it is morally just or appropriate
<i>Potential characteristics of institution</i>	Institution may be less efficient than previously available alternatives	Institution may be less functional than previously available alternatives	Institution may empower an elite group that was previously subordinate	Institution may be less consistent with values of actors than previously available alternatives
<i>Mechanism of change</i>	Increased competitive pressures; learning processes	Exogenous that transforms system needs	Weakening of elites and strengthening of subordinate groups	Changes in the values or subjective beliefs of actors

[Table taken from: (Mahoney 2000, p.517)]

For the utilitarian explanations, he argues that increased competitive pressures and learning processes might be the mechanism of change. For the functionalist explanation, he argues that change could happen only with an exogenous shock, which would transform the system. As far as the power explanation is concerned, elites should be weakened and subordinate groups should be empowered. According to the legitimation explanation, the mechanism suitable is a mechanism that would change the subjective beliefs of the actors (Hall and Taylor 1996; Mahoney 2000).

Although the majority of historical institutionalists argue that change is difficult, they acknowledge that it is possible. They argue that the concept of 'increasing returns'

offers a good start for the investigation of institutional reproduction and persistence (after rare but rapid change has occurred as a result of crisis-critical junctures). However, this explanation has been mostly helpful in explaining the winners' domination in politics and how specific policies persist once an institution has been established, and certainly does not make sense of how institutions change or evolve. In addition, few scholars have tried to provide information around the genesis, the form and function of the institutions around critical junctures, and adequate reasoning behind the concept of 'critical juncture', or under what conditions it occurs. Equally 'increasing returns' has been criticized as a concept that cannot tell the whole story, as losers in politics do not disappear and often they demonstrate a different kind of adaptation to the prevailing institutions, quite different from embracing or reproducing these institutions (Thelen 2003). As a result, recently historical institutionalists have begun to focus on incremental institutional change (Thelen and Steinmo 1992; Cortell and Peterson 1999; Thelen 2003).

According to Thelen (2003:213) "*arguments about institutional change through incremental patterns of change, such as layering or conversion incorporate elements of increasing returns arguments from the path dependence literature, but they embed these elements in an analysis of ongoing political contestation over institutional outcomes*". In that sense, 'increasing returns' may not be disrupted by the new institutions, and new institutions may not oppose the previous institutional setting. As such, incremental change can also have significant effects on policy processes or outcomes. Thus change does not occur only when episodic or radical incidents happen. As Schickler demonstrates with his case study about congressional institutions in the USA, institutions evolved through, "*.....tender layering of new arrangements on top of pre-existing structures...*" (Schickler 2001:13).

Historical institutionalists argue that nations have stable but different institutions, which provide settings for a variety of actors in public policy to exercise varying degrees of influence on the policy outcome of each country. The interaction between the institutional arrangements and the actors generally produces stable policy outcomes and institutional settings that are difficult to change. That is why even in the event of similar pressures for change (i.e. EU directives), each country accommodates these pressures

according to its own long established institutional arrangements (Immergut 1992; Steinmo and Thelen 1992; Thelen 1999).

## **Chapter 5: History and features of the Greek State, and Health System before 1983**

### **5.1 Introduction**

This chapter provides information about the socioeconomic and political characteristics of the Greek State. First it describes briefly the political system in Greece and it continues with a detailed account of the fundamental institutional features of the new born Greek State in 19<sup>th</sup> century. Secondly it contains a review of the literature relating to evolution the Greek Welfare State, and how this has been influenced by particular features embedded in the Greek State and society. Thirdly, it describes the evolution of health insurance and the attempts of the Greek State to reform the Greek health system. Finally, within the analysis of the evolution of Greek health insurance, emphasis is given to the existence of a non-system, which led to/or influenced the establishment of the Greek National Health System in 1983.

### **5.2 Background**

Greece is located in the South-Eastern part of Europe, and at the South edge of the Balkans. It borders Albania, Bulgaria, Macedonia and Turkey, has more than 14,880 kilometres of coastline, and over 80% of the country is mountains or hills (see Figure 5.1). The total area in square kilometres is 131,957, and its population is 10,964,020, according to the national census conducted in March 2001. The capital city of Greece is Athens, and its estimated population is 3,761,810, again according to the 2001 census.

Figure 5.1 – Political Map of Greece



In terms of governance, the Greek State is a Presidential-Parliamentary democracy, established in 1975<sup>5</sup>, after the restoration of democracy (1974), following a seven-year military junta. The head of the State is the President, who must be elected by the 300 members of the Parliament with a two-thirds majority, for a maximum of two terms, every five years. His authority has diminished since the 1975 constitution, and executive authority lies in the hands of the elected government. The government is headed by the Prime Minister and constitutionally is controlled by the Parliament. Legislative power rests with the President and the Parliament. Parliament is responsible

<sup>5</sup> The Greek Constitution has been amended twice after 1975, the first time was in 1986 and the second one in 2001

for passing laws, which then are promulgated and published by the President. In addition, Parliament may revise the Constitution, pass the Budget and exert more general control over the government.

The two powerful political institutions in Greece are the Prime Minister and the government. The Prime Minister ensures the unity of the government, heads the government and civil service, and presides over 19 Ministries (Triantafyllou 2007). Greece has a strongly centralised administrative system, and political and economic decision-making is concentrated in Athens. Recent legislative reforms have focused on decentralisation, such as strengthening the power of the regions and devolving some decision-making to elected regional governments. Greece is divided administratively into 13 regions, each headed by a regional governor appointed by the Ministry for Home Affairs, and these regions are further subdivided into 51 prefectures, each headed by a prefect, who is elected for a four-year term by direct voting at general elections. The functions that these decentralized administrative units pursue are quite different from the most Western European regions. This is because none of them has been granted an independent tax base to enable them to function independently from the central government. Having an independent tax base would place them in a position where they could meet their functional costs and even organize their development plans, separately from the 'State of Athens'<sup>6</sup>.

As policy making is centrally coordinated, with lower levels of government responsible only for local matters, the national government is in theory responsible for the formulation of Greek health policy. The Prime Minister sets the basic lines of policy in co-operation with the Ministry of Health, which drafts the legislation. Other important Ministries in shaping Greek health policy are the Ministry of Labour and Social Security (which oversees the administration of IKA, the biggest health insurance fund in Greece), and the Ministry of Finance (which is responsible for the budget of the Ministry of Health). However, given the high political costs, governments have to consult with

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<sup>6</sup> a saying widely accepted by many people living outside Athens and by this expressing their bitterness towards the fact that most of the decision - making is takes place in Athens, and as a consequence, the State does not take into account their views or their everyday struggle for survival.

medical trade unions (EINAP<sup>7</sup>), medical associations (ISA and PIS<sup>8</sup>) and general trade unions, such as GSEE<sup>9</sup> and ADEDY<sup>10</sup> in order to gain as much legitimacy as they can before they propose a reform law. Often, the social dialogue between the governments and other major stakeholders in the health system has ended in conflicts and strikes that influenced the plans for reforms. However, institutionalized consultation in Greek policy-

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<sup>7</sup> EINAP: acronym for Association of Hospital Doctors Of Athens and Piraeus (ΕΙΝΑΠ - Ένωση Ιατρών Νοσοκομείων Αθήνας - Πειραιά). Founded in 1974-1975, just after the military junta in Greece. Started as a very powerful trade union that played an important role in planning and implementing the Greek National Health System (1397/1983). The two most important governing bodies of EINAP, are the Executive Committee and the General Assembly. It is rather unusual to call for a General Assembly, but whenever this is done the assembly has greater jurisdiction than any kind of decision made by the Executive Committee. The Executive Committee is formed by 15 elected hospital doctors, and it is the body that makes decisions in every day practice for hospital doctors of Greater Athens. Labour Union membership for EINAP is not obligatory.

<sup>8</sup> ISA: Athens Medical Society, a quite powerful medical society dominated by the liberal medical professionals (private medicine), which traditionally supports the interests of "liberal" medicine and not the NHS. It is the biggest regional medical society in Greece and it is traditionally influenced and run by the Conservatives, except from the small period of 1981-1983, when ISA was dominated by the Progressive powers of that time, PASOK, Communists and the Greek Left.

PIS: Pan-Hellenic Medical Association, the highest in the hierarchy administrative level of all the Greek Medical Societies. It functions as the administrative tool of all the regional medical societies, such as ISA, Medical Society of Athens. Again its role is rather advisory and has no right in taking initiatives in planning, or intervening in central decision making, carried out in the MoH. We must admit though that most of the times the MoH does consult PIS, and especially ISA. Traditionally it has been influenced by the Conservatives, with the exception of the 1981-1983 era.

<sup>9</sup> GSEE: Acronym used to refer to the Greek General Confederation of Labour (Γενική Συνομοσπονδία Εργατών Ελλάδος), the leading employees' organization. Founded in 1918, it is essentially the one union confederation in Greece, which represents employees at national level, acts in their name in dealings with the government and negotiates the annual National General Collective Agreement. In the past few years the GSEE, whose members are the second level trade union organizations (union federations and Labour Centres), has represented all the different ideological factions of the trade union movement in reunited form and its representation has therefore become more meaningful. Its governing bodies are a Panhellenic Congress, which is its sovereign body composed of representatives of the second-level trade union organizations, a General Council, an Executive Council and an Audit Committee. Although as a rule the GSEE has been dominated by the political tendency of the government of the day, in the past few years it has been maintaining a new-found independence. This is obvious on the unanimous opposition coming from all the members of the Executive Committee of GSEE, no matter what political party they support, towards the Statutes for reform that the Conservatives try to pass nowadays

<sup>10</sup> ADEDY: Acronym used to refer to the Confederation of Public Servants (Ανώτατη Διοίκηση Ενώσεων Δημοσίων Υπαλλήλων), the central trade union organization of public servants in Greece. Founded in 1945, it represents all employees of the State and affiliates approximately 70 member organizations: sectoral federations, national unions, sectoral unions and local branches. The governing bodies of ADEDY are its Panhellenic Congress, General Council, Executive Committee and Audit Committee. Traditionally the 2<sup>nd</sup> biggest trade union that has the power to protect its employees' rights and interests.

In conclusion, both of them are rather powerful and influential in terms of when, how and if reforms can be implemented in Greece. This is because they influence a big proportion of the Greek Labor Force, and no political party would like to harm their interests. In addition to this, most of their presidents or general secretaries are strongly linked with the two major Greek parties, Socialists - Conservatives, and usually they follow careers as MPs after they leave their trade unions.

making does not exist. This means that the degree that medical trade unions or societies directly affect health policy making depends on the willingness of the government to listen to them. In addition, what is often observed is that consultations can be used as a façade that legitimizes decisions already taken (e.g. in the case of the 2001 Papadopoulos' reform). The fact that there is no institutionalized consultation within the Greek political system does not mean that the main stakeholders of the health care arena fail to influence policy-making.

Although the right to propose legislation rests with the government of the day and the Parliament, the President also has the right to issue legislative acts if requested by the government, but this is not very common. In these extraordinary cases, the texts issued by the President have to be presented to Parliament within 40 days for its approval. The most important Presidential political activity is the production of presidential decrees, which provide the details on the implementation of an existing law (Triantafillou 2007). The institution of presidential decrees is a very common way for the Greek government to avoid direct conflict with interest groups. That way the interest groups (e.g. the medical profession) are kept satisfied that although the legislation did pass, it did not include the enactment of articles that would harm their privileges. They hope that by the time the government decides to issue the presidential decree, its priorities might change or the specific government might lose power, or their lobbying against the legislation might be successful. Further information about the use of presidential decrees in health policy is provided in Chapters 8, 9 and 10. The next section demonstrates how the institutional pattern of presidential decrees is part of the Greek State's and society's particularities (fundamental features of the new born State).

### **5.3 Fundamental Features of the New Born Greek State**

The purpose of this section is to provide a brief historical and political description of the main features of the Greek State. The way the Greek State was born still influences the level of institutional, economic and cultural development in Greece. These aspects of development are closely related to the formation of wider public policy. That is to say, Welfare State policy, including health care policy dynamics, are shaped by this pattern of development (Tuohy 1999; Pierson 2001).



Various scholars, such as Venieris, have revealed a connection between the struggle for the establishment of the Greek State and the development of its Welfare State (Venieris 1997b). Research on the peculiarities of State formation enables us to understand the development of the Welfare State, and even more the health care system. Throughout the almost five hundred years during which Greece was occupied by the Ottomans, scholars have traced several characteristics of economic underdevelopment. Greek territories, as part of the Ottoman Empire, were indirectly influenced by rising Western capitalism during the sixteen and seventeenth centuries. According to Mouzelis (1978), Western growth was to a limited extent instrumental in shaping the Balkan economies through international trade, increasing demand for Balkan agricultural products, and the imposition of unfavourable terms of trade on the declining Ottoman Empire. In addition to that, during the second half of the eighteenth and the beginning of the nineteenth centuries, Balkan economies were shaped according to the needs of Western Europe. Mouzelis argues that at that time, the industrialization of England and later of continental Europe destroyed Balkan handicraft industries and stopped industrial development. The Greek territories found their economic growth curtailed by factors largely beyond their control (Mouzelis 1978).

The first salient feature of the Greek case derives from the fact that the Greek State was established after four hundred years of occupation by the Ottomans. The Greeks gained their independence in 1821, and since then they have been struggling to match the progress and evolution of other European countries. Contrary to the rest of the European States, the newly born State emerged after the formation of the Greek nation. It was established after the revolution against the Ottoman Empire in 1821, with the decisive help of Britain, France and Russia (Katrougalos 1996). As a result, the basic administrative and political structures were not indigenous, but mainly imported from the Great Powers. These structures developed faster than institutions of political control and social representation, creating a highly politicised and centralized pattern of governance, that tended to resist the notion of change (Katrougalos 1996; Venieris 1997b). Legg in his *'Politics in Modern Greece'* (1969), characterized the political system in Greece in the early twentieth century, *"as a system emerging from colonial or foreign subjugation in the nineteenth century that lagged behind Western Europe and the United States in*

*economic development, and its ability to cope with social change and the development of strong representative institutions”* (Legg 1969:1). Mouzelis’ research on the underdevelopment of Greece focused on the early stages of the formation of the Greek State. He believes that the political and cultural importation of institutions from the West contributed to the underdevelopment of Greece. Institutions developed to preserve the status quo. By status quo, Mouzelis means the preservation of current socio-political conditions in a conservative and highly centralized political environment that prohibits radical change. One method of preserving the status quo is ‘*formalism*’ (in its broad sense the term refers to tendency of people to focus more on the form of a text rather than its content). Mouzelis uses the term in the Greek context to show the degree to which discussions and disputes receive a formalistic-conformist character at the expense of social values (Mouzelis 1978). ‘*Formalism*’ is a way of distracting attention from substantial to insubstantial problems. It results in a situation where only minor changes are acceptable, and where most institutional reforms remain ‘*dead letters*’, as politicians are afraid of the political cost of change (Mouzelis 1978; Mouzelis 1986; Venieris 1997b).

The second feature has to do with the underdevelopment of Greek society and its persistent dependence on the State. Coming out of the 1820s, when Greece had struggled to gain its autonomy, the newly formed State had to face a destroyed economy. The State took responsibility for organizing the economy and restoring social order. Since then the State is considered to be the “*functional axis of the overall social formation of Greece*” (Vergopoulos 1978:309).

These two features had consequences for the development of the Greek State from its birth until recently. The first is that from the beginning, the State was considered to be the most desirable employer, most of the times in a ‘*parasitic*’ way (Katrougalos and Lazaridis 2002:46). In one of his early visits to Greece in 1905, Gobineau cited in Katrougalos (1996:46), observed that, “*all Greeks seem to believe that, since the State is the only one which has the finances, one should take advantage and work as a civil servant*”. This, in turn, created high expectations of the State on the part of the citizens, who came to believe that the State should provide them with the necessary means to survive. As a result, everyone wanted to work as a public servant.

The second consequence lies in the legitimacy of the State. Although the State created patronage relations with its citizens, at the same time, it lacked legitimacy, mainly in the eyes of the people who were not part of the State apparatus (i.e. not working as civil servants) and who were not profiting from the State against the rest of the society (Dent 2003). In addition to this, even those who relied on the State through patterns of reciprocal favours and mutual obligations between patron and client lived in uncertainty as they could be made redundant if their patron, mainly the dominant political party, lost power over governance (Katrougalos and Lazaridis 2002). These patterns may fulfil functions similar to those of official welfare policy, but they do not comply with the notion of the State as a neutral arbiter above cleavages and interests, as in Western Welfare States. It seems that the ideological hegemony of the Greek State has been quite weak and people have traditionally mistrusted it. For example, citizens may demand that the State provides them with a job (through reciprocal favours and mutual obligations), yet they cannot trust the State as the main redistributor of wealth between different classes through taxation. The consequence of this anomaly today is rampant tax evasion, leaving the State in a weak position, not having the necessary resources to improve basic aspects of its citizens' lives, such as health care and education (Katrougalos 1996; Venieris 1997b).

Another crucial consequence of the State's low legitimacy is the lack of economic support for the implementation of reforms. Economic problems affect not only the health care sector, but also other public policy sectors, such as education. Two main features of Greece's economy that result in fiscal constraints are tax evasion and the extent of the informal economy. Davaki and Mossialos (2005) estimated that the informal economy represented 28.5% of GDP in 2001/2. These two features make any universal coverage financing system very difficult to pay for.

The third consequence is associated with '*formalism*'. Sotiropoulos (2004) refers to formalism as a salient trait of underdevelopment in modern Greek society. He associates formalism with legalism, which is the tendency of most South European bureaucracies to view policy through the lens of the law and to address all new political and social problems by producing new legislation or amendment of existing laws. The overproduction of laws (especially in the case of health care laws, such as labour relations

of hospital doctors and university doctors issued in the form of presidential decrees, which dominated health care plans in the period since 1983 to 2001) then leads to significant discrepancies between what the law stipulates and what really happens. Sotiropoulos, like Mouzelis, believes that these discrepancies are the result of the superimposition of 'modern' political and administrative institutions on pre-modern societies in the 19<sup>th</sup> century and of the continuing informal workings of interests (for example, of physicians), related to social class conflicts, localism, and regional identities. The result of *formalism* in various policy areas, such as health, is that the State is highly permeable to interests and functions in a particularistic and clientelistic manner (Sotiropoulos 2001; Sotiropoulos 2004c). The narrative in Chapters 8, 9 and 10 demonstrate in detail how governments and Prime Ministers, the two dominant executive political institutions in Greece, use presidential decrees as a way of passing conflictual health care reforms. The majority of Greek governments pass legislation for their planned health care reform and then use presidential decrees as a way to determine when and under which circumstances the most conflictual parts of it will be implemented. As a result, the government appears to the public to have the necessary authority and capacity to implement reforms, while it avoids the political cost of having a conflict with the powerful interests groups of the Greek health care sector, such as the medical profession or health insurance funds. However, this gives plenty of time and opportunities to the interest groups to make sure that the presidential decrees will never be issued.

*'Clientelism'* is defined as "a particular mode of social and especially political organization, whose typical and structural element and characteristic building block is the patron-client dyad" (Mavrogordatos 1983:2-3) and is another typical characteristic of the Southern European State bureaucracy, and particularly of Greece. *Clientelism* is subdivided into two categories: 'clientelism at the top' refers to the extended politicization of the managerial level of the civil service and public sector hierarchy; and 'clientelism from below' refers to the relationship between political parties and society. Through the intermediation of parties, the public sector is used to fulfil a well-known social function in Southern Europe which is the alleviation of social pressures from below, from the unemployed and other insecure social categories of the population. This kind of *clientelism* consists of offering jobs to these categories of people during periods

of high unemployment or just before general elections, known as pre-election tricks, in order to collect more votes (Sotiropoulos 2004b).

In addition to this, Lyrintzis emphasizes that *political clientelism* can still be consistent with the political participation of the masses in politics (Lyrintzis 1983). The patron-client relationship is usually dyadic (Sotiropoulos 2004c), personal and contractual, and achieved informally. It is fundamentally instrumental for both sides of the relationship (i.e. politician-voter) and reciprocal, but also asymmetrical and vertical in the sense that the client depends on the patron (Mavrogordatos 1983). From an early stage in the formation of the Greek State (1820s), *clientelism* was associated with the culture that Diamandouros called, '*Underdog*'. *Underdog Culture* had derived from the remnants of the Ottoman Empire, and the strong Orthodox Church heritage - an influence that traditionally has resisted any kind of modernization or adaptation to a Western pattern of development. It is characterized by '*statism*' (the tendency of the State to control economic and social affairs) (McLean and McMillan 2003), '*formalism*' and '*introversion*' (the act of directing the people's attention to domestic issues, without taking into account the external environment), as well as ignoring capitalism or markets in general. This culture was also accompanied by a preference towards small and family structures of Welfare protection, and a mistrust of the structures of the formal State. This was widespread amongst the traditionally oriented, introverted and least competitive strata of Greek society in the 20<sup>th</sup> century (Diamandouros 1993; Mossialos and Davaki 2002).

Coexisting with the *Underdog Culture*, Diamandouros observed a second culture that contradicted the former, with its origins in the *Enlightenment* and the tradition of Liberalism and the French Revolution. This culture had been mainly imported by the Greek Diaspora (Mouzelis 1978), a very powerful part of the Greek nation (in financial terms), represented by merchants. This culture, which is less widespread and less powerful, supported the international links of the country with other States, was pro-constitutionalist, favoured commitment to democratic expression and structures, and preferred collegial power to reciprocal favours and clientelistic patterns.

The way modern Greek society has evolved, with the massive importation of Western liberal political institutions, and the mistrustful and generally antagonistic

relationship of the society towards the State, resulting also from the abrupt importation of Western institutions in key parts of the political and social infrastructure, made the conflict between the *'Underdog'* and *'Enlightenment'* cultures even more intense, with severe consequences for society and policy decision making processes (Diamandouros 1983; Malefakis 1992; Diamandouros 1993).

Proof of the strong conflict between the *'two cultures'* lies in recent decades. On the one hand, the *Underdog Culture* is perpetuated through party and individual clientelism, and many public sector posts still depend on these informal arrangements (Samatas 1993); on the other, there are forces of *Enlightenment Liberal Culture* in Greece that try to eradicate these phenomena. This effort is widely supported by the idea of further integration of Greece within the European Union. Yet there are scholars that argue that this might not be possible in the near future (Petmesidou 2000; Venieris 2003).

#### **5.4 Current Features of the Greek Welfare State**

This section provides information about the current status of the Greek Welfare State, and how this was shaped by the evolution of the Greek State and society, based on the fundamental features of the Greek State. After mid - 1970s, the social fragmentation and contradictions of the Greek State were intensified because of the growing political weight, and, as result, greater influence and power, of the Greek middle class (i.e. liberal professions, civil servants and petite industrialists). As a result, no consensus on social policy aims was achieved and governments lacked the political will to implement their reforms. This weakness of the Greek State is reflected in the attempts of the State to reform the health care system before 1983 and after, as shown in narrative Chapters 8, 9 and 10.

After a high rate of economic growth, but unequal development during the 1960s, and accompanied by an even more important maintenance of agrarian structures, Greece evolved rapidly to a post-Fordist position in the early 1970s in terms of social and economic structures, without passing through full industrialization. This rapid change, without any time for adjustment, resulted in weak working class and collective forms of solidarity (trade unionism), and an absence of universalism in social policy. Simultaneously, the State, being the sole provider and distributor of income for many

people, created what Petmesidou (1996) called an 'individualistic culture and ideology'. The lack of universalistic culture and identity, the clientelistic patterns that Greece has continued to experience since the 1970s, slow economic growth, the empowerment of the State apparatus and the fragmented organisation of the labour movement, legitimized Greek families and individuals to act as strategic units in seeking employment from the State, or more generally in securing income through formal or informal means from the State. In other words, the State in its effort to gain the support of its citizens developed clientelistic patterns of behaviour: it encouraged citizens to demand from the public sector extra revenue in the form of welfare provision, but at the same time created privileges for politically opportunist groups (Petmesidou 1991; Petmesidou 1996; Petmesidou 2000). This is what Tsoukalas (1987) calls '*clientelistic corporatism*', or what Lavdas (1997) and Triantafillou (2006) call '*disjointed corporatism*'. That is to say that the State has corporatist, differentiated and uneven relations with selected powerful social groups. More specifically, there is an unequal and uneven distribution of rights, opportunities and privileges to middle or upper class social groups and rarely to working class employees. That and the fact that trade unions do not have formal means of publicly expressing their objectives (during the 1970s and 1980s each Cabinet turnover meant that important trade unions, e.g. GSEE, ADEDY, would be staffed by pro-Cabinet leaders, and their aims and objectives would be tailored to party politics and clientelistic relations between government parties and the trade unions), result in a great degree of dependence of trade unions on governmental support for achieving their goals (Sotiropoulos 2004c).

Even in recent years, the socioeconomic structure of Greece has not changed dramatically. It still has a comparatively large agricultural economy, extended petty commodity production and self-employment in a concomitant service sector in the cities. The social strata that have been created by this economic structure are the following: a still sizeable agricultural class (of independent small-holding farmers); a working class (which went from Fordism directly to post-Fordism, so it has been shrunken and weakened, if it ever had power); an enduring old middle class, called by Sotiropoulos (2004c) and Petmesidou and Tsoulouvis (1994) the *petite bourgeoisie*; a well organized and mobilized category of public sector employees; a politically strong stratum of urban liberal professionals (lawyers, doctors and engineers); and a State-dependent capitalist

class made up of industrialists, bankers, land owners, ship owners, mass media businessmen and public works contractors.

The Greek State has traditionally promoted economic development through patronage of certain industrial sectors and business interests (statism). Statism involves protectionism (efforts of the State especially during the 1980s, to promote domestic products and restrict international trade, usually by tariffs, quotas, etc.), autarky (in the Greek case was combined with protectionism and efforts of the government to be self-sufficient and control the foreign balance of trade), transfers and subsidies, and control of specific industries. The civil service, which includes NHS employees, lacks a tradition of political neutrality, organisational coherence, status, class assets and expertise, unlike Western European civil services. Various Western European countries have developed similar strong and overprotective State policies in their efforts to control their economies by running specific industries or by offering subsidies to their citizens. What makes Greece different is that these strategies have a particularistic, even personal trait. Political parties have inflated the political component of the bureaucracy by colonizing bureaucratic structures and personnel through party factionalism and creating inter-ministerial committees of political appointees and councils of advisors to ministers. This has resulted in the formation of a central bureaucracy that is large, but has limited autonomy. Thus not only is *'civil society'* weak since a big part of the trade union movement and some new social movements have succumbed to the main political parties, but it is also not supported by a strong or autonomous Greek bureaucracy, and remains weak compared to the main political parties (Sotiropoulos 2004c). These common features of Southern European economic development throughout the 19<sup>th</sup> and 20<sup>th</sup> centuries have produced what is called *'assisted capitalism'* (Sotiropoulos 2004b), in contrast to competitive capitalism which is the more typical North Western European form.

What is also striking is that although Greece has experienced economic growth, it has not experienced consistent economic development. Uneven economic growth has resulted in an unfair Welfare State, as the State tends to be more generous towards certain categories of the population, and indifferent towards others. This discrimination has its roots in the Civil War of 1946-1949, after which the State clearly promoted the *'winners'*



(the Right) against the 'losers' (the Left). The aftermath of the Civil War led to the creation of a 'dual society' (winners and losers) that prevented the development of a social contract guaranteed by the neutral role of the State. On the contrary, there was a deliberate attempt to exclude the 'losers' from politics or even social welfare benefits. Entering the 1980s, the dualism caused by the Civil War gradually came to an end, as there was a dramatic change in the political scene. PASOK (The Socialists) came to power, its clientele representing the Underdog culture that had its roots in the Greek Revolution against the Ottoman Empire. As a result, the social strata close to the State during the 1980s were the business strata, the liberal professions (including physicians) and segments of the petite bourgeoisie. The relationship that was formulated by this interaction and interrelation of the State with for example, the liberal professions, cemented the long-term dependence of the latter on the State, and has increased their desire to control the State apparatus. This favourable treatment led the State to create specific jobs to accommodate their supporters and to enact legislation that promoted the interests of their supporters, such as the insurance funds of the so-called liberal professions or groups with special proximity to State power, such as civil servants. As a result, research carried out on ministerial and Parliamentary elites in Southern Europe shows that they contain a significant overrepresentation of the liberal professions and especially lawyers and doctors. Furthermore, it is possible that these key professional representatives can influence the centres of decision making in a disproportionate fashion, protecting or even expanding their interests [(Tavares de Almeida, Costa - Pinto et al. 2003) cited in (Sotiropoulos and Bourikos 2001; Sotiropoulos 2004c)]

### **5.5 History of Health Insurance before 1983**

This section describes the evolution of health insurance in Greece from the early 20<sup>th</sup> century until the Conservatives' attempt to establish the first organized health system in 1981 (The Doxiadis Plan). This evolution is marked by specific socioeconomic and political factors (i.e. WWII, the Civil War and military junta), and the empowerment of the Greek middle class and the intensified social fragmentation of the society (see section 5.4). Although several steps were taken towards the better accommodation of the rest of the population's health care needs, such as the establishment of IKA and OGA, the

growing political weight of the middle class resulted in no consensus on health policy, and lack of political will on behalf of governments to implement their reforms after WWII.

### **5.5.1 Development of Social Insurance before WWII**

Irredentism concerning parts of Greece that were still occupied by the Turks, Bulgarians and others, was on the everyday agenda of politicians during the early period of the twentieth century, to divert people's attention from domestic problems, such as the fact that Greece was one of the most underdeveloped parts of Europe. Furthermore, the physical infrastructure of the cities was devastated, and as far as social infrastructure is considered, associations and legal codes scarcely existed. Most arrangements were ad hoc, most people had to fend for themselves, and the working and middle classes were embryonic (Malefakis 1992).

These conditions also influenced the way health care and social security was dealt with in the early twentieth century. Before World War One (WWI), there was no public provision of health care and, in general, social policy was rudimentary. The first Social Insurance Schemes followed the German model. During the eighteenth and nineteenth centuries, a number of labour unions and professional groups had established, financed and governed their own insurance funds. The first one was the Naval Veteran Fund (NAT) which was created in 1838, and functioned until 1861. The second mutual aid fund was the Miners' Insurance Fund, established in 1861. At the same time, a pension scheme was set up and steps were taken towards supplementary insurance with the establishment of Army, Navy and Civil Servants' Funds. There were no strong elements of working class, technological or even agricultural development, and at the same time intense political conflicts dominated the socio-political life of Greece. The lack of industrial development inhibited the development of more widespread social security arrangements (Robolis and Dimoulas 2000).

The years from 1910 to 1914 saw governments trying to improve working conditions. That way they could gain the support of the masses against the Monarchy and the conservative upper classes, and control the spreading of socialist ideology amongst workers. By 1914, the Venizelos (Liberal Party) government had realised that growing

dissatisfaction would eventually lead to the foundation of a socialist party. Fearing such a possible reaction, he decided to legalize workers' associations and safeguard their members, by introducing a Special Law. This was a crucial moment in the relationship between the State and the citizens, as it was the first time that the State had played the parts of benefactor and patron for the newborn working class in Greece. Not to say that the advanced social legislation coincided with enabling of the government to exercise effective and strict control (Mossialos and Davaki 2002).

Before WWI health care was more or less a private matter for the Greeks. During WWI and particularly after it, there were efforts to establish some kind of social protection. The Ministry of Social Assistance (founded in 1917) had issued Law 748/1917, and some kind of protection was offered to orphans, handicapped people and war refugees. Especially for the refugees coming from Minor Asia after the defeat of the Greek army in Turkey, there was the establishment of a Committee for the Assistance of Refugees, which provided free medical treatment for refugees settled in Macedonia and Thrace. By 1931, about 160,000 people, around 6.6% of the whole population, were covered by public occupational pension schemes, mostly subsidized and supervised by the government, but only 26% of the 160,000 were covered for medical and hospital treatment (around 40,000 people). Also during the Interwar period a variety of self-employed people, such as doctors, pharmacists, dentists, lawyers, senators and traders, lobbied successfully for the establishment of their own pension schemes and health insurance (Kent 1989; Katrougalos 1996).

Tsalikis (1988) argues that the establishment of these funds acted as the basis for the further development of social insurance, and that the driving force behind further development was the international labour health and social security conventions signed by Greece at the League of Nations in the late 1920s. As a consequence, the introduction of Social Security Funds played a fundamental role in the development and the organization of health care services, and the first official attempt by the State to mitigate inequalities in the field of social protection. The first most important attempt at compulsory health insurance was the establishment of the Social Insurance Institute (IKA) in 1932 (Kyriopoulos and Tsalikis 1993). The Bill for IKA was introduced by the Liberals in order to cover the needs for health care and pensions of industrial and

commercial employees. As the benefits of IKA were later reduced by the Conservatives, several other sectoral and professional funds had been created by 1940.

Up to this period, there was little change in the way the State handled social protection and social policy issues. On the contrary, backwardness still existed and most social protection was based on institutional charity, clientelistic provisions and social insurance. Social insurance (mainly IKA) was characterized by limited State contributions, and divergent and unequal provisions between different insured groups in terms of quality and assessment conditions (Robolis and Dimoulas 2000). Although the Bill became a Law (5733/1932), it was never implemented because of the unstable political environment and the opposition of influential lobbies (e.g. the medical profession) and existing funds. A new Law was soon introduced (1934), which copied the previous one, but also contained critical adjustments as a result of the demands of the doctors and existing insurance funds. The medical profession insisted of being paid on a fee-for-service basis, while existing insurance funds (of the tobacco, flourmill, and bakery workers) provided exclusive coverage for their insurees against sickness and unemployment, using State subsidies. In other cases, such as the Bank of National Economy, and companies such as 'VIO', businesses provided health coverage to their insurees through private doctors. In the early 1930s the medical profession added to its claims for fee-for-service payments, the system of free choice of doctor, following the example of its British colleagues who in 1910 had specified the principles upon which they negotiated their participation in a new national health insurance scheme (Abel-Smith 1988)

The introduction of IKA succeeded in establishing some kind of general framework of health services in Greece, but failed to deal with the fragmented and unequal way that they were offered, and the poor quality of health care delivered. Many scholars have commented that the Law that introduced IKA in 1934 and the way it was implemented (crucial issues received only a mention in the Law, with official guidance to follow) was the precursor of the further underdevelopment of the Greek social security system, since it was marked by the low level of benefits, discrepancies, inefficiencies and inequalities (Venieris 1997b).

### 5.5.2 Welfare State and Health Services Development, 1945-1974.

The 1940's had severe and negative consequences for the socio-political development of the country. First there was the Axis occupation for almost four years, which devastated Greek society and the State. Following the foreign occupation, Greece involved itself in one of the ugliest civil wars in the history of Europe. Extreme ideological divisions, and social and political tensions erupted from it, and even in recent decades the Civil War continued to divide Greece (Malefakis 1992; Venieris 1997b).

This '*dual society*' prevented any substantial progress in social policy issues. Again, this is a striking difference between Southern Europe and North Western European countries. In most of the latter countries, a form of '*social contract*' was developed after WWII ushering in the golden era of development and expansion of the Welfare State. This never happened in Greece and other Southern European countries (Katrougalos and Lazaridis 2002).

On the contrary, in the following two decades (1950s and 1960s) Greece experienced the hegemony of the Right, and the separation of the society into two parts, with unequal rights and benefits increased (Kyriopoulos and Tsalikis 1993). Conservative party policies were supported by foreign powers that promised an economic reconstruction of the country. At the same time, the government continued its patronage relationship with the labour movement. As a result, many critical aspects of the conditions of working people, such as wages and working hours, were controlled by the State.

As far as the economy is concerned, the period between 1950 and 1956 was characterized by the State's efforts to reduce the public deficit. Investments followed after 1956, and the intention was to achieve a higher rate of economic growth. Economic growth was indeed achieved, but at the same time it did not guarantee consistent economic development. Unfortunately, the policy also brought high indirect taxation that decreased the income of farmers and peasants (over 50% of the total population were peasants and farmers) and a massive emigration (2.5 million people left the country, more than 30% of the total population). As 42% of public expenditure was devoted to defence

the percentage invested in health care was only 6% of public spending. This was not of course only a Greek phenomenon. The world was experiencing the consequences of the Cold War, and countries like Greece were 'obliged' to spend their resources on defensive mechanisms against the domestic Communist threat or an invasion from the countries of the Warsaw Pact. As a result, the pressing needs of the lower classes were accommodated by an inflated public sector. In addition to this, the restructuring of the lower middle class and bourgeoisie was based on clientelistic patterns and exclusion of some groups, but inclusion of others. An important factor in the economic support of the country at this stage, were emigrants' remittances, which unofficially relieved the Welfare State from its obligations towards the population that it was not covered.

Social insurance in the 1950s was influenced by the British Beveridge Report of 1941. This meant that the State attempted to provide more universal social insurance covering the unemployed, old, disabled, sick, and minor categories of workers (Venieris 1997a). On the health policy side, Minister Louros attempted to organise a kind of National Health Service in 1945. The proposed plan introduced for the first time administrative, financial and conceptual issues of an organised health care system, suggesting that the system should pay more attention to prevention and to the way policy making was being carried out. Doctors would have to be State employees or paid on a fee-for-service from a Unified Insurance Fund. The Unified Insurance Fund would incorporate the numerous social insurance funds, and from then on the system would be based on general taxation. As Venieris argued (1997b), Louros' plan was unrealistic because he did not take into consideration the socio-political environment of post-WWII Greece. An important part of the Greek population would not have been able to pay taxes and as a result contribute to the financing of the system. In addition to this, occupational groups like people working in public utilities, banking and teaching, were not willing to give up their privileged health insurance coverage. More specifically, high-income groups received significant subsidies from general revenues or consumer taxes that exceeded the ones IKA obtained. It was ironic that these higher benefits were secured by taxing commodities or services of mass consumption. Doctors were also not willing to give up their private practice (even if their salaries would be doubled), and the State lacked the capacity to implement such a plan. The country was devastated by the WWII

and the political environment was unstable and indicative of the impending Civil War (Venieris 1997b; Mossialos and Davaki 2002).

Thus, another striking difference between the Northern European countries and the South of Europe, strongly related to the industrial development of each, is the fact that most of the NWE countries had already shifted from manufacturing and manual work to service industries, creating a new middle class of administrators, managers etc during the 1950s and 1960s. This did not happen with the latter countries, where a large petit bourgeoisie has always been prominent and a middle class was never created due to incomplete industrialisation and the rudimentary Welfare State. As a result, conditions of perfect social fragmentation were created that have rendered corporatist arrangements untenable due to heightened social conflicts (Petmesidou and Tsoulouvis 1994).

In 1953 there was another attempt with Law 2593/1953 to achieve decentralization of the health system by creating health regions and district health councils. The legislation changed the organisational structure of public and charitable hospitals, but did not succeed in any of its decentralization and planning provisions. The reason for this failure could be traced to the fact that Greece had little or no institutional infrastructure, with insufficient resources and no staff to implement the changes. On the other hand, the government had a strong political mandate to implement its reforms, but it was Conservative and many politicians considered the proposals 'socialistic', and disapproved of them. As a consequence, there was a considerable expansion of the private sector in health care, with an increase in the numbers of physicians in solo private practice and many small private hospitals were created. The State, on the other hand, developed a few public hospitals in major cities and subsidized the functions of charitable, not-for-profit ones (Tragakes and Polyzos 1998).

1961 was marked by the creation of OGA (Agricultural Insurance Organization). The creation of OGA was a Conservative initiative to neutralise the political threat posed by the rising political party of EDA (Union of the Democratic Left). In the 1958 elections EDA had received 25% of the total votes. In order to preserve their support, the Conservatives decided to do something about the persistent inequalities in the distribution of health services between the rural and urban populations by insuring the rural population (which accounted for over 50% of the total population) against old age,

funeral expenses, disability, and crop failure. They also provided basic medical treatment, extended later to free medical and dental treatment, free laboratory tests and basic medicines. In principle, OGA looks similar to the British or the Scandinavian model of universal coverage but for the rural population, but unfortunately it was not fully implemented due to insufficient human resources and hospital infrastructure (Mossialos and Davaki 2002).

In 1964, EDA formed a short-lived government that was dismissed a year later by King Konstantinos. The next three years were marked by conspiracies and disarray which brought the military junta in 1967. The Colonels used a variety of alibis to justify their regime. So not only did they portray themselves as the saviours of the nation from conspiracies, but they also used the motto of the previous Conservative government, that Greece should not become an anarcho-communist country (Katrougalos 1996). The fact was that the dictatorship and its main architects tried to purge not only the Left, but also exiled other socio-political actors and simple citizens of the country, including Conservative democratic politicians

During the period between 1967 and 1974, there were no significant reforms in health care. Discussions took place about unification of the various insurance funds, but the government could not reach agreement with the interest groups represented by the various occupational insurance schemes (Kyriopoulos and Tsalikis 1993).

However, there was one serious attempt at health care reform during the dictatorship. In 1968, the Minister of Health presented his plan for the health care system of Greece. The Patras plan aimed, as many future reform plans, to reduce inequalities in the distribution of resources, to decentralize the system, to create a single piece of legislation covering all the insurance funds to put them all on the same basis, to establish a family doctor system and organize hospital doctors' labour relations, to build new hospitals and to expand the public health system, covering the poor and rural areas of the country. Although some might say that the strong military junta would have not faced any difficulties in implementing its will, the legislation was not passed. The Patras plan thus failed to address the existence of unequal and ineffective health care services that had beset Greek society for years. The Minister and his plans were victims of the general



unpopularity of the dictatorship, and the fact that the Colonels were not willing to court further public disapproval (Venieris 1997b).

Overall, health care expenditure during the 1960s and the 1970s was kept low (at around 2,5 % of the GDP), although the Greek economy experienced high rates of growth. At the time, the economic growth of the country was not materialized in creating heavy industry. Instead Greece experienced the growth of light industry concerning consumer goods, mainly creating small firms of largely unskilled people.

This kind of light industry did not help trade unionism to grow in Greece. The percentage of workers registered in trade unions even today is quite low, and reflects the scepticism of people in the merits of collective action. Unionism could not flourish, as only a third of the population was economically active, and only 40% of workers were in white and blue-collar jobs.

### **5.5.3 Historical Institutionalism applied to Health Care Reforms after 1974**

The focus of this thesis is on the post-authoritarian era after 1974 and the restoration of democracy. Until 1974, health policy, as other policy initiatives in Greece, was quite limited. Following the seven-year junta, the restoration of democracy in Greece created a demand for the initiation of a comprehensive national health system.

Until the dictatorship, politics was based on class divisions and foreign dependence. The Greek military junta had put forward as a strong pretext for capturing power of the State, first the political instability of the 1967 era and the Communist threat. After 1974, no pretexts such as the Communist threat could be used to legitimize any government (Lyrintzis 1983). New governments that were to follow had to pursue other plans for legitimizing their existence.

The junta in Greece collapsed in a dramatic way within a few hours. In July 1974 it discredited itself by first provoking instability in Cyprus, trying violently to oust president Makarios, and then by proving to be incapable of defending Greek Cypriot interests during the Turkish invasion of the island. Konstantinos Karamanlis was called from exile in Paris to form a government within a fortnight. Under the charismatic leadership of Karamanlis, the country was led to national elections (November 1974), at

which his party, ND (Nea Dimokratia), representing the Conservatives, received 54.3% of the votes, achieving an overwhelming majority. The result was the formulation of a strong and absolute government with a charismatic, but at the same time, authoritarian leader. His political strength was proved by the way he drove the 1975 Constitution through Parliament, on the basis of the party's substantial majority (Malefakis 1992; Katrougalos 1996).

Although his policies were for modernization of society and the State, supporting the idea that Greece should join the European Community, abolishing post-war laws and legalizing the Communist Party, he did not manage to escape from his historical links and the practices of the past. He had been the prime minister for eight years, during 1950-1960, when patronage flourished. Karamanlis continued this old style of politics, with the reappearance of clientelism and with the public sector again playing a major role in the election process, being an important electorate pool for the Conservatives in the 1970s and the Socialists in the 1980s (Lyrintzis 1983; Malefakis 1992; Katrougalos 1996). It is worth noting though, that patronage and clientelistic relationships had been transformed during the 20<sup>th</sup> century, from the traditional type of '*influencing local notables*' to '*party directed patronage*' (Lyrintzis 1983). Furthermore, it is significant that without the close cooperation of the State apparatus, the party or the party leader alone could not succeed in pursuing clientelistic patterns. Clientelistic patterns were perpetuated by both party leadership and the State apparatus. This is what Lyrintzis calls '*bureaucratic clientelism*'. It is quite natural for a country where the State has always played a central role in economic and political development to have the ruling party securing its power through the State apparatus (Lyrintzis 1983).

As far as Greece is concerned, the patterns of economic development are directly affected by the so-called Southern European Welfare Model<sup>11</sup>. Although there are many differences between these countries and especially between the regions within the countries, there are some common characteristics concerning their socio-economic development. An important one is the change in their economic structures during the 1970s.

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<sup>11</sup> Spain, Portugal, Greece and Italy

During the 1970s, Greece experienced economic contraction, and as we noted before a gradual but steady movement towards a service economy, with less dependence on agriculture, yet not fully industrialized unlike the Northern European countries. Overall Greece's salient economic characteristics are thin industrialization, spreading of small firms, usually run by households and representing the least competitive and skilful part of the society, lack of incoming capital investments, and tremendous technological underdevelopment which caused a huge deficit in the balance of payments (Petmesidou and Tsoulouvis 1990).

These trends in socio-economic and political society during the '*metapoliteush*' (meaning in Greek the period just after the restoration of Democracy-in1974) affected health insurance and health care services. The newly elected Conservative government led by Karamanlis, adopted in principle, a modernizing approach towards the evolution of the State and the accession to the European Community, but in reality continued its clientelistic and patronage practices, as some extra services and benefits were awarded to specific parts of the population and especially the public sector. These privileges were awarded to the public sector, as it represented the basic clientelistic 'pool' for the Conservatives, ahead of the elections of 1977. As a result, there was a further fragmentation of the social security system and more rudimentary social protection.

In terms of health care reforms and improvements, the most important outcome of this period was a research project carried out by the Centre for Planning and Economic Research (KEPE) in 1976. KEPE's report expressed the need for reform and its main results pointed out the importance of the harmonization of the services provided by the various health insurance funds. It also commented on the need to reduce geographical inequalities, the discrepancies in coverage and financing inequities among insurance funds, gaps in coverage in rural areas, capital investment problems concerning public hospitals and last but not least the need to improve organizational management. Moreover, there was for the first time significant reference to the issue of induced demand and the underground economy provoked by doctors and their unregulated working conditions. KEPE's proposals focused on three plans for possible change in the health care arena. The first was the creation of a National Health System, the second was

the unification of the three major insurance funds ( IKA, OGA and TEVE<sup>12</sup> ), and the third was the creation of the necessary preconditions to establish coordination and cooperation between the existing funds, which eventually would result in better coverage. Although the Working Party, which prepared the report, acknowledged the theoretical appropriateness of the first solution in terms of efficiency and equity, it decided to propose the amalgamation of the existing health insurance schemes (Venieris 1997b).

KEPE's suggestions were not far from the previous 1968 plan, and were for gradual transition of the system that would accommodate the establishment of a Greek NHS. The unification of the funds would cover over 85% of the population, more GPs would have to be trained, and the importance of the public sector would be enhanced. The Greek government failed to grasp this opportunity. Tuohy (1999) points out that when a 'window of opportunity' is opened, it is up to the government of the day to muster the will and power to use it. However, the political conditions of that era did not promote this. The Conservatives had the power, but they were prejudiced against any NHS plan. For them, the NHS expressed socialism and under no circumstances would they want to be identified or accused of being 'socialists'. Also the broader conditions of the political arena did not encourage the adoption of an NHS. Greece was coming out of a dictatorship, its society was characterized by cultural and political 'duality', and the wounds caused by the Civil War had not yet fully healed. Under these circumstances, the State prioritized its policies, and health care reform was not on the agenda or near the top (Tragakes and Polyzos 1998). There was no place for political risk taking, as the general elections were approaching and PASOK's (i.e. the Socialists') political power and influence was rising. Instead of implementing the radical suggestions of KEPE, the Conservatives chose to pursue minor structural adjustments ahead of the elections of 1977. In November 1977, New Democracy (ND), had already been in power for three years. ND led the country to general elections, highlighting two critical issues that a new government needed to be strong enough to deal with. First, there was Greece's entry to the EEC (European Economic Community), and second the renegotiation of the conditions of Greece's membership of NATO. Although ND lost 13% of its previous share of votes (ND received 54.4% of the votes in 1974, while in 1977 it received 41.9%,

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<sup>12</sup> Greek Fund for Craftsmen & Small Traders

Clogg, 1987), it managed to obtain an overall majority and took 171 of the 300 Parliamentary seats. The majority government that was formed continued its previous policies and ignored KEPE's plan (Lyrintzis 1983; Kyriopoulos and Tsalikis 1993).

The Conservatives had to deal with the same issues again just before the 1981 elections. In the meantime, political dynamics had totally changed. After the elections of 1977, PASOK, representing the Socialists, had become the second biggest political party in Greece, with 93 Parliamentary seats (in 1974 when PASOK was founded it had only gained 13 Parliamentary seats). By 1981, PASOK was able to win the general election. Its ideology was based on novel ideas and policies that had a tremendous influence on the electorate. Ideas such as national independence, popular sovereignty and social liberation were on the political agenda of Andreas Papandreou, the charismatic leader of the Socialist Party. He also expressed a radical position as far Greece's relations with NATO and EEC were concerned. He proposed withdrawal from these two international organizations. Plus, in terms of internal policies, he supported a number of social and institutional changes with the aim of establishing a Welfare State and democratizing the State apparatus (Lyrintzis 1983).

Taking the threat of Papandreou into consideration, the Conservatives were afraid of losing the forthcoming elections. In order to attract more voters, they produced a Bill called Measures for Health Promotion (also known as the Doxiadis Plan, from the name of the Minister of Health) for the reorganization of the health sector. The Bill was the product of a major research project that a team of scholars had carried out appointed by the Minister of Health. In spring of 1980 the team had published its conclusions which had produced various criticisms and resistance from the medical associations and from members of the Conservative party.

The Bill that was submitted to the Greek Parliament in 1980 contained provisions for the establishment of a planning agency for the coordination of health care, based on the needs of the population and lessons learned from international experience. Furthermore, it took seriously ways of decentralizing the system, tackling health care inequalities in rural areas by establishing a network of rural health centres and family doctors (GPs), getting various interested parties involved in the policy process and developing a plan for medical manpower (Venieris 1997b; Tragakes and Polyzos 1998).

It also contained several changes to medical training, such as a compulsory year of paid training in university hospitals or rural health centres after graduating from medical school. However, the Doxiadis plan lacked cohesion and strategic planning (long term objectives), plus it did not clearly state how the reforms would be funded. It also tried to implement cost containment by introducing hospital budgets.

Opposition came from all the political parties, and especially from the medical profession. The interests of the medical profession were seriously affected, since changes were proposed in the ways that hospital doctors were paid. It tried to transform junior hospital doctors into salaried employees. Senior hospital doctors were given the opportunity to practise privately, in their own surgeries, while junior hospital doctors were forbidden to practise privately (Kyriopoulos and Tsalikis 1993). The Pan-Hellenic Medical Association (Panellinos Iatrikos Sullogos-PIS), mainly controlled by Conservative doctors, and traditionally attached to New Democracy, the ruling party at that time, severely criticized the Plan. The privileged doctors; i.e. senior doctors with established reputations, affiliated with the Conservatives, mainly opposed the Doxiadis Plan (Venieris 1997b). Furthermore, Conservative Members of Parliament were also against the Bill, and in one particular case a Conservative MP characterized it as the 'Red Bill', implying that the reform was Communist.

The Conservatives tried to pass the Bill on the eve of the national elections. But as Tragakes and Poluzos (1998) note, no major legislation has ever passed the Greek Parliament within a year or so of national elections. Why had it taken the Conservatives almost three years, to introduce the Bill? Many scholars stress that the reason for this delay was the difficulty in reaching consensus between the political parties and the doctors' unions (Liaropoulos 1992; Tragakes and Polyzos 1998; Theodorou 2003)

PASOK characterized the attempted passing of the Bill on the eve of national elections as a pre-electoral trick by the Conservatives to win votes at the last minute. Furthermore, the Bill was sabotaged by members of the Conservative ruling party, the medical professionals, and opposing political parties. The next government thus inherited a legacy of entrenched opposition to reforms from many quarters. This legacy would shape the government's approach to any future 'window of opportunity' in health care reform (Tuohy 1999).

Summarizing the socio-political situation in Greece in the period after the restoration of democracy from 1974 to 1981, the following salient characteristics emerge: first, there was a slight increase in social protection expenditure, but the economic improvement overall was delayed, directly affected by the international environment oil price shocks in 1973 and 1979; second, Greek citizens had to get accustomed to a new post-authoritarian reality, including a new political system, which delayed them and the State from accumulating prospects of capital, like NW European countries successfully did. As a result the State continued to exercise control over social insurance schemes and organizations, but without being able to escape from the clientelistic patterns of the past, in particular the awarding of privileges and special benefits to middle and lower class strata of the population (Robolis and Dimoulas 2000; Mossialos and Davaki 2002).

As far as health policy is concerned, the Greek health care arena was characterized by the existence of a 'non-system' in the late 1970s. Before 1983, junior doctors were poorly paid, no one had determined their working conditions, and senior and university doctors dominated the hospitals at the expense of juniors. Hospitals did not have a clear legal status (lots of small private clinics and numerous private foundations and charity hospitals existed), and primary health care was not organised. As a result, there was a notable inequity in delivering health services; i.e. patients living in the countryside had to travel to big urban cities to be treated or even travel to other European countries if they required difficult surgery.

Between 1968 and 1981 there had been two major attempts, to tackle the aforementioned characteristics of the Greek health care sector, the Patras plan in 1968 and Doxiadis Bill in 1981. The failure to pass or implement the relevant legislation was due to the lack of political consensus, senior doctors' strong opposition, the lack of institutional infrastructure, administrative and managerial capacities, and the absence of political will to plan and implement non-incremental reforms (Tragakes and Polyzos 1998).

## Chapter 6: A Brief Description of the Current Health Care System in Greece relevant to Health Care Reform and the role of interest groups

### 6.1 Overview of the Health System: Finance and Provision

The current Greek Health Care System is a ‘mixed’ system of ‘public contract’ and ‘public integrated’ models<sup>13</sup> (Docteur and Oxley 2003), and is financed by a mixture of general taxation and social insurance. In addition to this, services are delivered by a combination of public and private providers (see Table 6.1).

**Table 6.1 Summary of the mix of public and private funding and provision of health care in Greece.**

		Public Provision	Private Provision
F U N D I N G	P U B L I C	<p><b>NHS:</b> tax financed system of universal coverage. Public hospitals and health centres provide services (almost) free at the point of use.</p> <p><b>Social Insurance:</b> In theory should reimburse NHS for use of hospital services by members. IKA (covering 50% of the population) directly employ doctors to provide primary care services to members. OGA members (25% of the population) use free-charge NHS for rural health centres and surgeries.</p>	<p><b>NHS:</b> Private medical services, e.g. laboratories, radiology and pathology, are reimbursed (fee-for-service) by the NHS provided to patients.</p> <p><b>Social Insurance (apart from IKA and OGA):</b> reimburse contracted providers (fee-for-service) for private medical consultations, medical services obtained in the private sector and services provided by private clinics and hospitals.</p>
	P R I V A T E	<p><b>Voluntary Health Insurance:</b> In theory should reimburse NHS for use of Public service by enrolees. In practice this never happens.</p> <p><b>Out-of-pocket payments:</b> Direct payments by patients to cover co-payments in the NHS for hospital outpatients consultations (rarely collected), and pharmaceuticals. Most self - employed pay 25% for diagnostic tests and therapeutic procedures, Additional fees (fixed for service) for private consultations by specialist in NHS hospitals.</p>	<p><b>Voluntary health insurance:</b> reimburse enrolees for fees paid for consultations, services and inpatient care provided by the private sector.</p> <p><b>Out-of-pocket payments:</b> direct payments by patients’ private consultations and other medical services.</p> <p><b>Source: (Mossialos, Allin et al. 2005)</b></p>

<sup>13</sup> “Public contract model” is one in which public payers contracting with private health care providers. Payers can be either a State agency or social security funds. On the other hand, a “Public integrated model” is one in which financing of health care provision and hospital providers are both part of the government sector.



There are three major categories of providers: The NHS (public hospitals, health centres, rural surgeries and emergency pre hospital care), insurance funds' health services with their representative units and polyclinics (mostly established within the Social Security Institute, IKA, which is the largest Greek insurance fund) and the private sector. Health care services are delivered through NHS, social insurance funds' health care units (IKA in most of the cases) and private sector health care units, that may have contracted or not with funds. This way 99% of the population is covered and people have access to a variety of services such as:

- Hospital Care
- Emergency Pre-Hospital Care
- Primary Health Care
- Dental Care
- Pharmaceutical Care

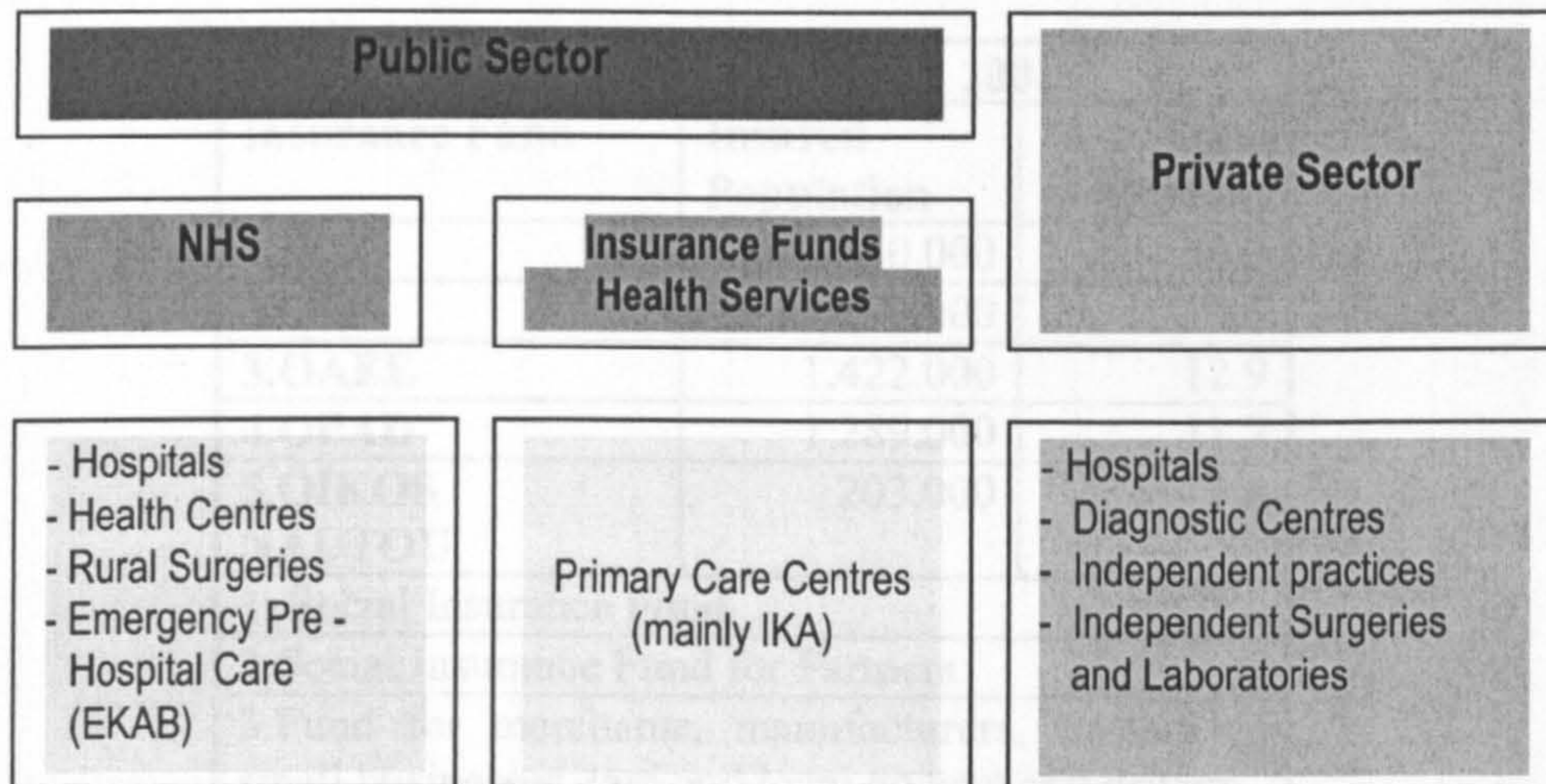
Theoretically speaking services are provided free of charge to all beneficiaries, and the Ministry of Health and Social Insurance Funds are responsible for the organization of delivery of the services. Uninsured people and the poor cannot access social insurance fund services. All citizens access private hospitals and clinics according to their willingness to pay.

In 2002, there were approximately 59,518 registered operational beds, of which 36,621 (61%) belonged to the NHS, 3,500 (5.9%) to the psychiatric NHS hospitals, 4,000 (6.7%) to public hospitals outside the NHS, mainly military and IKA hospitals, and the remaining 15,397 (25.9%) to private sector hospital and clinics. Greece has a relatively small number of beds (5.44)<sup>14</sup> per 1000 inhabitants, compared to other EU countries. The occupancy rate in the same year stood at 70.4%, suggesting that the number of beds is adequate to cover the population's needs for hospital care (see Figure 6.1).

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<sup>14</sup> The best ratio of inhabitants/beds is achieved in Netherlands, 10.8, and the worst in Sweden, 3.6.

**Figure 6.1-Health Care Services Provision**



**Source: (Theodorou 2003)**

The NHS offers universal coverage to the population, but only in theory. In reality, it covers only hospital care and primary care through 200 health centres and 1,000 health posts for the semi-urban and rural population. Social insurance is compulsory for the working population and is occupationally based, but with differing standards in terms of quality and quantity of the health services. There are approximately 240 social security funds that provide a variety of insurance schemes, such as health services and retirement pensions, or welfare and other benefits to the population. Around 30 health insurance funds offer coverage to 95% of the population (during the 1980s health insurance funds exceeded 50) (Karagiannis, Lopatzidis et al. 2003). The three largest funds are IKA, OGA (Organization of Agricultural Insurance) and OAEE (Fund for the Self-Employed). People employed in banks, public utilities and some self-employed (4% of the population) are covered by separate funds. In addition, the government runs separate schemes for civil servants, their dependents and military employees (12% of the total number of insurees (Sissouras and Souliotis 2003) (see Table 6.4)

**Table 6.4 - Major Social Insurance Funds/insured population/ % insured population/ total population**

<b>Major Insurance Funds, 2001</b>		
<b>Insurance Fund</b>	<b>Insured Population</b>	<b>% Total population</b>
<b>1.IKA</b>	5.530.000	50.3
<b>2.OGA</b>	2.150.000	19.5
<b>3.OAEE</b>	1.422.000	12.9
<b>4.OPAD</b>	1.289.000	11.7
<b>5.OIKOS NAUTOU</b>	203.000	1.8
1. Social Insurance Fund		
2.Social Insurance Fund for Farmers		
3.Fund for merchants, manufacturers, owners of small businesses, taxi and lorry owners and drivers		
4.Public Servants' Health Insurance Fund		
5.Social Insurance for Sailors and Shipmen		

**Source: Ministry of Labour and Social Protection, [www.labor-ministry.gr](http://www.labor-ministry.gr)**

All the sickness funds have their own administrative and budgetary arrangements. Health insurance funds are not-for-profit organizations and they are accountable to the Ministry of Health or other relevant Ministries (for example, Ministry of Defence for Armed Forces, Ministry of Internal Affairs for Civil Servants, etc). The management of the insurance funds is the responsibility of representatives of employees, employers and the State. They are usually administered by a board, and a chairman who is directly appointed by the Minister of Health for three years. As a result, the State has a considerable degree of influence on the way they set contribution rates, determine their services, and the level of benefits. Sickness funds are responsible for purchasing health services on a contractual basis from hospitals and doctors, but the prices are set annually by the Ministry of Health. This mechanism has been an important element in the State's policy of keeping the prices of health services very low since the late 1970s. This means that the State intervenes in pricing policies, but at the same time is obliged to fund the deficits in public hospitals because caused by the low prices (Matsaganis 1991). Yet, State health services price setting does not mean that the State has taken over health

insurance funds' management. On the contrary, as narratives in Chapter 8, 9 and 10 will demonstrate, the State has not succeeded in the unification of the health insurance funds, because of the strong opposition of the management of several funds.

In the case of IKA (the biggest social insurance fund, whose coverage is for health insurance), its Board of Administration is strongly influenced by the members of the biggest trade union in Greece, GSEE. IKA's health services' network of 300 primary care centres, five hospitals and 9,000 doctors, which is comparable in size with the GNHS (IKA Strategy Team 2003) is perceived by GSEE as a unique source of political and societal power. This means that whenever the State suggests the merger of IKA into the GNHS, GSEE intervenes in IKA's administration against the unification of the system. One explanation for this peculiarity lies in the fact that GSEE is controlled by trade unionists influential within PASOK, the political party that has been in government for 19 of the past 23 years (1981-2004).

Overall, the system is fragmented in terms of financing and providing health services. There are many social insurance funds offering different levels of quality and quantity of benefits to their insurees. Subsequently health care expenditure per insuree varies according to insurance fund. For example, the privileged or so-called 'noble' insurance funds, such as the civil servants' fund and the banking or public utilities' funds offer the most comprehensive benefits to their insured populations, and their total health care expenditure per person is much higher than on IKA or TEVE insurees (comprising around 17% of the total population-Table 6.5)

**Table 6.5- Major Insurance Funds' Health Care Expenditure/Person in 1995  
(in Euros)**

<i>HI Funds</i>	<i>Insurees/ % of the Total Populatio n<sup>15</sup></i>	<i>Total Health Care Expenditure /Person</i>	<i>Hospital Care Expenditure /Person</i>	<i>Outpatient Care Expenditure /Person</i>	<i>Pharmaceutical Expenditure /Person</i>	<i>Other Health care Expenditure/P erson</i>
IKA	5,462,000 /53.0	183	64	34	73	12
OGA	2,471,113 /24.0	230	127	0,7	102	0.2
TEVE	1,265,950 /12.0	128	32	29	40	27
Civil servants	1,330,000 /13.0	290	-	-	-	-
Bank Employees	155,285 / 1.5	377	102	96	103	76
OTE	150,552 / 1.4	324	70	110	78	66
DEH	149,033 / 1.4	307	75	106	101	25
TSAY	105,123 /1.0	239	95	6	98	40
NAT	170,000 /1.6	336	104	102	121	9

Table taken and adjusted in to Euros from (Soulis 1999:218), [www.statistics.gr](http://www.statistics.gr), and [www.labor-ministry.gr](http://www.labor-ministry.gr)

According to Yfantopoulos (1988), the discrepancies in the delivery and access to health services between the 'noble' and non-'noble' health insurance funds existed long before the establishment of the Greek NHS in 1983.

Greece spends approximately 10% of its GDP on health care (2005), a percentage that lies above the average of 9% in OECD countries, yet its per capita GDP is one of the lowest and its citizens the least satisfied with their health services (Mossialos 1997; OECD 2007). Health care in Greece is funded mainly through the central government budget (general taxation, 30.4% in 2000, of which 58.4% was from indirect taxes), social insurance funds (25.9% in 2000, comprising employers' and employees' contributions), private health insurance (2.3% in 2000), and out-of-pocket payments for the remaining 41.5%. A significant part of out-of-pocket payments is informal.

<sup>15</sup> Although according to the 1995 statistical bulletin the total population of Greece was 10,454,019, the number of insurees exceeds 11 million. This means that a certain percentage of insurees is registered in more than one health insurance fund.

In addition to this, the self-employed under-report their incomes to avoid tax, and while employees and employers together contribute above 44% of gross wages to the social security system, small entrepreneurs and traders make lower monthly lump-sum payments between 17% and 37% of the gross earnings of an average production worker. Farmers make no contributions, and professionals have their own contribution supplemented by third-party taxes - essentially earmarked levies that are transferred to the relevant institution (Bronchi 2001). As a result, civil servants, bank and telecommunication employees, professionals and the self-employed contribute less to the funding of the NHS and social insurance funds than the rest of the population, yet many of them enjoy better benefits and services than an employee insured in IKA would receive from his/her health insurance. Thus the financial burden of the NHS is not evenly distributed among occupational groups.

Out-of-pocket payments are very high, mainly composed of direct (for dental or primary health care) and informal payments for NHS hospital care. Informal payments reflect the inability of the Greek State to establish comprehensive coverage of the population, the way health insurance coverage has developed, the desire of doctors for supplementary income, and, some scholars argue, patients' willingness to express their gratitude to the doctor personally in order to encourage the doctor to provide better treatment.

Incomplete funding of the NHS also results in a flourishing market in private diagnostic services and private primary care. In addition, around 5-8% of the population has private health insurance. Unlike private medical insurance in the rest of Western Europe, the bulk is insurance taken out by individuals and only 30% of policies are through employers (Economou 2001).

The financing mechanisms described above mean that health care services' financing in Greece is regressive, relying on indirect taxes, with favourable treatment of high income earners, and the self-employed as far as tax and social insurance contributions are concerned, and with high official and informal private payments. Furthermore, as the administration of the insurance funds is not linked, their purchasing activities are not coordinated. Resource allocation is based on historical precedent, and regional differences in needs and access flourish.

Physicians working for the NHS are full-time salaried employees. Until 2001, they could not see patients privately in return for fees. However, many hospital doctors practised privately even when this was illegal and some special categories of hospital doctors have always had this privilege; i.e. university doctors and armed forces doctors. Doctors that practise privately comprise three groups: doctors providing services on an exclusively private basis, the cost of which is fully covered by the patients through out-of-pocket payments; doctors working in polyclinics of insurance organisations; and doctors contracted to one or more funds, working from their private surgeries and paid by fee-for-service.

The reimbursement methods used by the Greek health care system create perverse incentives to doctors to offer more services irrespective of their value. This is more obvious in the case of doctors contracted on a part-time basis to various health insurance funds, such as IKA. Since service in these institutions is poorly paid, doctors recruit private patients through their everyday institutional salaried practice. In addition to this, Greece has to deal with a severe over-supply of doctors since there are no controls on numbers trained or the quality of care provided. Once these physicians begin their practice they realize that the payment they receive does not meet their expectations. On the contrary, the payments they receive are consistent with the limited resources available to the Greek public health care system.

The involvement of the private sector in health care delivery is extensive and has been growing rapidly since the early 1990s. One explanation for the rapid growth of diagnostic centres is the restrictions that PASOK imposed on the private hospital sector in 1983, the under-investment in the public sector and the establishment of special relations between NHS doctors and diagnostic centres, where doctors act as promoters of private diagnostic centres and are paid to refer patients to them.

## **6.2 Physicians' Reimbursement, Health Care Workforce Allocation and Health Care Professional Organization**

### **6.2.1 Reimbursement**

The medical care payment followed by the Greek system provides perverse incentives to doctors to offer more services. Specialists working in hospitals and health

centres are paid a salary and contracted in ambulatory settings on a fee-for-service basis. As their oversupply continues and resources are restricted, no method of reimbursement will meet their expectations, and as a result they continue to receive informal payments. All hospital doctors are salaried full-time employees, but according to Law 2889/ 2001 (MoH 2001), they are allowed to see patients privately in the afternoon for fees. Of course many did so even when this was prohibited, receiving formal fees and informal payments. In many cases doctors use their time working in public hospitals or health centres as an opportunity to recruit patients for their private practices. This way they have powerful incentives to minimize their work and effort on their salaried institutional practice and spend more time in their private surgeries, whether this is illegal or not. This negatively affects patients' access to public hospitals and clinics, and of course, their disposable income, as they have to pay for more of their health care. Furthermore, there are no ways of measuring or monitoring quality and performance (e.g. peer review) of general medical activities. In addition, no collection of data on mortality or other outcome indicators is carried out.

Contracted physicians argue that their salaries are relatively low, and Davaki and Mossialos (2005) suggest that this is why doctors inflate their claims by adding false consultations. False consultations and increased referrals to private diagnostic centres, for those doctors that have 'informal' arrangements with private diagnostic centres, generate additional income for physicians. OAEE (the fund for merchants, manufacturers, owners of small businesses, taxi and lorry owners or drivers) pays its doctors on a capitation basis, and IKA has only full time or part time salaried physicians. OGA's (Agricultural Insurance Organization) members have access to salaried NHS doctors, health centres and 8,000 contracted specialists that are not paid by the fund for prescribing pharmaceuticals to their patients. In addition to that, OGA members must pay out-of-pocket for non-NHS consultations. Differences in the reimbursement schemes of physicians contracted by the insurance funds have an impact on primary health care expenditure. For example, OPAD (the civil servants' health insurance fund) , which pays physicians on a fee-for-service basis, spends three times as much per capita as the OAEE (capitation payments) and twice that of IKA (salaried). The interpretation of this



peculiarity should be undertaken cautiously as the majority of the retired population of OAE is insured by IKA, and IKA engages in cost-shifting to private providers.

The issue of informal payments to doctors has been troubling the Greek government for over two decades, but the complexity of the issue and the way it is culturally embedded seems to make things even worse. The doctors' unions continue to argue that informal payment is 'rare' and happens because doctors are poorly paid by the State (Colombotos and Fakiolas 1993). One could accept the fact that doctors' payments are not satisfactory, but one could also stress that their official payments are quite compatible with the country's level of economic development. In 1983, when the NHS was instituted and public hospital doctors had to work exclusively for it, without practising privately, a considerable salary increase was made, to compensate doctors for their loss of private practice and to abolish informal payments. As a result, their salaries went up by 250%, but this improvement in their reimbursement seemed to appeal only to junior and leftist doctors, who from the beginning had supported the NHS, and felt that it could provide them with a secure and fair income. Many senior doctors, on the other hand, who had previously enjoyed significant privileges in hospitals, as they had had dual practices and had already established a network of patients devoted to them, resigned from public practice and others just ignored the rules.

In 1992, there was a second attempt by the Conservatives to tackle the issue of informal payments (MoH 1992). The State this time allowed doctors to choose between three levels of employment, full-time, part-time or paid on a per-case basis. No more than 492 doctors joined the second or the third modes, as they were sure that they could continue to practise illegally without any consequences. The latest Law 2889/2001 permits doctors to practise privately twice a week within the public hospitals. It is not yet known whether this pattern will work or not, since doctors continue to be paid a salary, so they still have incentives to refer their morning public patients to their afternoon private clinics (Mossialos and Davaki 2002).

### **6.2.2 Health Care Workforce Allocation**

Human resources in the Greek NHS represent a typical example of the complexity of the health care sector. There is a significant oversupply of physicians, dentists and

pharmacists who benefit from an open-ended system of financing, and who are not subject to any kind of control of the quality or quantity of their practices.

Employment in the health sector in Greece grew from 1.5% of total employment in the early 1990s to 3.6% in 1998. Table 6.6 depicts the rise in the number of health sector by professionals.

Health Employment	1982	1992	1999
Practicing Physicians	25,909	38,738	46,124
Female Practicing Physicians	6,736	11,234	15,373
Practicing Specialists	16,197	24,889	31,112
Practicing Dentists	8,007	10,403	12,152
Practicing Pharmacists	5,082	7,834	8,767 <sup>17</sup>
Practicing Nurses <sup>18</sup>	21,050	36,505	41,151

Source: (OECD 2002)

The number of physicians has doubled over the past twenty years, while there has been a notable increase in female representation. What is more interesting is the observed concentration of doctors in Greater Athens and Thessalonica. It seems that 60% (24,487) of the doctors are concentrated in these two urban centres, leaving the rest of the country with only 16,543 (see Table 6.7). This lack of staff in the rest of Greece establishes the basis for inequity in health service access.

The total number of doctors in Greece was 43,037 in 1997, of whom 21,441 were hospital doctors and 21,589 were doctors involved in primary health care provision. Since 1969 the number of doctors has almost tripled, but this cannot be said for GPs. The number of GPs in 1969 was 2,227 and in 1997 only 3,509 (see Table 6.8). Over half (25,754) of the doctor population in 1997 were specialists.

<sup>16</sup> Data refer to both private and public health sectors

<sup>17</sup> 1998 data

<sup>18</sup> Registered and assistant nurses

**Table 6.7 - Number of doctors by Geographic area: Years 1974-1997 (National Statistical Service of Greece ( ESYE in Greek) 1970 - 2001).<sup>19</sup>**

Years	Greece Total	Greater Athens	Thes/Loniki	Rest of Greece
1974	17,942	10,342	2,736	4,864
1979	22,337	12,736	3,414	6,187
1984	28,212	15,486	4,297	8,429
1990	34,336	17,418	5,521	11,397
1992	38,738	19,861	5,793	13,084
1997	43,030	20,351	6,136	16,543

**Table 6.8 - Doctors, non-Specialists and GPs by geographic region. (Athens-Rest of Greece): Years 1969-1997 (National Statistical Service of Greece ( ESYE in Greek) 1970 - 2001).<sup>20</sup>**

Years	Greece, Total			Greater Athens			Rest of Greece		
	Doctors, Total	Without specialty	GPs	Doctors, Total	Without specialty	GPs	Doctors, Total	Without specialty	GPs
1969	13.712	4.134	2.227	6.864	1.319	1.357	6.848	2.815	870
1974	17.942	6.107	2.958	10.342	2.611	2.114	7.600	3.496	844
1979	22.337	8.697	2.770	12.736	4.682	1.755	9.601	4.015	1.015
1984	28.212	10.135	3.383	15.486	5.281	1.988	12.726	4.854	1.395
1990	34.336	12.268	3.007	17.418	6.012	1.485	16.918	6.256	1.522
1992	38.738	13.849	3.187	19.861	6.788	1.606	18.877	7.061	1.581
1997	43.030	13.767	3.509	20.351	5.982	1.667	22.679	7.785	1.842

Unsurprisingly, Greece has one of the highest doctor to population ratios among OECD countries. In 1997 Greece had 4.1 doctors per 1000 population, ranking third after Italy and Spain, with 5.8 and 4.3 doctors/1000 respectively (OECD 2002). The number of inhabitants / doctor was 252 in 1996 (in 1967 this figure had been 678 inhabitants/doctor, evidence provided by the ESYE) (see Table 6.9).

<sup>19</sup> Source: Social Welfare and Health Statistics, 1970 - 2001, and National Statistics, 2001, National Statistical Service of Greece. (ESYE)

<sup>20</sup> Source: Social Welfare and Health Statistics, 1970 - 2001, and National Statistics, 2001, National Statistical Service of Greece. (ESYE).

**Table 6.9 - Number of Inhabitants per bed and doctor: Years 1967-1996 (National Statistical Service of Greece ( ESYE in Greek) 1970 - 2001) <sup>21</sup>**

Years	Inhabitants/ Bed	Inhabitants/ Doctor
1967	167	678
1970	160	616
1975	154	491
1980	161	413
1985	182	341
1990	198	296
1995	200	255
1996	199	252

### 6.2.3 Health Care Professional Organisations

There are 3 types of collective medical organizations in Greece:

1. Official medical organizations;
2. Specialist medical societies;
3. Doctors' unions.

The first category includes the Pan Hellenic Medical Association (Panellinos Iatrikos Sullogos, or PIS), which was established in 1923 and codified in 1939 under the Metaxas dictatorship. It is mandatory for all doctors to register themselves with one of the 58 local societies of PIS. The local societies are responsible on behalf of the State for the detailed administration of the profession at the local level, including disciplinary procedures. As an organization though, it does not have much influence on the government, even in relation to central issues such as education, training and professional development.

The second category includes a variety of specialist societies. Within the profession their role is very limited, as the State pays little attention to the production of work by these bodies. They provide an autonomous sphere for the discussion of clinical developments and medical science. Parallel to that, the university doctors have

<sup>21</sup> Source: Social Welfare and Health Statistics, 1970 - 2001, and National Statistics, 2001, National Statistical Service of Greece. (ESYE).

established an informal network for academic physicians which has played an important role in negotiations over health reforms, but their role is not expressed through an official organization. The third category, are the Doctors' Unions, which represent the 'independent voice' of doctors. The main union is the Association of Hospital Doctors of Athens and Piraeus (EINAP-Ένωση Ιατρών Νοσοκομείων Αθηνών-Πειραιώς), which was established in 1976. Representing doctors working in public hospitals in greater Athens, it has 9,000 members. Many hospital doctors do not subscribe to EINAP. However, any demands put forward formally by EINAP and agreed to by the State apply to the whole body of public hospital doctors. EINAP was established just after the restoration of democracy (1974) and it represented the need of junior hospital doctors to have a trade union in order to make organized demands of the State. It also reflects the general notion of democratization and need for free speech that flourished after the restoration of democracy. EINAP was one of the most concrete and progressive trade unions of that time (Socialist and Left coalitions dominated EINAP's representatives).

Another important union is the Health Scientists of Social Insurance Institute in Athens-Piraeus (SEYPIKA Athens-Piraeus), established in 1980, representing around 6,000 doctors. Regional organizations of both of them are established around Greece. Although these two unions are supposed to be the most independent and powerful voices for their members' rights, they could not escape clientelistic practices, as EINAP had PASOK (Pan-Hellenic Socialist Movement) representatives sitting on its central committees during the 1980s. Nowadays, PASOK representation is also quite strong, but the majority of the votes go to the Conservatives. In the 2006 election, the Conservatives got just over 38% of the EINAP member votes, while the Socialists gained only 22%.

Finally, in each public hospital there is a health workers' committee, which formally represents the workers, including doctors and nurses, but doctors usually find these committees irrelevant to their concerns and interests (Colombotos and Fakiolas 1993; Dent 2003).

## **Chapter 7: Methods of Data Collection and Analysis**

### **7.1 Introduction**

This chapter describes firstly why a case study method was selected as the most appropriate research method to reach the aims and the objectives of this thesis, which are to reveal the influence of the medical profession and trace its origins, whether these are historical, cultural or institutional, taking into consideration the particularities of the Greek State and its policy making. Secondly it contains a review of the literature relating to case studies and their strengths and weaknesses. Thirdly, it describes the different methods of data collection used in the thesis. Finally, it provides an account of the analysis of qualitative data (documents and interviews) and a description of the content and thematic analysis carried out on documents and semi-structured interviews with key informants. Within the analysis of qualitative data, emphasis is given to the construction of three historical narratives (chapters 8, 9 and 10), which are based on written resources and on the information provided from the interviews with key informants. The last part of the chapter focuses on the interviews (selecting informants, conducting the interviews and checking the validity and reliability of interviewees' accounts), the limitations of the methods, and how the author dealt with them.

### **7.2 Research Methods**

Social research can be theoretical or applied. Theoretical research involves *“generating new theories or testing existing ones”* (Patton 2002:215). Applied research is about *“using the knowledge acquired through research to contribute directly to the understanding or resolving of a contemporary issue”* (Ritchie 2003:24). It is difficult to be absolute in terms of whether or not a research study is purely theoretical or applied (Silverman 2000).

This study is closer to theoretical research, as it borrows existing theoretical approaches from the international literature, and applies them to a specific country case study. Existing power theories of professions and ‘New Institutionalism’ are used to reveal the influence of doctors in health policy making, under the specific peculiarities of the Greek State and Welfare regime (Southern Welfare State Model).

The principal methods to address the research questions of this thesis are derived from qualitative research on policy analysis. The need for qualitative research methods

is dictated by the nature of the research evidence and the questions posed. Defining and quantifying key aspects of this study such as the 'power' or 'influence' of the medical profession is difficult, what qualitative experts call 'ill defined' or not well understood and difficult to measure. The subject of this thesis - the influence of organized medicine in health reform in Greece - is a complex, deeply rooted and sensitive topic; and one that is better addressed by the use of qualitative research methods (Plummer 2001; Ritchie and Lewis 2003).

### **7.3 Case Study Research**

The case study approach, as defined by Eisenhardt (1989), represents a strategy which focuses on understanding the existing dynamics in single settings, using an explanatory or descriptive framework (Eisenhardt 1989). Case studies in political science and sociology can focus on the microcosmic or the macrocosmic. The first category includes studies about several important political personalities such as important political leaders and the latter includes political groupings such as pressure groups, political parties, party systems etc. This thesis focuses on the macroscopic (Eckstein 1975). The predominant theoretical framework of this thesis, historical institutionalism, is applied to three sub-case studies or policy 'episodes', which are the establishment of the Greek NHS in 1983, and the reforms of 1992 and 2001, in order to study the influence of the medical profession on health care reforms in one case, that of Greece. Similarly, Gouldner's (1954) study about 'Patterns of Industrial Bureaucracy', which is about the evolution of bureaucracy within a Midwestern manufacturing plant, relied on theoretical insights from multiple cases. In his efforts to develop a theory about patterns of bureaucracy, he compared three separate programs: no-smoking, safety and bidding rules within the same plant. Drawing heavily on the contributions of authors such as Gouldner (1954) and Eisenhardt (1991), the role of the Greek medical profession is studied through three case studies, represented by the health care reforms of 1983, 1992 and 2001. The multiple case studies serve as a vehicle to replicate insights (Gouldner 1954; Eisenhardt 1991).

According to several critics, case study method is not suitable for generalization (Giddens 1984; Flyvbjerg 2006). Others would say much depends on the researcher's interpretation of the findings. Several other social scientists suggest that it is more useful

for generating hypotheses than testing them. Finally, there is a widespread belief that the results of a case study are difficult to verify. From these comments, it seems that three aspects of in depth case study research are being questioned: theory, reliability and validity. As a result, what is questioned is the scientific value of the case study as a research method (Flyvbjerg 2006). The above criticisms represent the most common misunderstandings on the role, context and utility of the case study as a research method.

### 7.3.1 Case Study and Misconceptions

There are many scholars, such as Campell (1975) and Eysenck (1976) who strongly doubted the scientific value of the case study as a research method in the past; however at a later stage in their careers, they acknowledged this doubt as a mistake. For example, Eysenck initially argued that the case study was just a method for producing anecdotes, and only at a later stage recognized that “..... *Sometimes we simply have to keep our eyes open and look carefully at individual cases - not in the hope of proving anything but rather in the hope of learning something.....*” (Eysenck 1976:9). Flyvbjerg (2006:224) argued that “*proof is hard to come by in social science because of the absence of a ‘hard’ theory, whereas learning is possible*”. Theories created through the use of case studies can be general, vague, incomplete and broad in their claims (Ragin 1992; Ragin and Becker 1992). Ragin argues that it is not a greater degree of theoretical clarity or specificity that is needed in case studies; rather researchers need to realize that practical limits exist on the degree to which theory can precisely guide empirical research. Empirical research can escape the limitations of theory. As a result, it is better to have broad perspectives in terms of where empirical research can lead and try to avoid general, vague, incomplete and misleading theories. In other words, case studies can be seen as an important learning method, which provide context - dependent knowledge and what Flyveberg (2006) calls ‘virtuosos’. Since predictive theories or universals do not exist within the context of the social sciences, it is more valuable to produce context-dependent knowledge, rather than searching for predictive theories and universals (Flyvbjerg 2006).

Much criticism has been directed at generalizations made on the basis of a case study. The current thesis about the Greek medical profession can be categorized according to Eckstein’s taxonomy as a ‘configurative – idiographic’ case study. The



combination of the two characteristics-figurative and idiographic-denotes the “...aim of the studies to present depictions of the overall Gestalt (i.e. configuration) of individuals: politics, parties, party systems, etc., through the idiographic element in them that either allow facts to speak for themselves or bring out significance by largely intuitive interpretation, claiming validity on the ground that intensive study and empathetic feel for cases provide authoritative insights...” (Eckstein 1975:97). According to the literature, figurative - idiographic studies are extremely useful, if well written with vivid statements on their topic. Their intuitive interpretation is usually persuasive and can be credited as having an impressive feel for the case study. There is an important disadvantage, however, if the researcher does not make clear what his/her intentions are from the beginning. As Verba (1967) argued, figurative - idiographic studies are difficult to develop when building general theory. However, as long as the researcher is clear from the beginning that it is not his/her intention to build a theory, which is the case in this research, then this criticism, can be mitigated.

The fact that knowledge possessed from the single case study of the Greek medical profession cannot be formally generalized does not mean that it does not belong to the general process of collecting knowledge and becoming an expert in the specific field of the Greek health care system. As Flyvebjerg argues, “a purely descriptive, phenomenological case study without any attempt to generalize can certainly be of value in this process and has often helped cut a path towards scientific innovation” (Flyvebjerg 2006:227).

At the same time, the generalisability of case studies can be enhanced if certain criteria are followed regarding the effect of the researcher’s bias on his/her on-going work. Vaughan (1992) argues that constant exchange of information with colleagues in the field, using insiders and outsiders, and comparison with existing documented cases, can help the researcher broaden his/her perspectives and avoid the fallacies of constructing ready-made results and interpretations. For example, during this research, the interim findings were presented in formal workshops and seminars, and in an article based on preliminary results which was peer reviewed and published (Nikolentzos and Mays 2008). The feedback received not only from the independent experts that reviewed the article, but also the advice on critical issues from several experts in health policy,

were also valuable. Overall, throughout the duration of the research, there were several opportunities to discuss the thesis topic with a range of people who were either outsiders or insiders, and to compare the findings with other case studies that were similar, although carried out in another field (Vaughan 1992). As a conclusion, the goal in doing a case study is “.....to expand and generalize theories (*analytic generalization*) and not to enumerate statistical frequencies (*statistical generalization*).....” (Yin 1984:10).

Questions to be answered by theories are usually restated as problems or puzzles. The next step is to formulate some sort of hypothesis, which means formulating, by some means a candidate solution for the puzzle, which is testable in principle and sufficiently plausible. Eckstein (1975) argues that while theories cannot be derived from case interpretations, such interpretations can, and should be derived from theories. The unique explanation of a particular case according to Verba (1967) can rest on general hypotheses, so the criticism that case studies are difficult to add up is not relevant.

Another misunderstanding relates to the risk of bias. In the worst case scenario, it means that the research was carried out to verify the researcher's preconceived notions. This usually reflects negatively on the scientific value of the research. Bias in verifying research results is a common disadvantage of many research methods, and should not be attributed only to case studies. However, a lot of researchers blame case studies and other qualitative research methods, for giving too much space to the researcher's subjective judgment (Flyvbjerg 2006). If a case study is rigorous, in the context of qualitative research, then it compares to a quantitative study in terms of risk of bias. In addition, case studies have the important advantage of offering an in-depth account of real life situations and test views or theoretical frameworks during the unfolding of the phenomena in practice. Within the terms of this research, a case study is able to offer an in-depth account of the patterns of influence of the medical profession which are then tested according to the real-life practice of the health care reforms that the country has experienced since 1974 (Eckstein 1975). In addition to this, an advanced understanding of a case study means two things are necessary: a close approach towards reality and generating knowledge. That is why Beveridge (1951) concluded that one has more things to learn from an in depth case study than from large surveys involving statistics in large samples (Beveridge 1951) cited in Flyvbjerg (2006).

The last misunderstanding regarding case studies has to do with fact that ideally a case study provides a detailed narrative, which is difficult to summarize into a scientific formula, theory or a general proposition. However, Flyvbjerg argues that for researchers conducting a case study this is not a problem, on the contrary a particularly thick and hard to summarize narrative is a sign that the study has uncovered a particular rich problematic (Flyvbjerg 2006).

#### **7.4 Overall Design and Methods of Data Collection**

There are two main sources of data for this thesis: documents and semi-structured interviews. Written resources included government documents (public announcements, Parliamentary bills and legislation, reports, debates, Parliamentary minutes, health care reports, formal guidelines, legal opinions/court reports), position papers and publications of medical associations and other interest groups in health care, and accounts of the major health care reform struggles in newspapers, journals and periodicals.

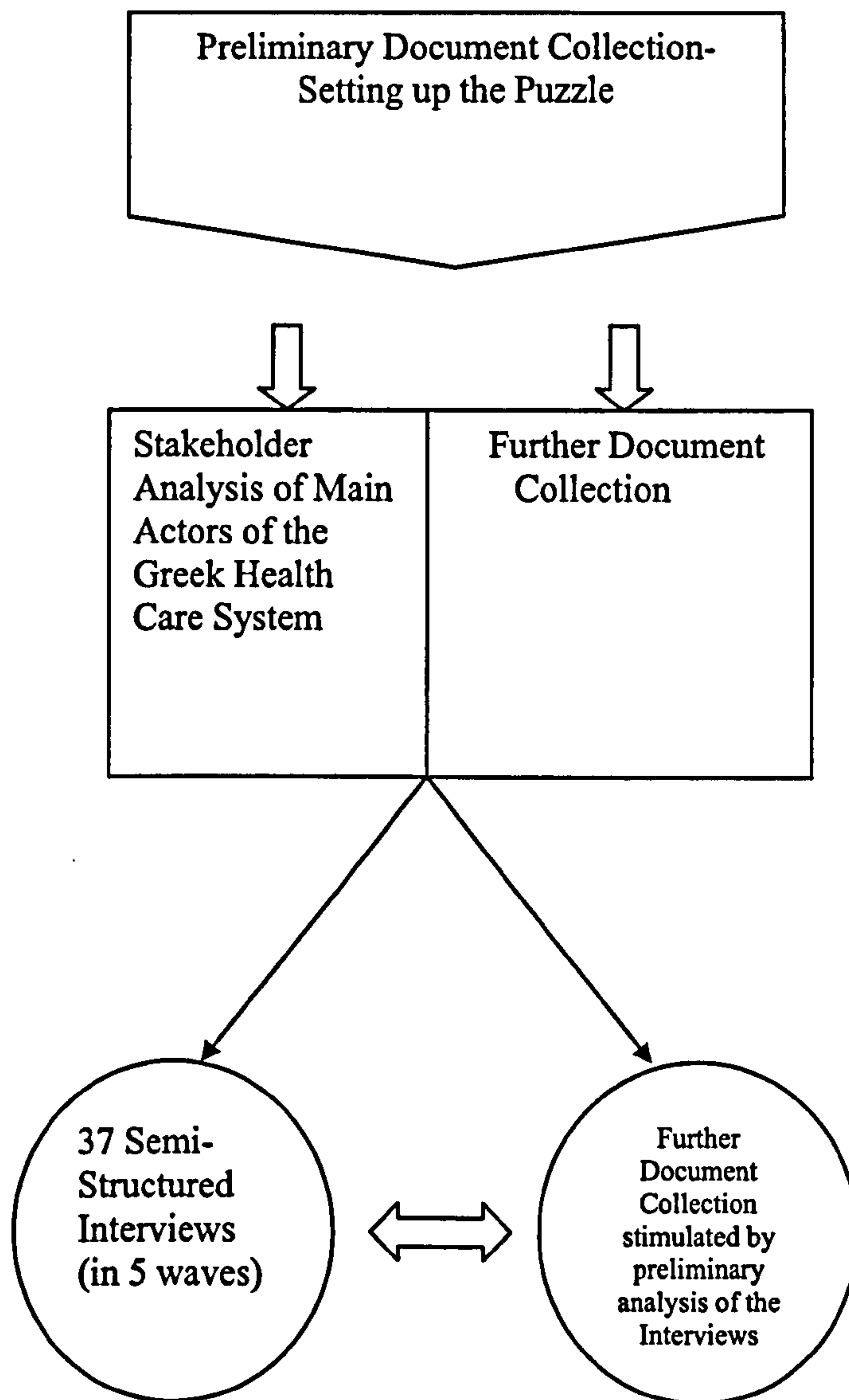
Documentary analysis provided crucial information about the puzzle of the Greek health care system. Setting up the puzzle meant that a lot of background information needed to be collected relating to the time when the three reforms took place. A literature review contributed to the collection of data by identifying the main theoretical frameworks applicable to international health care systems (theory of professions, structural interests and new institutionalism). However, additional information was analyzed in the light of understanding the peculiarities of the Greek health sector. As a result, a significant amount of information was collected on the Southern Welfare State peculiarities and the birth of the Greek State and its development. The first stage of documentary data collection was completed in December 2003 and January 2004. This first part of the documentary collection contained minutes of the Parliamentary debates on the 1983, 1992 and 2001 reforms, public announcements and correspondence between the Ministry of Health and the main medical associations, together with articles from newspapers relevant to the debate on these reforms. Most of these articles were written by government officials, academic doctors and medical association representatives. This material was used to prepare a preliminary account of the health care reforms in Greece

since 1974 using a broadly historical institutionalist perspective (Nikolentzos and Mays 2008).

In order to proceed with the second main part of the data collection, the semi structured interviews, it was necessary to identify the key interviewees. The identification of specific names and organizations benefited from a stakeholder analysis as an interim stage between collecting documents, identifying themes/explanations, and conducting interviews. It was then possible to identify the main organizations-interest groups in the health care arena-and map their interest (i.e. goals, motives, strategies) and set out their network of alliances, formal or informal (Varvasovszky and Brugha 2000). Simultaneously further written data collection continued because the preliminary results of the stakeholder analysis dictated that further information was needed for the appropriate selection of interviewees.

37 semi-structured interviews were undertaken with key informants that had been involved in various ways in planning or implementing the reforms. From them the first five were preliminary interviews conducted in order to test the topic guide. Preliminary interviews revealed the need for more interviews, as gaps in knowledge around the reforms were realized, and further collection of documents (mainly Parliamentary minutes and newspaper articles) was undertaken for the extended time periods (1984-1989 and 1994-1997). Information accumulated from this procedure contributed to complete the narrative before and after the 1983, 1992 and 2001 reforms. Figure 7.1 presents the process of data collection:

**Figure 7.1-Data Collection-A 3 Stage Process**



#### **7.4.1 Semi-Structured Interviews with Key Experts of the Greek Health System**

The type of interview chosen was semi-structured interviews with key informants. Generally speaking, experts in any field, including health care, can be a unique source for inside information about policy-making process (Dorussen, Lenz et al. 2005). Carrying out semi-structured interviews means that the researcher interviews the key informant on a face-to-face basis, using a checklist, but adjusted according for each of the key informants (e.g. academics/health policy experts, ministers of health/politicians,

bureaucrats, trade unionists, university doctors and journalists). Semi-structured interviews enable the researcher to have a basic structure of the interview, but at the same time be flexible and interactive, leaving the respondent room to express him/herself. In addition to this, semi-structured interviews generate a wealth of information and are more effective in complex research topics (Bowling 2002). Generally speaking, experts in any field, including health care, can be a unique source for inside information about policy-making process (Dorussen, Lenz et al. 2005).

Interviews were digitally recorded, but not all of them were transcribed. As a result, the main data collection tool from interviews was contemporaneous notes that enabled systematic data analysis in terms of subjects and codes. Each interview lasted between half an hour and one and half hours depending on the issues raised by the informant and his/her willingness to talk. It was a common practice to carry out the interviews in the interviewees' own space which was normally their office, house, or in places that the interviewees felt comfortable to speak which in several cases were small cafés.

Three key informants requested copies of the transcripts from their interviews; thus in order to fulfil their request, three interviews were transcribed. In addition, a further five transcriptions and translation of specific parts of the interviews were made for quoting purposes. Indicators of which interview should be transcribed in full were the well rounded knowledge the key informants demonstrated in relation to all three reforms, the key role of informants in the planning or the implementing of the reforms, the results of the preliminary documentary analysis which indicated key informants who were the 'protagonists' of the Greek Health Care System since 1983, and important candidate interviewees that key informants suggested during the interviews. During the interviews one of the most important prompts to choosing which interviews to transcribe or give more weight to than others was if the interviewees had been recommended by other interviewees.

The majority of the interviews were conducted in Athens in five one month periods in August 2005, November 2005, February 2006, June 2006, and November-December 2006. The topic guide used in the interviews included questions about three health reforms between 1983 and 2001, with adjustments according to the interviewee's

background and post within the health care sector or relevance to the three reforms. Interview questions were derived from the contextual analysis of the Greek health arena, and from the preliminary historical account of the evolution of Greek health insurance, that had already been carried out. It is not appropriate to use a formal questionnaire, as the aim of semi-structured interviews is to provide the interviewee with the necessary space to express him/herself. The interviews were carried out based on the following topics:

- Health Care and Political Agenda settings
- Decision making and implementation of health care reforms
- Financing issues of the Reforms and reimbursement of the main actors. (i.e. Doctors and Social Insurance Funds)
- Political ideology issues concerning: A. Political parties, B. Medical Associations, and C. Trade Unions.
- Path dependency and critical conjunctures of the Reforms. (please see APPENDIX 2)

Informants were chosen because they were experts in health policy (academic health policy experts), or they were directly involved in health policy making or implementation (ministry of health officials or ministers), or they were representatives of the main trade unions, or they had a long professional interest in health care. In addition to this, the medical profession was separated into hospital and university doctors, since they have different labour relations, reimbursement and social status within Greek society. Finally, journalists specializing in health care issues were extremely valuable sources of information, as there was a strong need for background and secondary information. They were extremely useful in terms of connecting incidents in the health arena with the broader political arena.

It was also essential to try and interview politicians and ministers of health from both the biggest political parties in Greece, the Conservatives and the Socialists. This was difficult, as for almost the last 20 years the Socialists had been in power and only recently the Conservatives managed to gain power. As a result, Conservative politicians were generally reluctant to talk.

Interviews with key informants in the Greek Health care arena were finished by December 2006, and each set of interviews was supplemented by collection of written data, that was necessary for the verification of the interviewees' arguments. Throughout data collection, a fieldwork diary was maintained to record all the actions of the past (i.e. document collection or interviews) and also to note down all the difficulties and peculiar conditions under which a researcher has to carry on with his research, especially in terms of asking important key informants to give him an interview.

The interviewees fell into six categories, although the nature of individual career progression often meant that there was a significant degree of overlap between these:

- Academics/Health Policy Experts
- Ministers of Health/Politicians specialized in health
- Bureaucrats
- Trade Unionists
- University Doctors
- Journalists

The list below provides a detailed profile of the 37 interviewees, while Table 7.1 shows how the informants related to the three health care reforms.

#### **Academics/Health Policy Experts:**

1. Health Policy Consultant (late 70s-early 80s)/Lawyer,
2. EKKE researcher & Academic,
3. Professor of Health Economics & Health Policy, Consultant to the Ministry of Health,
4. Lawyer/Health Care Law Expert
5. Health Policy Expert & Social Medicine Academic
6. Professor of Health Policy, Ministry of Health Consultant and Ex-President of IKA.
7. Professor of Public Health, Foreign Expert on the Greek Health Care System
8. Professor of Health Policy, Consultant to the Ministry of Health.



**Ministers of Health and Politicians specializing in health:**

9. Minister of Health and MP,
10. Deputy Minister of Health and Trade Unionist,
11. Minister of Health, Doctor and MP,
12. Minister of Health & Academic,
13. Minister of Health and MP,
14. Minister of Health and Doctor,
15. Deputy Minister of Health and University Doctor,
16. Conservative MP and Doctor,
17. Deputy Minister of Health and University Doctor,
18. Conservative MP & Consultant to the Ministry of Health.

**Bureaucrats:**

19. Ministry of Health official, Health Policy Expert Academic),
20. President of IKA and Academic,
21. Vice-President of the Central Health Council, General Secretary  
for the Ministry of Health and Legal Expert,
22. President of IKA and Deputy Minister of Health,
23. President of a Regional Health System, Consultant of the Ministry  
of Health.
24. Director of a Regional Health System and Manager to a Public  
Hospital

**Trade Unionists:**

25. Public Hospital Doctor/Far Left Trade-Unionist
26. Public Hospital Hospital Doctor-EINAP Trade Unionist,
27. Public Hospital Doctor-EINAP Trade Unionist,
28. Public Hospital Worker-POEDHN Trade Unionist,
29. Private Doctor and Member of the Athens Medical Association,
30. Public Hospital Trade Unionist-OENGE Trade Union,

31. Public Hospital-EINAP Trade Union and Member of the Committee of the Athens Medical Association

**University Doctors:**

32. University Doctor of Pharmacology

33. University Doctor of Cardiology

**Journalists:**

34. Journalist of 'H KATHIMERINI' Daily Newspaper,

35. Health Sector Journalist of 'H KATHIMERINI' Daily Newspaper.

36. Health Sector Journalist of 'H KATHIMERINI' Daily Newspaper.

37. Health Sector Journalist of 'RIZOSPASTIS' Daily Newspaper.

**Table 7.1 - Informants' Knowledge of the 3 Reforms**

Key-Informants	Health Care Reforms in Greece		
	1983	1992	2001
<i>Academics/ Health Policy Experts: (A)</i>			
1. Health Policy Consultant/Lawyer (1A)	x		
2. National Centre for Social Research Researcher (2A)	x	x	x
3. Health Policy Expert, Academic & Consultant (3A)	x	x	x
4. Lawyer/Health Care Law Expert (4A)			x
5. Health Policy Expert/Consultant & Social Medicine Academic (5A)	x	x	x
6. Academic/Consultant/Ex-President of IKA (6A)	x	x	x
7. Professor of Public Health (7A)		x <sup>22</sup>	
8. Professor of Health Policy/Consultant & Health Policy Expert (8A)	x	x	x
<i>Ministers of Health/Politicians: (MoH/P)</i>			
9. Minister of Health (9MoH/P)	x		x
10. Deputy Minister of Health (10MoH/P)	x	x	x
11. Minister of Health (11MoH/P)	x	x	x
12. Minister of Health (12MoH/P)	x	x	
13. Minister of Health (13MoH/P)	x		
14. Minister of Health (14MoH/P)	x		x
15. Deputy Minister of Health (15MoH/P)			x
16. Conservative MP (16MoH/P)	x	x	x
17. Deputy Minister of Health (17MoH/P)	x	x	x
18. MP (Conservative) (18MoH/P)	x		

<sup>22</sup> The key - informant generally commented on health politics in Greece in early 90's and presented his own experience in 1994, as a member of the foreign experts committee that Prime - Minister Papandreou invited to make suggestions on the Greek Health Care System.

<b>Bureaucrats: (B)</b>			
19. Ministry of Health Bureaucrat & Health Policy Expert (18B)	x	x	x
20. President of IKA (19B)	x	x	x
21. Secretary of the State in the MoH & Ex-Vice-President of the Central health Council (20B)	x	x	x
22. Vice President of IKA (21B)	x	x	x
23. President of a RHA (22B)	x	x	x
24. President of a RHA (23B)			x
25. President of a RHA (24B)	x	x	x
<b>Trade Unionists: (TU)</b>			
25. Hospital Doctor & Trade Unionist (25TU)	x	x	x
26. Hospital Doctor & Trade Unionist (26TU)	x	x	x
27. Hospital Doctor & Trade Unionist (27TU)	x	x	x
28. Hospital Worker & Trade Unionist (28TU)	x	x	x
29. Private Doctor & Member of the Athens Medical Association (29TU)	x	x	x
30. Hospital Doctor & Trade Unionist (30TU)	x	x	x
31. Hospital Doctor & Trade Unionist (31TU)	x	x	
<b>University Doctors: (UD)</b>			
32. Professor of Pharmacology (32UD)	x	x	x
33. Professor of Cardiology (33UD)	x		x
<b>Journalists: (J)</b>			
34. Journalist (34J)	x	x	x
35. Health Care & Health Policy Journalist (35J)	x	x	x
36. Health Care & Health Policy Journalist (36J)	x	x	x
37. Health Care & Health Policy Journalist (37J)	x	x	x

During the semi-structured interviews, a reshuffle was carried out by the Greek Prime-Minister in late February 2006. This inhibited the minister and deputy minister of health from giving me an interview, on the basis that 'the political scene at that moment was not fertile for any kind of interviews'. On one occasion a representative of the Pan-Hellenic Medical Association avoided the already scheduled interview at his office in the public hospital, by saying that he was very busy. He implied that he did not remember my research topic and that he was not well prepared for the interview, making sure at the same time that I was not a journalist. He was instead, treating patients on Saturday morning in a public hospital, and the majority of them had already prepared the typical informal payment, called 'fakelaki' to give to him after the consultation was finished. I believe that one of the main reasons that he did not want to have the interview was likely to have been the issue of me being present while he received informal payments. My belief was enhanced a few days later when I tried to call him, as he had already told me to do, in order to set another appointment and he deliberately avoided me via his secretary. Other problems that came up during the interviews included:

- interruption by phone calls, colleagues and the general working environment
- Interviewees raised issues within the interviews that they did not want to have tape recorded.
- Interviewees that had experience of only one aspect of the research, i.e. only one of the three health care reforms.

However most of the interviewees were more than willing to speak when contacted for the first time, and engaged in an open and relaxed conversation.

#### 7.4.1.1 Reliability and Validity in Qualitative Research

Reliability is a concept originally developed in natural science and it *“means that applying the same procedure in the same way will always produce the same measure”* (King, Keohane et al. 1994:25). However, according to the ‘constructivist’ school *“there is no single reality to be captured in the first place so replication is an artificial goal to pursue”* (Ritchie and Lewis 2003:270). Ritchie and Lewis understand reliability as replicability and argue that replicability in qualitative research findings is a naive concept. This is because of the complexity of the phenomena being examined. Within this context, the interviews with each of the 37 experts in this research, revealed unique facts; so as a result there was no point in repeating the interviews and there was no way to repeat them (e.g. if a key informant of the original set of interviews is dead, then, there is no way to repeat the exact same study). This is why findings are taken as parts of the research dynamic, strongly related to the context of the research (Ritchie and Lewis 2003).

Instead, qualitative researchers tend to investigate similar issues that are close to the notion of reliability, such as the confirmability of the findings, which is also a way of discussing validity. Glaser and Strauss (1992) prefer ‘trustworthiness’, Hammersley (1992) prefers ‘consistency’ and Lincoln and Guba (1985) ‘dependability’ (Glaser and Strauss 1967; Lewis and Sheps 1983; Lincoln and Guba 1985; Hammersley 1992). All these concepts assess the degree of soundness of a qualitative study. In fact, when a researcher is looking for consistency, dependability and replicability of the data collected, then she/he is looking for the *“collective nature of the phenomena that have been generated by the study participants and the meanings they have attached to them that would be expected to repeat”* (Ritchie and Lewis 2003:271). In other words, there has to

be a degree of certainty that the internal characteristics of the original data, appear outside the study population (i.e. that there are not other interpretations and accounts that are not included in any of the interviews). Another requirement, is the consistency and rigorousness of the analyses made on the data collected.

Ritchie and Lewis (2003) argue that reliability is important for qualitative research and that can be checked at two levels: first, to check the robustness of the study, by making sure that frequent checks are being carried out in terms of the quality of data and their interpretation, and second, to provide as much information as possible for the research process. The ideal process of replication would be if another researcher repeated the original research, like the study of Middletown, Indiana, by Robert and Helen Lynd, published in 1929 and replicated by others in 1937. However, usually there is no need for such an extensive degree of replication (King, Keohane et al. 1994).

Lewis and Ritchie suggest practical questions that the researcher should continuously ask during his/her research:

- Was the sample representative or biased?
- Was the researcher consistent when he/she carried out his/her fieldwork?
- Was his/her analysis comprehensive and systematic?
- Did he/she produce a sound interpretation of the findings according to his/her underlying data?

As with reliability, validity is a concept first conceived for quantitative studies. However, validity is also applicable to qualitative research. Qualitative researchers need to find “*effective means of verifying accuracy or truth in their social inquiry*” (Ritchie and Lewis 2003:274). The fundamental question that researchers need to answer in terms of ‘assessing’ the validity of their study is, “*whether or not we are accurately reflecting the phenomena under study as perceived by the study population*” (Ritchie and Lewis 2003:274).

Flick (2000) suggests practical guidelines to increase the reliability and validity of qualitative research. He argues that in terms of reliability it is important to train the interviewer sufficiently and to analyze the results of the pilot study. In addition to this,

reliability is increased if the interviews are carefully documented and sufficient written information has been gathered about the context of what the interviewees had said. Furthermore, the better the transcription of the interviews, the greater reliability is achieved. Although, only eight interviews were transcribed for this research, reliability depended more on the quality of contemporaneous notes taken from the rest of the interviews.

In terms of validity, checks can be achieved in two ways; first, by sending the data/or the interpretation of the data to the key informants, who might give their consent, correction or reject them (communicative validation); and second by 'triangulation', which is verifying data and their interpretation with multiple resources (documents, interviews, quantitative reports, etc). Transcriptions were not part of the initial design of this thesis, because of the limited resources, type of interviewees (key informants) and the purpose of conducting interviews (mainly verifying preliminary results already found in documentary collection and analysis, and not trying to develop a new theory). However, transcriptions were provided when this was asked (Bauer and Gaskell 2000; Flick 2000).

#### **7.4.2.2 Addressing Reliability and Validity of the Interviews**

One of the main issues in semi-structured interviews with key-informants, (some might classify this process as elite interviewing) is the ability and skills of the interviewer conducting the interview. Since the interviewer and the author is the same person, a particular aspect of the interview process was to make the interviews seem like a 'good talk among old friends' and this was enhanced by the fact that a topic guide was used and not specific questions. On the other hand the flexibility of interviewing key informants on the basis of a topic-guide raises critical issues of validity and reliability. This means that specific actions were followed in order not to compromise the validity and reliability of the data.

The ultimate goal during the interviews was to uncover the truth about what had happened for example - how the Bill was prepared, who lobbied against it or in favour, how the government had to make concessions, how the implementation of the reform was monitored. There were some cases that one interviewee sounded more convincing than another, and in some cases a 'memorable' interview could have shaped the interviewer's

understanding of the reforms. However, the interviewer must always keep in mind that the interviewee is not obliged to tell the truth during the interview. That was a fact taken into account during the interviews and the later stage of analysing them, especially when the interviewees were politicians. Each interviewee had a specific issue that they wanted to point out during the interview, especially if they were politicians. As a result, issues about their possible attempt to increase their reputation were taken into account, and the majority of the politicians - interviewees selected were not active any more, at least in the health sector. In addition to this, another way of minimizing the problem of bias in the interviews was using multiple resources. This meant that the information used from the interviews had been corroborated by written sources (articles in newspapers, Parliamentary minutes or announcements of medical associations) or by other interviews. Furthermore, all of the interviewees were asked to critique their participation in the reforms and to recommend other interviewees who, in their opinion, would have valuable information for the research. By doing this, enough evidence was produced to judge the reliability and validity of the interviewee. Even when the interviewee had not been helpful in clarifying specific issues that were particularly important for this research, or when they wanted only to stress their importance, the interview overall was important as a process and for the information it provided (e.g. one Greek academic/health policy expert argued that the main factor in the Greek health care reforms was the inability of the State to organize primary health care under a unified insurance fund. Although he/she was not very willing to talk about the role of the medical profession, I focused my interest on health insurance funds and I got some very valuable information).

Another important issue in the interviews with experts in the Greek health care sector was the exaggeration of the interviewee's role in the Greek health care sector. This was more obvious in the interviews with politicians who wanted to stress their contribution to the improvement of the system. Unfortunately, there is not a remedy that can fully solve this problem, but specific norms and rules were followed in order to avoid the effect of exaggeration. The first one had to do with the interviewer's preparation for the interview. Each time an interview was scheduled the interviewer was fully prepared and informed about the interviewee. This minimised any chance of being misled during the course of the interview. In addition to this, the interviewer tried to move away from a

particular issue when he noticed that the interviewees tried to emphasize their own importance, and continued with other issues raised by the topic guide.

Another important factor in terms of the reliability and validity of the information coming from a semi-structured interview is the appropriateness of the topic guide, and the trade-offs with probes. The preliminary stage interviews in 2005 helped in improving the topic guide and the researcher's probing skills. Probing is an essential task during interviews, and many times different interviewers might not probe at the same points even if they receive the same answer. As the interviewer was preparing for fieldwork, and specifically after the preliminary interviews, several written in the topic guide for areas were included, which proved to be intriguing or incomplete (i.e. the implementation process of the 1983 reform, the power politics during the Conservative government of 1992 and the importance of the 1994 committee of foreign experts, and power politics within the Socialist party during the implementation process in 2001, and after Minister Papadopoulos had resigned). There is always a theoretical trade-off between strictly following the topic guide, and following up incomplete or intriguing questions, but in the majority of the interviews this was not the case, as there was sufficient time for all interviews (Berry 2002).

Another critical issue in semi-structured interviews is whether and if so how to protect respondents' anonymity and/or confidentiality. A detailed table with all the key-informants is provided, which informs the reader about the main characteristics of the interviewee, (main profession-discipline, information categorisation according to the three reforms), but at the same time it respects the interviewees' anonymity and confidentiality. Both anonymity and confidentiality played an important role in fieldwork, due to the nature, sensitivity and dynamics of the Greek health care arena. In addition to this, several researchers have argued that the greater degree of confidentiality and anonymity achieved in a research study, the better its validity, especially when the research topic is sensitive and the researcher cannot afford any kind of negative repercussions (Berg 1989; Lofland and Lofland 1995; Palys 1997).

One of the objectives of the 37 semi-structured interviews with key informants was to make them feel that this was a risk-free procedure. However, one should admit that even experienced qualitative researchers find it quite hard to fulfil their promises in



terms anonymity and confidentiality (Miles and Huberman 1994). The interviewer has done his best in this aspect by being very careful as to how and when he attributes a quote to someone, or how key informants are linked with important incidents in the Greek health care sector (Silverstein and Sharp 1997).

Ideally all the interviewees would be willing to be identified and quoted (as long as confidentiality is maintained) since the research concerned public policy yet there is a trade-off between getting evidence and getting identifiable informants, which has to be taken into account, when the list of key informants is composed and when the consent form is written. For these reasons, certain precautions were made. These include obtaining informed consent (see APPENDIX 1). The consent form ensured that respondents did not participate against their will and that their participation was based on a full understanding of possible implications. As a result, respondents' privacy and representation were protected (Green and Thorogood 2004). Furthermore, in order to avoid any misunderstandings or misinterpretation of what a respondent said in an interview, whenever it was requested, a copy of the transcribed interview was provided and feedback was asked for. All the interviews were recorded for archive reasons and for transcription and all of the interviewees had access to their recorded file or the transcribed document (Miles and Huberman 1994).

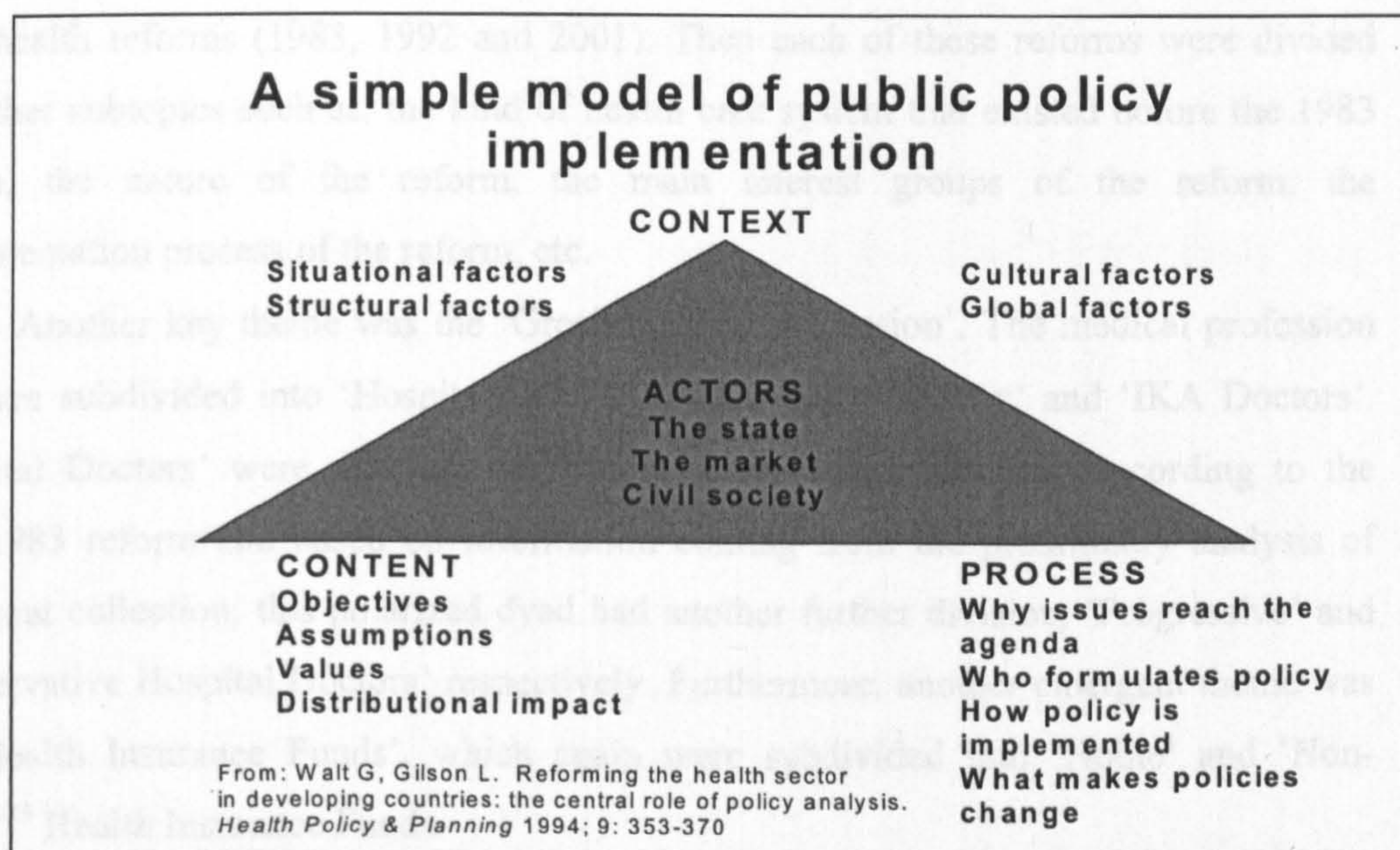
Although both anonymity and confidentiality were high on the agenda, and all the interviewees gave their written or oral consent for participating in the research, there were one or two informants who asked me to turn off the digital recorder when they wanted to report something more personal or to discuss people high in the political hierarchy, or when they did not want the researcher to mention specific names.

## **7.5 Methods of Data Analysis**

### **7.5.1 Preliminary Written Data Analysis**

Initial collection of documents and research carried out in public policy making in Greece by various Greek scholars (Sotiropoulos 2001; Venieris 2003; Sotiropoulos 2004b; Sotiropoulos 2004c; Davaki and Mossialos 2005; Mossialos, Allin et al. 2005; Mossialos and Allin 2006) served as a preliminary analysis stage of becoming familiar

with the role of the major interests in the Greek health care system. Stakeholder analysis followed, which benefited the preliminary results of the document collection. Stakeholder analysis was also benefited by the model of contextual analyses, most suitable for health care arenas and public policy in general, produced by Walt and Gilson (1994), (see the following schema, and Leichter (1979) )(see APPENDIX 1). The model of public policy-making by Walt and Gilson was used as background information for a first approach to understanding the political, economic, cultural, and institutional context of health care reform in Greece, and the stakeholder analysis demonstrated the main players of the system. These are the hospital doctors, the university doctors, the State, the health insurance funds and the private sector (including pharmaceutical companies).



After identifying the main stakeholders, the next stage was to select the key informants for the semi-structured interviews. The categories of key informants were identified through the contextual analysis carried out on collected documents and the results of the stakeholder analysis. This technique has potential weaknesses, for example the sample may not have been entirely comprehensive, but every effort was made to prevent this as far as possible through the author's personal knowledge of the Greek health care sector and its people, and through background discussion with health care 'insiders' during the formulation of the research plan.

### 7.5.2 Combined Analysis of Interviews and Documents

Preliminary findings from documentary collection had already helped to map the Greek health care sector (stakeholder analysis) and understand the interaction and interrelation between the different interest groups (medical profession, health insurance funds and the private sector) within the Greek political, historical and societal context. The documentary analysis provided the first level of the Thematic Framework Analysis used in this research (Ritchie and Lewis 2003). As a result, the data were organised and classified according to key themes, concepts and emergent categories, which according to the National Centre for Social Research, is the optimal way of producing a series of main themes, which then can be enriched by sub-themes (Ritchie and Lewis 2003). For example the key theme of 'Health Reforms in Greece after 1974' was subdivided into the three health reforms (1983, 1992 and 2001). Then each of these reforms were divided into other subtopics such as, the kind of health care system that existed before the 1983 reform, the nature of the reform, the main interest groups of the reform, the implementation process of the reform, etc.

Another key theme was the 'Greek medical profession'. The medical profession was then subdivided into 'Hospital Doctors', 'University Doctors' and 'IKA Doctors'. 'Hospital Doctors' were divided into 'Junior' and 'Senior Doctors' according to the 1397/1983 reform and based on information coming from the preliminary analysis of document collection; this polarized dyad had another further division, 'Progressive' and 'Conservative Hospital Doctors' respectively. Furthermore, another emergent theme was the 'Health Insurance Funds', which again were subdivided into 'Noble' and 'Non-Noble'<sup>23</sup> Health Insurance Funds.

In addition to this, there was ongoing documentary collection (familiarisation with extended periods of investigation before and after the relevant health reforms), and the main themes and categories evolved and were expanded in a cross-sectional level within the three health care reforms.

However, a crucial part of the research policy analysis, apart from the document analysis, is the qualitative interviews. Health policy experts have traditionally used semi-structured interviews with key informants to verify and expand their findings from

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<sup>23</sup> The division of Greek health insurance funds to Noble and Non-Noble demonstrates the discrepancies observed in the level of access in health care services, and especially in the health care expenditure per insuree.

written resources, such as archives, Parliamentary minutes, journal articles, and minutes of meetings etc. (Immergut 1992; Giaimo 1994). As a result, this research used an additional method of verifying and expanding preliminary findings by conducting 37 semi-structured interviews with key informants. This meant that once the indexing and labelling from the documentary analysis had become quite comprehensive, each theme was displayed in a thematic matrix where each key informant would be allocated a row and its column denoted a separate sub-topic (Ritchie, Spencer et al. 2003).

Key informants were chosen as the appropriate method of collecting detailed information because they are individuals that have proved themselves to be well informed and well connected, but have also demonstrated a capacity to adopt the standpoint of the investigator, informing him of rumours and the sequence of events, suggesting secondary informants (snowballing or chain sampling (Silverman 2000; Lewis 2003)), preparing the way, advising on tactics and tact, securing additional data on their own, and assisting the researcher in numerous other ways (ProjectTeam 2005). In evaluating informants' data, the following issues were taken into account:

- Current emotional State of the informant,
- Informant's opinions,
- Informant's values,
- Informant's hypothetical reactions, and;
- The actual tendencies of the informant to behave or feel when confronted with certain stimulus situations (e.g. hospital doctors trade unionists talking about 'informal payments') (Dexter 1970).

A good interview is not all about asking penetrating questions, but it is also about drawing conclusions from the responses. The interviewee is not expected to spell out all the conclusions. Wildavsky (1989:86) says: *"Like a detective you must piece together the bits of information provided by different respondents. The answer you reach may be different from the conclusions of all the people you interviewed"*.

USAID<sup>24</sup> suggests that careful notes should be taken and developed immediately after the interview to ensure accuracy, using subheadings, selected with an eye to the major issues being explored. Common subheadings help to facilitate subsequent data analysis. At the end of each interview, a page interview summary was produced, reducing information into manageable themes and issues, and recommendations. Each summary provided information about:

- the key informant's position and career,
- reason for inclusion in the list of informants,
- main points made,
- implications of these observations,
- And any insights or ideas the interviewer had during the interview (who to interview next, or who the key players of the reforms were politicians, trade unionists, health policy experts or academics).

The researcher then began reading the summaries of the transcripts and made notes on them, in the margins or on separate piece of paper. Then the data from each respondent were categorized and filed under the emergent themes and key issues produced by the Thematic Framework Analysis of the documents. Additional emergent themes from the interviews were added, where necessary. An example of a key theme or emergent category is the nature of health care reforms after 1974. Each key theme (e.g. 1397/1983 Reform) was then displayed or charted in its own matrix, where every respondent (10MoH/P-Female) was allocated a row and each column which denoted a separate subtopic, such as, the kind of health care system before the 1983 reform, the nature of the reform, the main interest groups of the reform, the implementation process of the reform (see BOX 7.1)

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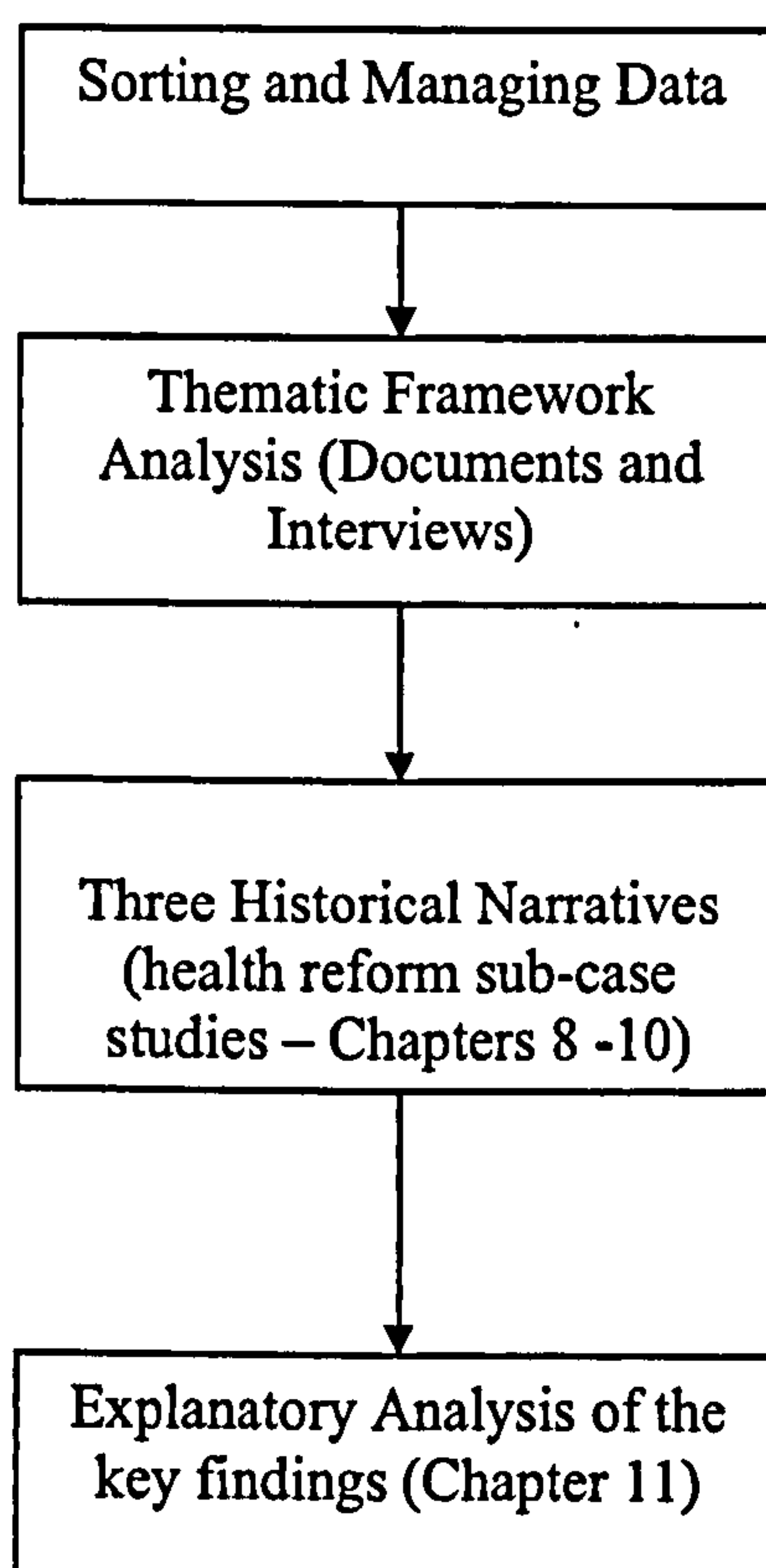
<sup>24</sup> United States Agency for International Development, Centre for Development Information and Evaluation.

<b>BOX 7.1 EXAMPLE OF A THEMATIC CHART</b>					
	<b>Health Care Reform Aspects/Characteristics</b>				
<b>1397/1983 Reform</b>	<b>1.1 Before the Reform</b>	<b>1.2 Nature of the Reform</b>	<b>1.3 Interests</b>	<b>1.4 Implementation</b>	<b>1.5 Notes</b>
<b>Interviewee</b>					
10 MoH/P, Female	<ul style="list-style-type: none"> <li>-Non existent system before 1983,</li> <li>-Senior Doctors were established/Junior Doctors wanted to establish themselves,</li> <li>-Low quality of Health services/unequally accessed,</li> <li>-Minister Doxiadis attempted a similar reform in 1981, but Conservatives turned down his plan</li> </ul>	<ul style="list-style-type: none"> <li>-Socialist Ideology,</li> <li>-Based on equity and Efficiency in principle,</li> <li>-According to the general notion of 'change' that was the promoted by the Government</li> <li>-Popular demand for change, but not specifically for a NHS</li> </ul>	<ul style="list-style-type: none"> <li>-Hospital Doctors (Senior who were against and Junior Doctors who where in favour),</li> <li>-University Doctors, who where in favour as long as they were not obliged to stop private practice,</li> <li>-'Noble' Insurance Funds that where against a unified insurance fund, and pharmaceutical companies were against the Bill because the government wanted to 'socialize' the pharmaceutical industry,</li> <li>-private clinics were also against, as the government banned any future establishment of a private clinic</li> </ul>	<ul style="list-style-type: none"> <li>Implementation of the Law was carried out by Minister Gennimatas,</li> <li>-the State lacked the capacity to implement the Law,</li> <li>-Concessions were made in favour of the university doctors, hospital doctors (nominal paid overtime, no appraisals, the number of doctors in the Greek NHS exceeded initial planning,</li> <li>'noble' insurance funds were not obliged to merge into a single insurance fund.</li> </ul>	<ul style="list-style-type: none"> <li>-The whole medical profession wanted the reform, but expected different things from its implementation</li> <li>-party politics and clientelism played an important role in the implementation stage, in the end all parties and ideologies were part of the NHS,</li> <li>-STATUS AND INFLUENCE OF DOCTORS IN THE GREEK SOCIETY WAS VERY IMPORTANT</li> </ul>

This analysis enabled the researcher to sort and order the data so that material with similar content or properties was located together. In this way a firm basis was prepared to proceed to explanatory analysis which involved finding linkages that

repeatedly occurred between sets of phenomena, explaining and going further in the analysis of issues that the interviewee mentioned only once or on the other hand that the majority of the interviewees mentioned, and which were triangulated with the documents. Each of the three health care reforms is examined as three separate historical narrative sub-case studies of the Greek health care sector. The following three chapters represent the information derived from the Thematic Analysis carried out on the information collected from written resources and the semi-structured interviews. Each chapter is a historical narrative constructed used to answer the research questions about the explanation of the origins, patterns and degree of the influence of the medical profession in the Greek Health Care System. The overall procedure of data analysis is briefly described in Figure 7.2:

**Figure 7.2-Data Analysis**



## **Chapter 8: The Populist Era (1981-1989)-Understanding the 1983 Reform: The Foundation of ΕΣΥ (Greek National Health System)**

### **8.1 Introduction**

This chapter firstly describes the process by which the Greek State in the post-authoritarian era, which began after 1974 with the restoration of democracy, established a National Health Service health system in 1983 in theory, but not in practice. Secondly, it contains a detailed account of the different stages that comprise health policy-making including the planning, drafting, discussion in Parliament and the voting of the fundamental Law 1397/1983. Thirdly, within the different stages of policy-making, the chapter discusses the power and influence patterns which various interests groups such as medical trade unions, medical societies, health insurance funds or the pharmaceutical industry exercised. Finally, as one of the most important stages of a policy reform is implementation (Tuohy 1999), it describes the implementation of the GNHS up to 1988, and provides the basis for the explanatory and thematic analysis presented in Chapter 11. This is done through the lens of Historical Institutionalism and the particularities of the Greek State and society, such as party politics, disjointed corporatism, formalism, and the lack of a universalistic culture. Table 8.1 presents a schematic presentation of the provisions of law 1397/1983 and what has been implemented. This table will be used throughout the following sections.



<b>Law/Plan Provisions</b>	<b>What happened?</b>	<b>Main Actors</b>
-Universal Coverage	-95% population, only in theory (Sissouras, Karokis et al. 1999)	<b>{</b> <b>-Junior Hospital Doctors</b> <b>-Senior Hospital Doctors</b> <b>-University Doctors</b> <b>-Health Insurance Funds</b> <b>-Pharmaceutical Industry</b> <b>}</b>
-Equity in delivering and financing health services	-regressive financing and unequal distribution of the quality and quantity of health services	
-Organization of Primary Health Care	-180 rural health centres, no urban health centres, focus on outpatient hospital health services	
-Unified Health Insurance Fund	-Never implemented, distinction between 'noble' and 'other' health insurance funds	
-Hospital Doctors full-time and exclusive practice	-Only on paper	
-University Doctor choosing private practice or NHS exclusively	-article excluded, Ministry of Education responsible for regulating academics' terms of service	
-banning of the opening new private clinics	-ban implemented, and as a result lots of small clinics closed down, but a few powerful survived and expanded	
-Decentralization of the System under Regional Health Systems	-not implemented	

## 8.2 The Post-Authoritarian Era, 1974-1981

In 1974, Greece was coming out of an unstable historical and political period, marked by a civil war and a dictatorship, the aftermath of which was a society of winners and losers, Right and Left respectively. Although one might expect that this dividing line would be erased during the restoration of democracy, this was not the case until the Socialists came to power. The charismatic leader of PASOK took the responsibility not to lift off the inequities of a divided society, but instead to bring to the surface and unite all the progressive powers that had been set aside by the winners of the Civil War (Underdog culture - (Diamandouros 1994)) under the slogan of 'change'. Just after the restoration of democracy, the medical profession - mainly its young members, junior and resident doctors - started a debate about establishing a system of organised health care in Greece. There had been quite a few attempts to establish a system during the junta (1967-1974), but they were not embraced by the dictators.

According to medical trade union key informants, the critical moment was the national hospitals' conference organised in Athens by EINAP in 1975. Most of the participants were junior doctors and trainees who expressed their determination and commitment to establish a system of health care. They had not decided on the form that this should take, but their decision was unanimous on the necessity of a system. It seems that the progressive doctors, usually young residents or specialists (junior doctors), taking into account that the country had just regained democracy, were embraced by all the progressive political parties, especially by PASOK of *metapoliteush*<sup>25</sup>, and produced their own program for future health reform.

PASOK did not win the election of 1977, but it was obvious that the next government would be Socialist<sup>26</sup>. By the end of 1981, the Conservatives were leading the country into another election which they knew that it would be difficult for them to win. Nevertheless, Minister Doxiadis produced a Bill for the reform of the health care system called 'Measures for the Protection of Health' (1981). However, opposition from his own MPs prohibited him from bringing it to Parliament for discussion.

### **8.3 1983 - Foundation of ESY (Greek National Health System)**

During the period 1974-1981, PASOK managed to create an image of a totally new party with innovative ideas. Its main ideology in the beginning was the socialist transformation of society, and ended up at the 1981 elections with the motto 'Allagi', which means 'change'. Furthermore, Andreas Papandreou focused his political analyses on issues such as national independence, social liberation of the working classes, sovereignty of the people and participatory democracy. Overall, the main aim was social liberation, and it included the socialization of health care and the expansion of social insurance, covering all risks for the whole population. These were the main elements of the populist rhetoric that PASOK used in order to implement its acts after 1981 (Sunday Dash-Eξόρμηση ΤΗΣ ΚΥΡΙΑΚΗΣ in Greek 1981).

The socio-political and economic context of Europe in the 1980s was one of recession and slower economic growth in the aftermath of the oil shocks of the 1970s.

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<sup>25</sup> After the *Junta* era (after 1974)

<sup>26</sup> This was confirmed almost by all my key-informants

Most European countries had already introduced a National Health Service or national health insurance during the expansion of their Welfare States after World War II, and were implementing cost containment policies. In contrast, Greece experienced a rapid increase in public expenditure, driven by the populist rhetoric of PASOK as the winner of the elections of October 1981. PASOK's populist policy focused on the need for reforms in the interests of the urban middle classes and peasants. Although public expenditure rose significantly during PASOK's period in government, the political scene was not generally supportive of a new Welfare State. However, one way for the government to express its commitment towards people's needs and make steps towards legitimising its own position, since the Socialists had already gained an overall majority and consolidation of authority by receiving 48% of the votes in the 1981 elections (Clogg 1988), was to attempt to repair the damage caused by the socially divisive period of Conservative government through proposing a Bill for the establishment of a NHS. As Guillen (2002:50) puts it, any social protection system generates "*strong legitimation, consolidation of entrenched interests and institutional inertia*".

With hindsight we can see that the majority of Greek governments since the 1920s or 1930s had tried to achieve legitimation by implementing new plans for the benefit of civil society. For example, in the 1920s, Venizelos introduced reforms because of pressure from trade unions and for fear that they might be taken over by communists. In this way the State was able to manipulate and intervene to shape trade unionism in favour of the ruling political party. The second example comes from the 1960s, where the leader of the Conservatives (ERE), Konstantinos Karamanlis, decided to establish the OGA - social and health insurance coverage for the farmers - in his attempt to win the upcoming general elections and again to head off the 'communist threat'. Similarly, during the late 1970s the Doxiadis Bill, although it had been under negotiation for over three years, was brought to the Greek Parliament for validation on the eve of the general election. The Conservatives hoped to win the elections with this specific pre-electoral device, but the opposition from members of the Conservative party, and the majority of senior doctors to the reform plan was so severe that it did not even reach Parliament (Mossialos and Davaki 2002).

Furthermore, PASOK wanted to maintain support and attract new voters, and the NHS was one way of pursuing this goal. Most of the socialist party supporters were what Diamandouros (1994) calls 'the politically excluded strata' of the post-civil war period, normally being the least skilled and least competitive members of society who survived by running small firms, mainly employing the members of their own households. PASOK not only wanted to support this kind of clientele, but wanted to secure its future by growing its support, thereby consolidating its position as the ruling party (Diamandouros 1993; Katrougalos 1996; Mossialos and Davaki 2002).

### **8.3.1 Planning the Reform of 1397/1983**

#### **8.3.1.1 PASOK is setting out the health care agenda**

PASOK won the 1981 election and formed the first socialist government in Greece. Papandreou then had to decide whether his first major attempt at change would be in the education or the health sectors. Key informants did not suggest that the general public embraced or demanded a National Health System, as the general public most likely did not know what a NHS meant. However, there was widespread anticipation of a general change in various sectors of public life such as health and education, and the people apparently were agitated by Papandreou's vision of change at a very general level. He decided to go for health reform rather than education, since there was already a plan to hand (produced by prominent members of EINAP, who had been members of PASOK during the late 1970s). Socialists called the draft plan the 'Green Book', and it was the basis for Law 1397/983.

Several key informants suggested that the plan was tailored at this crucial moment according to the interests and, some said, the ideology of the junior doctors that mainly belonged to the progressive political parties of PASOK, the Communists and the Greek Left. Many of the main exponents of the plan had been influenced by the British NHS and tried to implement a similar plan that took into consideration the differences of the Greek society and geography.

Minister of Health Avgerinos set up a committee to form a Bill out of the existing draft plan. By the end of 1982, the plan for the Bill was ready and was given to the public, trade unions, and medical societies for discussion and suggestions. The plan contained most of the clauses that later became Law 1397/1983, except for the voluntary

unification of health insurance funds and the exclusion of university doctors from full-time and exclusive working status. It encompassed equity in delivering and financing health care services, with universal coverage and equal access, a new private-public mix in the provision of health services (by expanding the public sector and reducing the private, for example banning private clinics and establishing a national pharmaceutical industry), an organised primary health care system, obligatory unification of health insurance funds, and full-time and exclusive permanent tenure for all the hospital and university doctors employed by the NHS. Agverinos envisaged the decentralization of the system, by creating what the plan called 'institutional hospital doctor posts' which would provide health care services to the most deprived areas of Greece.

#### 8.3.1.2 Opposition to the Plan

According to all key informants, at that time, the medical profession appeared to be unified in demanding an organized system, but two main parts of the profession - senior and junior doctors - had different aspirations from the system, regarding its basic principles, yet they saw themselves as unified (as interviewee 25TU argued: "*They had a dream and they needed to find ways of sharing it*"). Two examples demonstrate their unity in favour of their guild's interests. The first comes from the late 1970s when doctors went on strike demanding an organized health care system, and the government decided to take their trade union representatives to court, which was supported by all the political movements of EINAP. The second is a number of big assemblies that EINAP held in the late 70s-early 1980s, where the participation of hospital doctors was almost unanimous, and where the dominant discussion issue was the demand for a new system.

In early 1980s, EINAP, ISA (Athens Medical Association) and PIS (Pan-Hellenic Medical Association) were all in 'progressive hands' meaning coalitions of the Centre-Left Parties and, as a result, were dominated by the interests of the junior doctors in favour of the Avgerinos plan. This does not mean of course that there was no dissention, but at that time EINAP, ISA, and PIS had majorities which supported Avgerinos' proposals, in principle.

Opposition to several articles of the minister's plan came mainly from the so-called senior or well established hospital doctors, owners of private clinics (the plan banned private clinics), university doctors (who had to stop private practice) and

pharmaceutical companies (the plan anticipated that a national pharmaceutical company would be established and family doctors would be introduced, meaning that they would have difficulties competing with the State-owned pharmaceutical company and that their sales would possibly be restrained by a successful family doctor institution).

The well-established senior doctors wanted to protect and expand their interests, by maintaining their right to have private practice, and, on the other hand, junior doctors wanted at last to be 'part of the game', and secure a stable and generous salary as well as access to future promotions within the system. Senior doctors wanted to maintain their privileges and control over the new system, and they were against practising full-time and exclusively in the public hospitals. On the other hand, junior doctors saw the implementation of ESY as a unique opportunity to avoid the authoritarian attitude of senior doctors in the late 1970s and receive a salary that far exceeded the pay cheque of an ordinary public servant (two and a half times more than what the ordinary civil servants received). Senior hospital doctors argued that the plan was Marxist (in line with the Conservatives' health committee's view that it suited totalitarian and Communist Eastern European countries), and that it violated their human rights since they would be forced to choose between public and private practice. Dr. Halazonitis, former president of ISA (affiliated with the Conservatives), accused the government of producing a plan that satisfied the needs of the junior hospital doctors and left the senior hospital doctors with poor reimbursement (Petritsi 1983e). Thus one might wonder why would senior doctors should sacrifice their interests, when they knew that as self-employed people they would have a better income outside the NHS?

The first reactions of the organized doctors' associations and trade unions towards the Avgerinos plan were in January 1983. PIS (Pan-Hellenic Medical Association) acknowledged the need for reform, but suggested that the plan needed improvements. In its general assembly, PIS decided that the government should postpone the plan as there were many points that needed further clarification in order to satisfy the needs of the citizens and the medical profession. As a result, Avgerinos postponed the submission of the plan to Parliament and waited for the suggestions of the medical profession's representatives (Antonopoulos 1983; Diamantakos 1983; Ntaountaki 1983; TA NEA

1983; H KATHIMERINI 1983b; H KATHIMERINI 1983e; H KATHIMERINI 1983g; H KATHIMERINI 1983i).

The PIS's suggestions included the introduction of the 'hospital doctor institution' (the institution of public hospital doctors with specific obligations, privileges and working relations did not exist before the 1397/1983 Law) over a five-year period, strategic macro planning of the medical profession's human resources, a minimum wage of 70,000 drachmas for junior hospital doctors, instead of 60,000 drachmas as the Ministry of Health had proposed, and lifting the retirement age limit from 65 to 70 (H KATHIMERINI 1983c; Petritsi 1983c). In addition to this, 60 out of the 70 speakers in the general assembly opposed the idea of doctors being governed by disciplinary councils formed by the Ministry of Health, an institution that ex-Minister of Health Dr.N. Kaklamanis (his ministerial term was 2004-2005) and member of the university doctors' committee of the Athens medical school at that time (1983), characterized as outrageous (Petritsi 1983f).

One may wonder then why the government could not submit its plan for reform to Parliament and vote it through, rather than postpone the procedure, since the majority of doctors' representatives in trade unions and medical associations were politically attached to the ruling government in 1983, or at least their ideology was closer to socialism, mainly represented by PASOK. The answer to this paradox lies in the fact that even trade unionists who were in favour of the plan, in principle, did not support the specific proposals and did not trust the government. Instead, they objected and included demands that would make them better-off in specific aspects, such as working conditions, knowing that the government relied on the support of junior hospital doctors. Papadelis' words, representing ISA (accounting for over half the Greek medical profession) vividly described junior doctors' aspirations and interrelations with the government, "*it is about time that the State recognizes the difficulty, the responsibility and high mission of the medical profession and reimburses it with a wage plan specifically tailored to their needs*" (Papadelis 1983). Evdokimidis (1983) summarizes the medical profession's position in one phrase, "*Everything that it is good for doctors is good for the public health and for the Greek people*".

Even EINAP, one of the most progressive trade unions of that time, which mainly represented junior hospital doctors and supported the idea of a National Health System, criticizing the health care system in Greece before 1983 (on the grounds that private medicine did not provide a safe and secure environment for junior doctors, and gave senior doctors conflicting interests with junior doctors, as the senior doctors were established within society and earned a better income), announced a strike in spring 1983 asking for better wages and working conditions, and pressured the government to implement the Avgerinos plan as soon as possible in line with their suggested improvements (Ntaountaki 1983; H KATHIMERINI 1983f; H KATHIMERINI 1983m; H KATHIMERINI 1983n).

Following EINAP's call to the government, it was ISA's and PIS's representatives' turn to ask the government not to waste any more time and submit the Bill for voting in April 1983. Daily newspapers though, reported that Socialists were behind this gesture. The fact that the Socialists did not represent the majority of their members was obvious in the case of ISA (Athens Medical Association) and its general assembly that would decide the policy of the association towards the reform. Although ISA's registered members exceeded 10,000 (almost half of the medical population of Greece in the early 1980s, while in 2006 ISA had 23,870 members and PIS 56, 310), during the assembly only the members that had already paid their subscriptions had the right to vote. As a result, only 330 were present and the assembly was postponed, and ISA's view of the plan remained comprised of the arguments of the socialist-affiliated representatives (Greek Parliament Minutes 1983; H KATHIMERINI 1983r).

Opposition to Avgerinos' plan came also from many MPs. According to the newspaper KATHIMERINI, alongside the Conservative doctors MPs that opposed the plan on the basis of ideology and in alliance with the senior doctors' demands - there were a lot of individuals among the Socialist doctors MPs who questioned the financial feasibility of the plan introduced by Minister Avgerinos, protecting that way the interests of their guild. They even appealed to Prime Minister Papandreou to delay the submission of the plan to the Greek Parliament, pointing out the need for changes to the plan or its gradual implementation, so that enough financial resources could be secured and doctors



could adjust to the idea of working full-time and exclusively for the NHS (H KATHIMERINI 1983a; Petritsi 1983a; Petritsi 1983b; H KATHIMERINI 1983d).

After that Papandreou, formed another Parliamentary committee, including Gennimatas, who would be appointed as Minister of Health in 1984, to verify that the reform was financially feasible. It concluded that it was. During this period EINAP decided to go on strike demanding that the Bill should be put before the Greek Parliament without any amendments, because they foresaw a possible alteration of the initial plan as being against their interests.

The reactions peaked around the spring of 1983, and even the MPs and Ministers of PASOK were having doubts about putting this law forward after they had been influenced by their personal connections with private clinic owners, university doctors and senior hospital doctors. Ministry of Health officials and academics/health policy experts of that time (10MoH/P, 14MoH/P, 6A, 3A, and 20B) pointed out that even Prime Minister Papandreou had serious doubts about the NHS at this time, as there were many ministers that thought that this was a very radical, expensive reform that would destroy the Greek economy. As an ex-President of IKA said, Minister of Finance Koulourianos demanded an econometric analysis of the plan in order to have an idea what the State had to spend, and when he received this report he announced that it would be a total disaster for the Greek economy. The latter had explicitly expressed his concerns on whether this reform was financially feasible because of the financial constraints that the Greek economy faced. He argued that *"This is a tailor-made plan for medical professional interests, and it is going to be a tombstone of Greece's economy"*<sup>27</sup>. After receiving the Parliamentary committee's report Papandreou signed the Bill, but the very next day Koulourianos also signed and then resigned from his post expressing his opposition.

In general terms, although most of the medical associations' representatives acknowledged the need for reform and that the establishment of a NHS had been a constant request of the medical trade unions since the restoration of democracy, they wanted to put themselves at the centre of the future system and of the reform process, stressing the importance of the medical profession for its success. The medical

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<sup>27</sup> Information coming from key informants verified by written information from daily news papers of that time.

profession's representatives argued that, on the one hand "*the profession supports the plan in its general principles and believes that it is the determining factor in a successful health care system*" (H KATHIMERINI 1983h), thus making suggestions for further improvement, to protect the citizens, while on the other hand, its specific proposals were limited to its own guild interests, such as wages, working conditions and hours, medical training and reimbursement for days on strike.

### 8.3.2 Parliamentary Discussion of the Bill

After all the delays, PASOK eventually introduced its Bill in August 1983, and aimed that way to fulfill its pre-electoral commitments to the Greek people, and honour the 'social contract' that PASOK had proclaimed with the Greek people. The opposition to the Bill during the Parliamentary process came from New Democracy (The Conservatives), while those in favor of the Bill were the Socialists and the Communists. The president of The Conservatives, Evaggelos Averof, argued that the Bill was a typical example of totalitarian Eastern European type governance, which '*will affect the most crucial and sensitive sector of our country*'. MPs on both sides expressed doubts as to whether the Bill would be implemented, as the implementation period exceeded five years, and as had happened in the past the vested interests of doctors, health insurance funds, private clinics and finally pharmaceutical companies could render clauses of the Law or the whole of it a dead letter (Greek Parliament Minutes 1983).

During the discussion, opposition was strengthened by various doctors' associations, which argued that the transformation of doctors into employees with permanent tenure would create a medical proletariat (H KATHIMERINI 1983k). Unions, of New Democracy Doctors, specialist doctors and senior doctors strongly criticized "*the way the government promoted one part of the medical profession, in order to secure its support during the implementation of the NHS*". They stressed that the Bill violated basic principles of freedom under the pressure of socialist ideology (H KATHIMERINI 1983p). The Pan-Hellenic union of specialized doctors argued that doctors would have to practise medicine under a police State. As a result, the State would violate doctors' professional autonomy to the point that they would not be able to work freely and offer their services to whoever they pleased (Petritsi 1983d). In addition to this, the senior

doctors who were directors of hospital unions characterized the Bill as *“bossy, tough, inflexible and inapplicable to Greek reality”* (H KATHIMERINI 1983p). Former Conservative Minister of Health Doxiadis argued that the Bill eliminated every possible freedom that doctors had in their work, and transformed doctors into *“a bunch of checkers that are ruled by the State and possibly by political parties”*. According to his views, doctors would be stratified into three categories: first, the new young junior doctors entering the system, who would be satisfied with what the system provided them and would be willing to support it in the beginning, as long as they are still juniors; second, doctors that were already established and had their own private practices, would assume that they would lose at least 50% of their income so they would leave the NHS and only practise privately; and last, probably the worst category for the system and for the citizens, doctors in the second category who would not quit public practice, but would continue to practise privately. According to Doxiadis, doctors in the last category hoped that *“the new system would collapse and they would do their best for that to happen”*, so that the new system created would find them inside and ready to cultivate their private and public practice, just as in former times (Doxiadis 1983).

EINAP's representatives, however, supported the idea of permanent tenure for hospital doctors, but opposed the effort of the government to pass the Bill in the summer of 1983, so that trade unions would not have the opportunity to make any suggestions for further changes to the Bill. According to an announcement by EINAP on August 25<sup>th</sup> 1983, *“PASOK's Bill is not a complete national health system proposal”*, and the way the Bill was debated and forwarded for voting proved that the government wanted to isolate, divide and weaken the trade unions of the medical profession. This is because the government had already started to realize the difficulties of implementing an NHS, especially in terms of financing, and at the same time a unified and empowered medical profession would demand many more things than had already been agreed. ISA and out-of-hospital doctors were also concerned with the same issue (H KATHIMERINI 1983j).

Opposition to the Bill continued from various local medical associations all over Greece, such as Thessalonica, Alexandroupoli, etc. They expressed their opposition to the Bill and asked PIS for a general assembly. They said that the Bill was anti-medical and anti-public. More specifically the Medical Association of Magnhsia (one of the 54

prefectures of Greece) accused PIS of being a formal supporter and spokesperson of the government and not of the medical profession (the president of this association was a very well known supporter of the Conservatives). It seems that there was a big difference between what the local medical trade unions had decided in their general assemblies and what in the end PIS had supported. Some of them accused the president of PIS of being a traitor to medical trade unionism for not protecting the interests of the medical profession (Greek Parliament Minutes 1983; Petritsi 1983g).

Representatives of ISA once again declared their support for the basic principles of the Bill, and their determination to fight until all of their suggestions were incorporated into the legislation. They also demanded that the academic and military hospitals of the country become part of the NHS, and that military doctors enter the NHS and comply with the labour conditions of the NHS doctors. They also wanted to be informed and in control of the recruitment of hospital doctors, as they argued that the bureaucrats of the Ministry of Health would not respect the aims and objectives of the health care system, and doctors would be isolated from the procedure.

Hospital doctors' opposition was just the beginning as according to several key informants, university doctors were also important in the way the Bill was finalized and later on implemented, in protection of their labour relations and whether they could practise in public hospitals and at the same time have their own private surgeries or practise in private clinics. This did not come as a surprise as two of the main members of the initial planning team (which consisted of Dr. Moraitis, Prof. Sfaggos, Dr. Papadimas, Professor Sissouras, Dr. Papadelis and Mrs Panopoulou) Dr. Papadelis and Prof. Sfaggos, were prominent members of the medical profession and university doctors. Dr. Moraitis was and still is a doctor and an expert in Primary Health Care Professor Sissouras was and still is a Professor of Operational Research in the University of Patras and a policy expert and consultant to the Socialists for over 20 years. Finally Dr. Papadimas is a doctor, a Socialist MP and was Minister of Health in 1999.

Key informants (21B, 18B, 25TU, 27TU) accused the members of the committee of serving their own personal interests (for example by setting up their own private practice) while they introduced the NHS plan, and later on Bill. Another influential figure in politics and more specifically in the health care sector was Prof. Stefanis, a famous

psychiatrist and personal friend of Prime Minister Papandreou at that time. Several interviewees commented on his role in relation to the fact that university doctors were eventually unaffected by the 1983 reform, since the presidential decree necessary for obliging university doctors to choose between public and private practice was never issued (10MoH/P, 13MoH/P, 20B, 21B).

University doctors were against the Bill, as it obliged them to quit private practice. The specific clause at issue was a continuation of a previous Law (1268/1982) - a Law settling university matters, such as funding, personnel and administration) that had introduced the concept of 'full-time and exclusive' practice to all university teachers, but which had stated that this would be activated only by presidential decree at some time in the future. This had not yet happened, as the powerful academic elites, who kept close relations with Prime Minister Papandreou, had influenced him in favor of their professional rights. As a result, academic and armed forces doctors were two categories of doctors excluded from 'full-time and exclusive' practice (Greek Parliament Minutes 1993).

The Bill (later becoming Law 1397/1983) was debated in the Greek Parliament for about four weeks (August-September 1983), and although in the beginning the government wanted to establish a unified insurance fund, in the end organized opposition from the MPs representing the so-called 'noble' funds (representing only 6% of the population in 1983), whose 'insured population would lose their benefits and access to better health services', obliged the government to amend the Bill and go for a voluntary unification of the insurance funds in the future (by 1989), which again never happened. According to various articles in the daily newspapers, bank and public utilities employees' organizations, and professional societies announcements, they all expressed their opposition to the unification of the health insurance funds (H KATHIMERINI 1983o; H KATHIMERINI 1983q). A closer investigation of Parliamentary minutes of that period reveals that the government supported the specific clause in the beginning, but withdrew its support after the organized opposition of most of the health insurance funds, led by former president of the banking trade union and current president of the Greek Parliament, Mr Alevras, who threatened to resign if the unification went ahead and encouraged banking employees to rebel if it was included in the law.

Opposition from university doctors and the 'noble' insurance funds resulted in the exclusion of university doctors from full time and exclusive practice within ESY, and the alteration of article 16 from obligatory to voluntary unification of the various sickness funds. In both cases, the final of Law 1397/1983 mentioned that the Greek government would have to produce specific presidential decrees in order to settle the two issues. In the case of university doctors, it was up to the Ministry of Education to issue this presidential decree as part of its forthcoming law (called in Greek 'Nomos Plaisio', and Avgerinos had personally received the Minister's reassurance that he would follow through and produce it), but this never happened (Greek Parliament Minutes 1983; H KATHIMERINI 1983i).

Key informants from several perspectives believed that the pharmaceutical industry too was against the ESY (3A, 5A, 6A, 8A, 9MoH/P, 10MoH/P, 14MoH/P, 18B, 20B, 21B, 22B, 25TU, 27TU, 28TU, 32 UD, 35J, 36J, 37J). In fact, the reform attempted to establish a national pharmaceutical company that eventually would create a monopoly in the market, but this plan was quickly abandoned due to pressures from pharmaceutical industry owners and the State's inability to run such a national institution. In addition to this, the pharmaceutical companies did not want to see a successful implementation of the family doctor scheme, as then drug use would be monitored and over-prescribing restricted.

Finally, the private clinics also had a strong interest in the preservation of the status quo in health care and the failure of the NHS. The private hospital sector had experienced rapid growth during the late 1970s. Forty-five percent (45%) of the hospitals beds were in the private sector. During the six-year period, 1975-1981, only 1505 public hospital beds had been refurbished and 5578 private beds built. It was thus reasonable according to that era's Socialist government to ban the building of new clinics and in that way to shrink the private sector, and protect the new-born NHS. Private clinic owners opposed the Law, as they were not allowed to expand or invest in their companies, a provision that, they argued, would jeopardize the survival of small operators. On the other hand, the government's decision to ban the building of new private hospitals was perceived by some journalists of the daily newspapers as an effort to enhance the power of specific private clinic owners that wished to create an oligopoly.

In addition, the reform intended to outlaw 'under the table' or informal payments, including both doctors receiving fully paid trips to conferences from pharmaceutical companies and doctors receiving informal payments from patients. However, the pharmaceutical companies and doctors prevented this from happening by making this interaction an informal procedure that the State could not or did not have the capacity to control, or did not want to control, because it would provide hospital doctors with additional earnings thereby reducing the pressure on the State to increase in their salaries (Greek Parliament Minutes 1983).

### **8.3.3 Implementation Period of ΕΣΥ (Greek National Health System, 1983-1986)**

Law 1397/1983 signaled the foundation of a universal system of health care, in theory free at the point of use, based on the principles of equity and efficiency. Prime Minister Papandreou announced 1983 as 'a year dedicated to the health of Greek citizens'. The health care reform was the start of a series of social and economic reforms, including education and the nationalization of public utilities.

Many researchers have characterized Law (1397) of 1983 as a landmark in the development of Greek health care because it was the first time that basic principles of an organized health care system were formally articulated within the framework of a Law. It is worth enumerating its original articles:

- Equity in delivering and financing health care services, with universal coverage and equal access to health care services (the NHS was the first institution to be explicitly universal);

- A new public-private mix, with the provision of primary and secondary health services mainly from health centres and public hospitals. That meant that the public sector as a provider of services was to expand, and that new private hospitals were prohibited;

- Primary Health Care development, mainly by establishing a network of urban and rural health centers. PASOK planned the creation of infrastructure in rural areas, so that primary health care would be improved and promoted (a number of primary health care centers were created);

➤ New financing mechanisms allowing lower cost access to health care services, along with incentives for patients to use the public sector more than the private. This included provisions for the future voluntary unification of the three major insurance funds, IKA, OGA and the Public Servants' Fund;

➤ NHS labour relations and reimbursement methods for health care providers to be determined by the State. As a consequence, NHS doctors were to be fully employed by the State and paid a salary with significant salary increases. Military doctors and military hospitals were to be excluded from the NHS. The initial plan of Law 1397/1983 obliged university doctors to choose academia or NHS, but before the Bill became Law university doctors managed to exclude themselves; and

➤ Decentralization in the planning process, improvements in health sector management and the promotion of active community participation in determining the health care needs of the population (Ministry of Health 1983).

A key informant (14MoH/P) identified by other health policy experts, academics, trade unionists and journalists, told me that he believed that when a Law was voted (the Bill for 1397/1983 Law went through Parliamentary procedure in September 1983), it would be implemented, but he later on admitted that it was naive to think that all these various interest groups would not try to sabotage it, or find their way to protect their interests or even expand their privileges within the ESY. This became quickly apparent as soon as the Ministry of Health tried to decentralize the system and convince the doctors of the system to go to regional prefectures where there was a huge demand for medical staff. Minister Avgerinos attempted to establish the so called 'institutional hospital doctor posts' for the allocation of medical human resources all over Greece, and to his disappointment, doctors who were supposed to respond to the needs and reduce inequalities in access and delivery of health services in the countryside, went on strike under the powerful guidance of EINAP. The industrial action against Avgerinos' Law was undertaken, although the representatives of EINAP who were politically aligned with the Socialists supported Avgerinos and blamed the Conservatives and the representatives from the Greek Left for sabotaging the Law. EINAP is a multiparty trade union which at that time was under the control of both Conservatives and the Left, with an elected President from the Left, who argued that not only should doctors not cover the empty



posts in the countryside, but also demanded even better wages and insisted that when full-time and exclusive practice started, each and every doctor should be part of it (the government proposed an interim stage of coexisting full-time and part-time doctors).

On 17<sup>th</sup> January 1984, Minister Avgerinos resigned under pressure from the strikes, accusing hospital doctors of burying the recent reform and saying that the strike was illegal, prompting the Administrative Hospital Councils to prosecute the hospital doctors who participated in it. EINAP was outraged by the prosecution of its members under article 4 of Law 1365/1983, regarding 'socialization of public entities' (this Law states that since employees cannot oppose policies implemented by the Socialist government, the government is dedicated to fight and protect the rights of their employees), and united doctors against Avgerinos. EINAP said that "*Minister Avgerinos has no right to say that, and that he should realize that hospital doctors are the ones that can implement the Law and support the newly born NHS*" (H KATHIMERINI 1984c), making it clear in absolute terms that the Greek NHS was built by them, for them, and that without them, it would be impossible for it to function.

EINAP's power and influence over hospital doctors was reflected in the very successful strike. According to EINAP's announcements published in 'H KATHIMERINI' newspaper, more than 90% of the hospital doctors participated in the strike. In some cases, like the Athenian hospitals, this reached 100% and proved that it was not only the Conservatives and the Greek Left (beyond the Socialists, more to the left, but not Communists) that wanted the strike, or opposed specific articles of the Law, but there was general medical disapproval of the changes that the reform would bring in terms of their impact on doctors' labour conditions. EINAP expressed its desire for an NHS that was "*friendly to the patients, but also to the doctors*" (H KATHIMERINI 1984e) and reassured the public that "*EINAP's intentions are good and that doctors are on the right track in pursuing them. There is no other trade union in the health care arena that fights like us for the sake of change, and for full-time and exclusive employment. As a result, the public should be aware that whenever they hear that doctors are on strike, they are fighting against something wrong that affects Greek society in general and not only doctors*" (Deligiannis 1984).

The dispute ended with the Minister's resignation proving that the hospital doctors who participated in the strike were right and obliging the next Minister of Health, Gennimatas, to allow their claims. Following these events, EINAP demanded that the prosecution of their members should stop if the State wished to have negotiations again with the hospital doctors. Overall, the EINAP trade union had managed to undermine the credibility of a Law that was the cornerstone of PASOK's policy. The fact that the government backed down and replaced the main actor in the dispute, Minister Avgerinos, vindicated hospital doctors and put in jeopardy several institutions that PASOK had introduced (Greek jurisdiction bodies, Law 1365/1983 and the NHS Law 1397/1983). The most important victory of the medical profession was the fact that the majority of the EINAP representatives had put aside their political party affiliations with the Conservatives and the Socialists, and managed to start negotiations again for the implementation of an NHS moulded to their interests (EINAP even demanded that doctors should be reimbursed for the days that they were on strike).

Avgerinos' post was taken by Gennimatas, one of the founders of PASOK, and a very popular and respected figure by all parties who had already been involved in convincing Papandreou to support the ESY Law. According to most of the PASOK-orientated key informants, Gennimatas was a very pragmatic politician who did not support the 'dream' that Avgerinos had had for ESY. He was the Minister who had to implement the 1397/1983 Law and faced several challenges. First he had to convince doctors<sup>28</sup> to enter ESY. Secondly he had also to convince them to go and practise for a period of time in the less privileged parts of Greece that suffered from the inequalities of the 'non-system'. And last, he had to establish the unification of the health insurance funds.

However, the late Gennimatas was not willing to continue a clash with the medical profession or the so-called 'noble' insurance funds. First of all, he himself was a member of one of the most powerful guilds in Greece, the Civil Engineers, and he understood and supported the way the President of the Greek Parliament, Alevras, had condemned the possibility of bankers losing their health insurance privileges. Secondly, he and his political party PASOK were unable to bear the political cost of a continuous

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<sup>28</sup> Mainly the well-established doctors, or else senior doctors of the old "non-system"

clash with the hospital doctors. The government was under the threat that doctors would not join the NHS or that the 'best', mainly the senior doctors, would not join the NHS and PASOK would not be able to fulfil one of its most prominent and powerful plans for the transformation of Greek society (14MoH/P, 20B, and 10MoH/P). From then on, the Ministry of Health was hostage to the combination of demands, aspirations and interests of the medical profession. The medical profession and specifically hospital doctors had realized their power, and were determined to re-negotiate the implementation of Avgerinos' Law, using as a weapon the threat of strikes. As Gennimatas realized later on the implementation stage, the junior doctors who supported unconditionally the Avgerinos plan in the late seventies and early eighties, have established themselves and they have become middle class doctors with different aspirations from the NHS.

Gennimatas immediately acknowledged hospital doctors' demands and declared his opposition to the attempt of Avgerinos and KESY (Central Health Council) to promote health centres and doctors practising in the countryside, by introducing the supplementary legislation to Law 1397/1983 (Law 1579/1983). This way Gennimatas satisfied hospital doctors' demands to practise in big cities such as Athens and Thessalonica, which resulted in a huge oversupply of doctors in Athens and Thessalonica, with a lack of staff in the underdeveloped regions of Greece, like Epirus and the Aegean Islands. The Ministry of Health ended up resolving this problem by employing private specialists in the regions in ESY while allowing them to enter the Greek National Health System not according to their appraisal or their qualifications, but according to locality and the need of the Ministry to attract doctors in the new established NHS.

In addition, Gennimatas' Law 1579/1985 increased reimbursement for 'active service' (referred to as nominal overtime pay' in the Greek health care arena). He then proceeded with the appraisals of doctors entering the new system on a party clientelistic basis (Ploritis 1986a; Ploritis 1986b; Vimatodotis 1998; Fyntanidou 2003; Papadopoulos 2006), doubled the number of ESY doctors that entered system (from the 3200 that Avgerinos had initially proposed to over 7000 by 1986) and kept doctors who had failed their appraisal in the system (these were specific and individual posts that were not included in the initial planning for the NHS, which were suspended in the future when individual doctors retired).

Lastly, hospital doctors who did not make it into the System the first time or failed their first appraisal (1984-1985) could remain within the system as employees of ESY, occupying a similar post to that which they had had<sup>29</sup>. A doctor and trade unionist told me that at his prompting, Minister Gennimatas decided not to fire the doctors and make them pursue their interests within ESY, no matter what their party origins were or the result of the appraisal of their practice. That way the medical profession formed a solid and powerful interest group within ESY and no political party would even think of abolishing it.

The change in Avgerinos' initial plan for the Greek NHS was striking and Gennimatas was responsible for this. According to him *"the battle of the health arena nowadays is in the hospitals, tomorrow it might be primary health care."* He continued then by praising the role of the hospital doctors in the Greek NHS by saying that *"...hospital doctors in the NHS are poorly paid, and as a result they mistrust ESY. This should change...doctors have to regain their trust in the system"* (H KATHIMERINI 1984d). Gennimatas often told his colleagues in the Ministry of Health to 'let the doctors get into the system ... on whatever terms'. Unfortunately, according to a key informant who had had several key positions in the MoH (20B), Gennimatas did not realize the future problems surrounding the controlling of doctors' labour relations that this attitude would provoke. As a result, hospital doctors started to break the Law in terms of continuing to receive informal payments, undertaking private practice, and everyday working hours and conditions, and no one was there to criticise them or even try to demand some kind of discipline. In other words, the doctors gained freedom, in terms of making their own appraisals and protecting their working conditions. Gennimatas was not able to safeguard the institutions and ideals that Law 1397/1983 had introduced.

The medical profession's success in the negotiations with the State about the implementation of the GNHS could have been harmed by the differences in the interests of the medical societies (PIS and ISA, mainly representing the interests of private doctors) and trade unions (mainly EINAP). However, after Gennimatas' arrival in office as Minister of Health, both sides supported each other on the basis of protecting the status

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<sup>29</sup> These were posts specifically created and "named" after the individual doctor that came to the system as an employee over exceeding the 1983 business and human resources plan. These were called in Greek "prosopopageis theseis", Law 1579/1985.

and the prestige of the profession. For example, when ISA wanted a two-day strike, mainly because the senior hospital doctors were against full-time and exclusive employment in the NHS, EINAP provided the necessary legal cover for it to proceed with the strike, notwithstanding that the main demands of EINAP included full-time and exclusive employment and were not in line with what the senior doctors were asking for. Furthermore, collegiality was not only between different trade unions and medical societies, it also occurred between the different parties in ISA for the sake of the prestige and status of the profession. For example the Greek Left (ΚΚΕ-Εσωτ.) participated in a strike for the 'protection of the prestige of doctors' (TO VIMA 1984; Tsipira 1985).

In 1987, Gennimatas resigned after pressure from hospital doctors for better salaries and working conditions and serious health problems. As far as the third aim of unifying the insurance funds is concerned, he did not take many steps. As several key informants told me (10MoH/P, 20B, 21B, 25TU, 35J, 36J), Gennimatas believed that the 'noble' insurance funds should continue having their privileges.

As a result, the reforms of 1983 were only partially implemented. Indeed, key provisions were not implemented at all. The State was unable to prevent hostile interests undermining important parts of the reforms. Issues such as decentralization, the prospect of unification of the major insurance funds to generate revenues in a more effective way, and the setting up of a primary health care system were never realized. According to the National Medical Conference of 1983 the Greek health care system still suffered from inefficiency and unreliability. However, this was not because doctors were underpaid, or because of a lack of medical technology and infrastructure. On the contrary, it had to do with other factors such as the lack of consensus between the various interest groups within the health care arena. Furthermore, doctors were responsible for the quality of the system since they monopolised the everyday running of the health care system, and resisted any kind of social control. They succeeded in preserving the myth of their unique power to treat people in order to maintain their professional autonomy and protect their interests (Marinos 1983). Professor John Kyriopoulos has argued that the medical profession resisted and finally stopped the transformation of the Greek health care system into a national health system in 1983 through their ability to be very close to the political decision-making centres in Greece (Kyriopoulos 1983).

Overall, the majority of key informants agreed that one of the main reasons that the 1983 reform was not completed had to do with the accommodation of the State to the interests of the medical profession and with the fact that unification of the health insurance funds, as article 16 (Law 1397/1983) mentioned was never implemented, and, as a result, primary health care was not established, especially in urban centres. They also pointed out the role of the university doctors, the State's lack of capacity to implement reforms, and its lack of financial resources. Only one key informant (5A) argued that the main reason for the failure of the reform was the inability to unify the health insurance fund, ignoring the role of the medical profession.

#### **8.4 After the establishment of the Greek National Health System (1986-1987)**

The next Minister of Health was Professor Georgios-Alexandros Magkakis. He was a well known professor in the Law School of Athens, a member of the junta resistance and a prominent PASOK MP. He was appointed in January 1987, and he resigned on 25<sup>th</sup> September 1987. His tenure was, long enough for him to understand the Greek health care sector and its peculiarities. After his experience in the Ministry of Health he never again got himself involved in any kind of health sector issues. However, he was probably not sufficiently knowledgeable about health policy making.

He argued that he had to solve two very important issues that Gennimatas had decided not to pursue. The first one was the issue of hospital doctors' and university doctors' double practice, in the private and public sector; and the second one, the merging of IKA with ESY (the biggest health insurance fund) under the administration of ESY. He thought that IKA and its extensive network of multi-practice clinics could be the solution to ESY's inability to create primary health care in urban cities. But his intention was not well supported by various interests.

First of all, the president of IKA would not easily relinquish his power and interest in one of the biggest health insurance funds in Europe, with over 5.5 million insurees. Second, half of IKA doctors (9,000 in 2001) who had a permanent post, also had the privilege of private practice after they had finished their morning shift. Being part of the ESY meant that they would have a good pay rise like the rest of the hospital

doctors, but at the same time they would have to quit private practice, something that they strongly opposed. At the same time, the majority of the non-permanent doctors of IKA would be made redundant, as ESY could not absorb all of them (initial planning in 1983 talked about 3,200 doctors working for the NHS. By 1986 this number was double and a total of 7,000 doctors practised in the NHS. This number was about 10,400 in 2003, and in addition to this, there were 9,000 IKA doctors). As a result, they also had an interest in not merging with ESY.

At that point of time, Minister Magkakis realized his difficulties and had already also heard the rumours that the president of IKA had the full support of the Prime Minister, as he was a family member. Magkakis also noted that the possibility of creating a new and powerful ESY, including IKA multi-practices, threatened the vested interests of the existing private hospitals.

After a long summer, with one of the worst heat waves that ever hit Athens leaving hundreds of people dead, and with the Prime Minister displeased with Magkakis' handling of things, he resigned after his failed effort to merge IKA to ESY.

### **8.5 Conclusions**

Overall, high expectations and demands were at the top of the medical profession's agenda and these claims were often backed by successful strikes. Doctors managed to justify their claims by manipulating public opinion and by simply exposing the bad condition of the Greek health care system. The medical profession missed the opportunity to make their claims more specific and to develop a realistic plan for political action and improvement of the Greek health care system. The medical profession presented itself as a homogeneous and united guild that was focused around its demands. On the other hand, the Greek medical profession suffered during the 1980s from the typical characteristics of Greek society, such as party politics and clientelism. However, this does not mean that when necessary, i.e. when the profession was challenged by the State, doctors blocked the reforms during their implementation. More importantly, the medical profession convinced the general public that doctors' intentions about the Greek health care system would automatically benefit the health care needs of the Greek population. This period of reform supports the idea that the Greek health care system was lobbied, defined and eventually manipulated by various vested interests and most of all

by the different segments of the medical profession. In addition to this, interviews revealed the weakness of the Greek State to implement a reform and to resist the interests of privileged groups. As almost all the key informants told me, the medical profession is not only powerful in terms of its esoteric knowledge, but it is also a very important voting clientele that influences patients on their voting patterns. It makes sense that no government wants dissatisfied medical profession.

The fact that the hospital doctors, university doctors and health insurance funds obliged the government to make several compromises determined the fate of 1397/1983 and of the entire Greek Health Care System. As a result, the trajectory the health care system followed during the 1980s set the limits of future reforms. This is what Mahoney (2000) calls *path dependency*, which is better demonstrated in the paradigmatic reform narrative of early 1990s.



## Chapter 9: The Conservatives' reform of 1992 and the PASOK comeback

### 9.1 Introduction

This chapter firstly describes the general socio-political background which marked the return of the Conservatives to government after eleven years. Secondly, it contains a detailed account of the steps the Conservative government took towards the planning, discussion in Parliament and voting of Law 2071/1992, in theory a piece of neo-liberal ideology legislation aimed at cost containment. Thirdly, it describes the role and influence of various key actors of the Greek health system on Law 2071/1992, and on post 2071/1992 legislative amendments, such as hospital doctors, university doctors, health insurance funds and the private sector. Finally, it briefly touches on the return of the Socialists to government in 1994, which was marked by the Committee of Health Experts' Report on the weaknesses of the Greek health system. Table 9.1 offers a schematic description of the main provisions of Law 1992/2071, their degree of implementation, and the main actors involved.

<i>Law/Plan Provisions</i>	<i>What happened?</i>	<i>Main Actors</i>
-State acts as a guarantor of the citizen's right to seek care, in accordance with his/her freedom of choice	-only in theory	{ -Hospital Doctors -University Doctors -Health Insurance Funds -Private health sector }
-hospital doctors in the NHS may practise full-time or part-time	-only 492/8,300 took the opportunity	
-university doctors had 1 year to decide whether to practise privately or in the NHS exclusively	-not implemented	
-restrictions regarding private clinics, etc. withdrawn	-numerous private diagnostic centres established, in 1996 they were 403 in total, and 67% in Athens (Fyntanidou 2000a)	

### 9.2 Conservative planning for reform (1990-1993)

The establishment of the Greek NHS did not succeed in reforming major aspects of how health care was organized, planned and delivered. Efforts at decentralization, establishment of primary health care, unification of financing and development of managerial capacity, had failed or at least fell below expectations (Lampsias 1992;

Marakis 1992; Pipili 1992; H KATHIMERINI 1992c). By the end of the 1980s, Greece was in an unstable economic and political condition. As a result, the EU had proposed an economic stabilization programme in order to avoid further recession. Austerity programmes reduced inflation and social expenditure. Following two years of political instability, general elections in 1990 brought the Conservatives back to power. New Democracy (ND) ruled until 1993 and pursued neo-liberal policies (Apostolides 1992). The requirement to meet the economic criteria of the Maastricht Treaty (1991) offered ND a convenient macro-economic, external justification to pursue policies of cost containment across the Welfare State and resist public expectations as well as the entrenched system interests, (i.e. the 'noble' insurance funds and the medical profession) that favoured increased health spending (Carpenter 2003). As a result, the Conservatives were able to pass a law in 1992 (Law 2071/1992) that fundamentally altered the provisions of the 1983 reform. The plan for reform focused on individual responsibility for health care, on a shift from public to private provision, and from public insurance to private finance of health care. In addition to that, it included a huge increase in the per diem hospital reimbursement rates. It also permitted insurance funds to contract with private clinics and diagnostic centres, and introduced co-payments for drugs, and fees for visits to out-patient departments and inpatient admissions. Furthermore, the Conservatives intended to increase social insurance contributions and introduce tax deductions for private insurance premiums. Most of the articles of the plan were dedicated once again to the medical profession's labour relations, introducing non-permanent tenure and part-time posts for hospital doctors, and obliging university doctors to be academic teachers in the university or academics working full-time for the NHS

However, the health care sector was not top of the government's agenda, as apart from the fact that it had to face huge opposition in Greek society which did not welcome the strict financial austerity policy that they followed, the Conservatives had to face another critical issue, the diplomatic dispute about the name of a newly formed country, Macedonia (*To Makedoniko*, as it is known to the Greek public). The Greek government's persistence in not allowing the former Yugoslavian region to use the same name as the Greek region of Macedonia, the nationalists' manipulation of public opinion as well as the Conservative Party's efforts to gain public support by embracing extreme

nationalistic arguments, all led Greece and its government into a difficult position in terms of international diplomacy and other EU countries' attitude towards Greece and *Makedoniko*.

The government planned neo-liberal reforms in various aspects of social life, including, health, social security, education and taxation. These kinds of reforms had already been negotiated with trade unions in most other EU countries; however this was not possible in Greece because of the nature of Greek trade unionism and its relations with the Greek State. While other Western European trade unions would reach a consensus, meaning that both the State and the unions would have 'a fair share of losses and gains' (e.g. in the case of IG metal and the German State), the Greek trade unions would inflict long term strikes on society rather than compromise. Strikes in Greece were not the *ultima ratio* that the trade unions were forced to use in order to negotiate their rights. In fact some researchers claim that there was no negotiation and that the trade unions went on strike straight away. This was because suitable representative institutions were non-existent; which meant that strikes were usually politicized and that the only employer that was socially acceptable was the State. In addition, there were no institutions of collective autonomy; instead guilds financially depended on the State, which they mistrusted at the same time. It was within this sociopolitical context that the Conservatives introduced and later failed to implement law 2071/1992 (Teloglou 1992).

Interviews with key ministerial authorities and a Conservative MP (12MoH/P, 16MoH/P) confirmed that the Conservatives' rationale for the 1992 reform was first to make patients responsible for their own health, and at the same time provide them with freedom of choice in terms of their doctor. They also mentioned that according to the Conservatives' health care pre-election plan, and the requirements of the Maastricht Treaty, the Conservatives made sure that "*ESY is supported in financial and administrative terms, but at the same time that the private sector has potential to operate clinics according to international standards*" (12MoH/P). They also argued that giving the opportunity to hospitals doctors to practise part-time was part of the cost containment effort of the government and the commitment of the Ministry towards better service to patients who could visit their doctors outside the hospital. They also said that according to the Ministry's estimates, the majority of hospital doctors did not work for eight hours

as they should, so they could easily switch to part-time employment and fulfil their duties inside the hospital. The MoH also acknowledged the existence of a huge black market economy and thought that by giving the opportunity to the hospital doctors to practise part-time, the minister would be able to convince them to be more ethical and earn any supplement to their salaries out of legal private practice.

The MoH invited all the medical associations and trade unions to make their suggestions by 19<sup>th</sup> February on the plan for reform and specifically on how to limit hospital doctors' informal payments. PIS and various local medical associations supported the plan as they had already made their suggestions on an early draft of the plan. A few of these suggestions were included in the final draft such as the freedom of choice of doctors and hospital institution, protecting the interests mainly of the private doctors<sup>30</sup> (Galanopoulos 2001 ). It also encompassed two additional suggestions that PIS had made. The first one was the time frame for assessing doctors' continuing competence to practise which was changed to every three, four or five years instead of every two that the Ministry proposed, and the second, which, provided the opportunity for failing doctors to be transferred within the area where they worked rather than anywhere in Greece (IATRIKO VIMA 1992).

However, representatives of EINAP (Association of Hospital Doctors Of Athens and Piraeus), OENGE (Confederation of Greek Hospital Doctors' Unions), and POEDHN<sup>31</sup> (Confederation of Public Hospital Employees) declared, 'we will fight the reform by any means' and invited hospital doctors to participate in a warning one-day strike in February 1992. They opposed the plan on the grounds that "*the reform does not secure access to health services and to decent conditions of hospitalization to each and every Greek citizen*" (H KATHIMERINI 1992a). They also argued that the MoH planned to divide hospital doctors into different employment statuses which might

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<sup>30</sup> Representing more than half of the PIS members

<sup>31</sup> POEDHN: founded in 1983, and in the beginning its members had to be exclusively nurses. Later on this has changed and now it is a federation of all the employee's working in public hospital (mainly again nurses dominate). In 30/10/2005 it accounted for 75.000 members, and usually two thirds of them participate in the federation's election. As a result, it is one of the biggest public servant trade unions, fundamental member of the second powerful trade union in Greece, (ADEDY-Confederation of Public Servants), and has played an important role in the opposition towards the 2001/2889 Statute that Minister Papadopoulos introduced.

provoke friction in the medical profession. In addition to this, they opposed the privatization of the Greek health care system in any way and wanted to maintain their permanent tenure. Trade unionists argued that the Conservatives had just started implementing a plan that would make the NHS collapse and then they would designate the private sector as the only alternate choice. Several articles of the plan revealed their true intentions, such as the introduction of part-time hospital doctors and managerial staff, and the withdrawal of restrictions about the establishment and development of private hospitals and clinics (ELEUTHEROTUPIA 1992b).

According to statistics published by OENGE on the strike of hospital doctors on February 1992, participation of doctors exceeded 50% in Attica, and 80% in the periphery (H KATHIMERINI 1992b). These figures can be interpreted in different ways; it could be that hospital doctors did not bother to strike for only one day as they could not achieve their aims in this way, so the percentage striking did not indicate the scale of opposition to the plan. On the other hand, another more challenging interpretation would be that the majority of hospital doctors, and especially the senior ones, did not oppose the plan, as they would be able to resume practice in public and private sectors.

Overall, the effort to rearrange doctors' labour relations could be seen as an attempt not to harm the vested interests of the hospital doctors; however few of them regarded it as a serious measure. The majority of them took it as an attempt to satisfy the Conservatives' clientele of private doctors who dominated ISA and PIS, who wanted to have access to the ESY hospital doctor's privileges of permanent tenure and informal payments. Key informants directly involved in PASOK (27TU, 28TU, 20B) also mentioned that behind the Minister's effort lay the vested interests of private clinic owners, doctors outside of ESY (private practice) and private diagnostic centres (especially because of the proposed increase in their number (Pipili 1992)).

### **9.2.1 Parliamentary discussion**

The debate on the Bill started on February 7<sup>th</sup> 1992 and was focused on specific articles of the Law which mainly concerned doctors' working conditions. Most medical associations, except the Pan-Hellenic Medical Association, were against certain categories of doctors having privileges within the NHS (full-time or part-time hospital

doctors, with the latter being able to have private practice), and especially against the article that established non-permanent residency for hospital doctors hired after 1992<sup>32</sup>. A few MPs argued that most of the local medical associations were in reality against the Bill because doctors preferred to receive informal payments in the NHS rather than to work part-time in the NHS and at the same time be taxed for their afternoon private surgeries (Greek Parliament Minutes 1993).

University doctors who were also registered with the NHS were, according to the Bill, forced within sixty days to choose whether they wanted to be academic teachers in the university or academics working full-time for the NHS, which would mean an end to their teaching (Greek Parliament Minutes 1993). Daily newspaper TO VIMA argued that Minister Sourlas was forced to change the clause due to pressure from above, which probably meant from the Prime Minister. Sourlas again tried to convince the Greek Parliament that university doctors should choose between public and private practice, thereby freeing some university teaching posts for the university doctors who really wanted to teach, rather than just having a university post to attract more patients. The majority of the key informants acknowledged the power and influence of university doctors (especially in Athens and Thessalonica). Many informants mentioned the Athens medical school 'troika' that supposedly influenced the Greek government, and whose members changed each time according to election results. All these were speculations and no informant offered any specific name that directly and openly influenced Sourlas to change his Law. On the other hand when asked why most of the Ministers of Health survived for only a short time, Sourlas replied: *"It is a very difficult ministry that requires huge capacity of knowledge. It also needs power and strength in order to face the huge financial and guild interests.....otherwise they will send you away.....I had to fight with the university doctors and even my party was not pleased with my attitude towards them.... I have to say though that university doctors are a special group of doctors that needs special treatment, but at the same time they should ease their fight with the hospital doctors and stop being an elitist group...."*

As a result, the sixty-day deadline was later changed to a one-year deadline, and the final decision on when the clause would be implemented and on what terms was

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<sup>32</sup> After the statute 2071 was voted in late February 1992

transferred from the MoH to the Ministry of Education under a new Bill that the Minister of Education, Souflias, prepared - Bill that the government did not have the opportunity to vote for, as the Conservatives lost power during 1993 (TO VIMA 1992).

Apart from the information coming from documents, key informants from several different perspectives (2A, 3A, 6A, 8A, 10MoH/P, 18B, 20B, 21B, 26TU, 27TU, 28TU, 36J) acknowledged how university doctors were again excluded from the 1992 reform. They attributed the last minute changes to the article obliging them to stop private practice in one month to one year, to specific lobbying from high status university doctors in the government elite. A few of them also added that there were specific university doctors who were given the opportunity to open their own scientific medical centres under the promotion and funding of the State. The strong opposition and lobbying of the university doctors was also verified by a personal interview with civil servants (21MoH/p) of that era.

### **9.2.2 Law 2071/1992**

The reform was passed in the Greek Parliament in late February 1992. According to the 2071/1992 Law, doctors no longer had to work 'full-time and exclusively' within the NHS. They could practise either full-time or part-time within the NHS. According to Article 64 of the 2071/1992 Law there were three categories of hospital doctors. The first included doctors working full-time and exclusively for the NHS, appointed before 2071/1992. These doctors retained permanent tenure. The second category included part-time doctors who had guaranteed fixed-term contracts and the right to practise privately. The third included part-time doctors who were appointed as consultants according to the each hospital's needs and the decision of the relevant General Council of the hospital (Paparrigopoulou 1993). In reality, the system created two types of doctors: (a) junior doctors that would work full-time and exclusively in the NHS as they did not have the necessary experience or financial resources to establish their own private practice; and (b) the medical elite (consultants) who were free to work part-time within the NHS, while at the same time recruiting patients using the public hospital infrastructure for their afternoon private surgeries. Hospital doctors saw this measure as a threat to their permanent posts as public servants and to their income, as they would have to be taxed

for their private practice. As a result only 492 hospital doctors (out of 8,300 in total) went part-time and when PASOK returned to power, 330 of these returned to full-time and exclusive tenure. An EINAP trade-unionist who was high in the hierarchy (27TU) said “...they got a quite bitter taste of what the private sector could offer to them and they decided to return to their safe and uninterrupted interests within ESY.”

Law 2071/1992 also focused on individual responsibility for health care, with a shift from public to private provision and from public insurance to private financing of health care. In addition, it included a huge increase in the per diem hospital reimbursement rates (almost tripling them thus provoking huge deficits in health insurance funds). It also permitted insurance funds to contract with private clinics and diagnostic centres and introduced co-payments for drugs and fees for visits to out-patient departments and inpatient admissions. Furthermore, the Conservatives increased social insurance contributions and introduced tax deductions for private insurance premiums (IATRIKO VIMA 1991). The Conservatives did not take any steps towards the establishment of a single insurance fund. Law 2071/1992 simply stated that it would be better for insurance funds to establish a single insurance fund some time in the future; echoing the outcome of the 1983 reform when severe opposition had postponed the unification indefinitely.

The following points sum up the 2071 Law of 1992:

- The State acts as a guarantor of the citizen’s right to seek preventive and curative care in accordance with the principles of freedom of choice and respect for human dignity, (whereas in 1983 the State guaranteed universal coverage and equity in health services provision).
- Freedom of choice of doctor and hospital institution.
- Hospitalized patients have rights according to the European Charter of Patients’ Rights.
- Changes to the managerial staff of the healthcare workforce.
- Doctors employed in the public hospitals become free to choose full or part-time employment within the NHS, with the latter permitted to practise in the private sector. University doctors must choose within one year whether to work in academia or the NHS. Newcomers to the NHS will not be granted permanent tenure.



➤ All the restrictions that the previous Law had contained concerning the establishment and development of private hospitals and clinics, were withdrawn (Ministry of Health 1992).

The reform was not perceived as a very important piece of legislation by the majority of the key informants interviewed (with the exception of those who had introduced the legislation). Almost all of them argued that it was not important as the Conservatives were quickly replaced (after three years) by the Socialists. In terms of the Law itself, key informants universally identified that it was too complicated with 158 articles and that it had no clear ideological perspective. One key informant (6A) pointed out that Minister Sourlas could not make fundamental changes in doctors' working relations, as ESY was already a 'prisoner' of its own health care professionals who had maintained their own interests within the ESY and would not easily relinquish them. Hospitals Doctors employed by the State were of different political origin (Socialists, Conservatives or Left) but they all had one common characteristic, they were all part of the medical profession and they were all hospital doctors in public hospitals. This meant that all of them were interested in preserving the *status quo* and they would not tolerate any negotiation of their formally (i.e. permanent posts, hospital doctors' special payment arrangements, etc.) or informally (i.e. nominal overtime payments, no appraisals, etc.) vested interests.

Some key informants though, from the Socialist Party (6A, 10MoH/P, 11MoH/P, 20B, 27TU), felt that corruption among the hospital doctors had peaked after 1989, and that informal payments had been a widespread secret that the majority of doctors received, but none of them wanted to speak out about. A variety of key informants (25TU, 26TU, 27TU, 28TU) also mentioned that their claims or strikes for better wages and working conditions had not been powerful during the 1990s. Part of the explanation lies in the polarized party politics environment that the medical profession experienced during the 1980s, which resulted in a lower participation of doctors in their trade unions, and strong belief that their trade unions will not succeed additional salary increases. Another explanation is that they did not have any reason to fight for better salaries, since they received their 'nominal overtime' pay, and their informal payments from patients.

*“What more they could possibly ask for?”* a health sector policy - related journalist (35J) covering health issues in KATHIMERINI asked.

EINAP had made it quite clear that they were against the Law and especially with the changes to labour relations. Trade unionists saw the Law as the beginning of the end of the permanent tenure that they enjoyed in ESY. However, as another EINAP trade unionist from the Conservatives said, opposition from EINAP (26TU) was not strong as there were many doctors that did not believe that this was a Law that would be implemented. On the other hand, the majority of the private practice doctors, who after 1983 never again had a socialist trade union administration (ISA and PIS), perceived the Law and its articles as an opportunity to get into ESY and at the same time keep their private practice. The system, as a senior official of the health care workers association told me (POEDHN-Pan-Hellenic Federation of Public Hospital Workers), had already found its balance and the intention of the Minister to clear ESY of hospital doctors that illegally had private practice, was hypocritical, since hospital doctors did not have any incentive to turn their illegal and unrestricted private practice into an official one.

### **9.2.3 Post 2071/1992 amendments and complementary legislation by the Conservatives**

Alongside other issues, Minister Sourlas planned to challenge the institution of informal payments received by doctors. The MoH asked the medical profession to make suggestions for dealing with ‘fakelaki’ (H KATHIMERINI 1992d). Representatives of OENGE, ISA and the Medical Association of Piraeus accepted responsibility for making proposals to regulate this informal economic and socio-political institution and to announce the results to the Committee of Social Issues of the Greek Parliament. The first conclusions included the following: ‘a) the black market economy is a common feature of the Greek reality and society, though the fact that this symptom appears in the health sector, should make us more cautious and sensitive; b) the main reason that doctors receive under-the-table payments is their poor wages; and c) because of the peculiar, personal and very close relations between doctors and patients, it seems that quite often doctors receive a kind of a symbolic gift, that it is within the limits of someone expressing his gratitude’. This, according to the committee ‘is something insignificant

and within the limits of human relations' (Ntailiana and Pantelakis 1992; Stassinou 1992; ELEUTHEROTUPIA 1992a; H KATHIMERINI 1992e).

All the medical trade unionists that I spoke to agreed that informal payments were common due to poor pay and were a private matter. Furthermore, they stressed that the phenomenon of the black market economy was widespread throughout the public sector in Greece. On the other hand, they acknowledged the peculiarity of the health care sector and the fact that medical science dealt with the saving human lives and so therefore it should not be turned into a financial transaction.

The recommendations were forwarded to the relevant Committee of Social Issues of the Greek Parliament. The committee prepared an early draft of their findings, which appeared in the daily newspaper 'TO VIMA', and clearly mentioned that hospital doctors received informal payments. After two weeks, this changed and the committee argued that it might be the case that only a few hospital doctors received informal payments, but that it was not widespread, that the payments were not initiated by doctors - rather patients spontaneously offered them, or as journalist G. Lakopoulos wrote "*patients tempted doctors with them*" (Lakopoulos 1992). The same argument was also made by journalists of H KATHIMERINI newspaper. They both concluded that the report was strongly influenced by the fact that all the members of the inter-party committee were physicians and so a unanimous argument supported the medical profession. Yet, a unanimous decision in the Greek Parliament was something rare, so it seems that the Greek doctors' lobby transcended party politics (Kalliagkopoulos and Kontogiannis 1992).

The final version of the Parliamentary Committee Report was a way of dealing with the complaints that doctors received from the public about informal payments. The fact that a Committee of MPs decided to deal with this issue was something that the Greek Parliament had never experienced before, and the way doctors managed to manipulate the committee's findings and blame patients protected the medical profession from future accusations from patients. Who would try and accuse a doctor of receiving under-the-table-payments, when he/she knows that he/she would also have to face the law?

It was also peculiar that one day before the findings were announced, Minister Sourlas in a Parliamentary speech continued his criticisms of informal payments by revealing more evidence about the various networks of exploitation of patients within public hospitals. Later that night he continued by saying that *“although there are lots of patients who want to reveal their personal experience of doctors receiving or even asking for informal payments, they are afraid of going to court to testify as to what they have experienced”* (Lakopoulos 1992). One could imagine what would happen if the government decided to put the same level of responsibility on doctors and patients. Doctors would carry on blackmailing patients for more informal payments, knowing that patients would not dare report them because they would be afraid of the repercussions if the same doctors treat them in the future. In addition, if at some point in time patients managed to file a case against the doctors in a Greek court, it would be the patients’ word against the physicians’ word, which would mean that the patients had very little chance of winning the case.

The institutional gap that some doctors exploited in order to escape their responsibilities or the high level connections that some members of the profession had to State mechanisms including the Greek Parliament, explained how the Committee’s report was manipulated. It was not a coincidence that in 1992, the Greek Parliament had 48/300 MPs from the medical profession, which staffed the committee investigating informal payments. As the daily newspaper TO VIMA argued, these MPs acted first as doctors and then as representatives of the Greek people, thus keeping their profession very well protected.

Minister Sourlas’ comment was indicative of the strength of the medical lobby in the Greek Parliament and even in the Ministry of Health: *“...I believe that ‘fakelaki’ is a crime committed by two sides. There is an individual that gives the money and there is another individual that receives the money. As a result, we cannot put the blame on doctors who receive informal payments...”* (Greek Parliament Minutes 1993)

Several key informants had different opinions about the existence of a strong medical lobby in the Greek Parliament. Interviewee 26TU said that this could be true, but it was not as powerful as the lawyers or the civil engineers. Interviewee 25TU opposed my suggestion and said that *“it is true that there are a lot of doctors in the Greek*

*Parliament, but this does not mean that they form a lobby*". Interviewee 27TU, strongly opposed my speculation of a possible lobby based on the Lakopoulos article (Lakopoulos 1992), but at the same time acknowledged that *"doctors form a powerful social class within the Greek society and that the Greek society has not changed its patterns of voting and it is not a coincidence that after lawyers, doctors are the second biggest group of MPs"*. Finally according to a representative of POEDHN<sup>33</sup> (28TU) doctors do form a strong lobby in the Greek Parliament and in addition to my example, he/she mentioned the case of clinical chemistry laboratory directors who had appointed non-doctors since 1983. In 1994 all MPs who were doctors united to alter this specific article, allowing only medical doctors to be the directors of clinical chemistry laboratories. Overall, almost all doctors' trade unionists identified that they did not know anything about a possible medical MP lobby inside the Greek Parliament. But they added that if this existed it was certainly not the biggest and most powerful. They all agreed that lawyers were the most important lobby.

At the same period, EINAP suggested that committees for protecting patients' rights should be established, comprised of members of the medical profession, lawyers and representative members of the public. The President of the Medical Association of Athens, Dr. Giannakis, added that cases taken against doctors regarding their practise should be judged by elected members of the medical associations and not by any kind of disciplinary committee appointed by the Ministry of Health (Karamouzi 1992). As a result, doctors would judge doctors, since no appropriate consumer-based consciousness of health services existed in Greek public opinion.

Furthermore, the medical profession was also against any penalties for malpractice or negligence. They went on a two-day strike to avoid any kind of penalties. They argued that this procedure was not objective and fair to doctors, as *"in courts, decisions are not made according to scientific criteria, but according to emotional load"* (Foura 1992a). Doctors' efforts to avoid any kind of disciplinary control were evident in the specific clause of the 2071/ 1992, according to which doctors were to be rated every year by the Judgment and Selection Council of Medical Human Resources. For this

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<sup>33</sup> (Pan-hellenic Federation of Public Hospital Workers - mainly nurses and other care professionals that usually strongly oppose doctors, as their role is strongly downgraded in GNHS)

reason, the Conservatives founded the Institute for Quality Investigation and Assurance of Health Services which was never functional. By 2001, doctors were to be judged every five years and for this reason the Council of National Judges was established.

After the 2071/1992 Law, the medical profession expressed its dissatisfaction with taxation reform that included a new tax system for various professionals including doctors and lawyers. Out-of-hospital doctors would have to keep a daily account of consultations and treatments to limit the informal economy. Pressure from Conservative doctors (ND) who were also party committee members led the Minister of Finance to express his belief that even if the clause was approved it would be rendered a dead letter due to the medical profession's opposition and the difficulty of implementing it in practice. The result was that in late May 1992, the government reversed its intention to oblige doctors to keep a daily diary of the patients they had treated (Karamitsos 1992; H KATHIMERINI 1992f; H KATHIMERINI 1992g; H KATHIMERINI 1992h).

Minister Sourlas returned to the Greek Parliament and asked for amendments, a couple of months after Law 2071/1992 had passed. Opposition MPs reacted against the specific amendments, accusing the government of wanting to serve the interests of certain members of the medical profession. Furthermore, even MPs from the governing party were surprised at the way the government tried to push through the amendments without a proper debate. Proposed amendments related to the appeals process in relation to medical disciplinary bodies (Halvatzakis 1992), and provided doctors occupying senior NHS hospital posts under law 1821/88, who had lost their jobs, and who had been supported by the second-degree judgment council or a civilian court, the opportunity to return to their posts. If these posts were not available, then they could take an equivalent post as replacement. Parallel to that, ex-MPs who were medical professionals, retired public sector doctors, and military doctors could take posts in the NHS. Furthermore, the MoH decided that doctors, who had not registered with their local medical association within 30 days, were committing a disciplinary offence. In addition, doctors practising in one of 200 public NHS rural surgeries were entitled to become general practitioners after five years of continuous, salaried practice. However, they had to do one year of practice in pathology (4 months), cardiology (2 months), general surgery (2 months), gynaecology (2 months) and paediatrics (2 months) (Halvatzakis 1992).

In the end, the government failed to implement this new Law for specific reasons. The Conservatives did not have the necessary political strength to implement the major policy reforms which were part of their neo-liberal agenda in health, education and the general public sector. They did not have a majority of the Parliamentary seats anymore (only 150/300, as one of their MPs had left the party) and thus lacked a sufficient mandate for a major policy reform. Tuohy (1999) has argued that the common agenda for all countries in the late 1980s and early 1990s was to reduce or stabilize health expenditure. This debate was part of a wider debate on the role of the Welfare State and its economic, fiscal and political challenges during the 1970s and 1980s. Incrementalism was the salient trait of the Law introduced by the Conservatives through their four-year period of office. They focused on fiscal priorities and the reduction of the State apparatus and responsibility. The public did not like the consequences and quickly turned against ND policies.

The Conservatives tried to address the issue of cost containment in health care sector in the early 1990s by implementing Law 2071/1992. Unfortunately, they focused on implementing blunt instruments of budget constraint and cost-shifting, instead of attempting to change the systems of decision-making in health care, in particular the production and consumption of health care services (Pipili 1992; Foura 1992b; Tragakes and Polyzos 1998).

Overall, the reform of 1992 served specific vested interests, particularly the medical profession (specifically, doctors that were close to the Conservative party and wanted to be part of the ESY, and doctors that were already in ESY but did not want any kind of change to their informal ability to practise in the public and private sector), private clinic owners, private diagnostic centres, and university doctors. According to interviewee 25TU (Board Committee Member in ISA and EINAP), Sourlas was just an unsuccessful small clinic entrepreneur and later an MP of the Conservative Party<sup>34</sup> who wanted to cut down the cost of the system, while at the same time realising that there was nothing he could do to change its status. Interviewee 27TU's perspective was that the Sourlas reform did not affect the basis of the system, but it did provide the necessary institutional ground for more private sector and less State involvement in the future. In

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<sup>34</sup> Who lost his seat in the Greek Parliament later on

other words, it provided fertile ground for the familiarization of the public with issues such as cost containment, but at the same time it was not taken seriously, as most of the stakeholders predicted the failure of the government and as a result, the short term nature of the reform.

### 9.3 The 1994 Committee of Health Experts Report

The Socialists won the election in 1993, and this time a university doctor (Prof. Kremastinos) became the Minister of Health. Key informants from various perspectives (6A, 8A, 10MoH/P, 20B, 28TU, 36J, 35J) thought that this offered a unique opportunity to reform Greek Health Care, as Kremastinos was a very close friend and personal doctor of Prime Minister Papandreou. They thought that he would have the political strength to reform the health care system since the support of the Prime Minister was assumed. The implication was that Kremastinos did not have to worry about the political cost of his decisions and most importantly he could get the necessary funding from the Ministry of Finance.

Kremastinos, key informants argued (6A, 8A, 10MoH/P, 20B, 28TU, 36J, 35J), wanted to return to the 1983 legislative situation, abolishing most of the Conservatives legislative alterations. As a result, he re-established hospital doctors' full-time employment and redefined the role of the State in providing health care to all Greek citizens. He also announced his intention to pursue major health care reform by setting up two committees, one of Greek Health Care and Policy experts and another of foreign expert (many Greek health care experts, health professionals or even journalists called this *'the committee of wise men'*). The Greek experts committee prepared the background information and stressed specific points that the foreign experts needed to focus on in order to elaborate and suggest a new reformist policy. The expert committee from abroad was chaired by Brian Abel-Smith, with J. Calltorp, M. Dixon, And. Dunning, R. Evans, W. Holland, B. Jarman and E. Mossialos.

The overseas expert committee's suggestions did not coincide with the Ministry's official view on quite a number of issues. Nevertheless, it represented a comprehensive analysis of the status of the Greek health care system in 1994. The committee worked in Athens for almost a week, since much of preliminary work had been previously carried



out for them by the Greek experts. Overall, they concluded that they had never before come across such an ineffective and puzzling system and that the government should implement a ten-year plan for reform, to be followed by successive governments in order to establish a well-defined health care system. They concluded that *“the Greek health care system will not improve even in the case that health care expenditure is drastically increased, but the organisation remains the same”* (Abel-Smith, Calltorp et al. 1994).

The committee noticed that the system was in constant evolution, but that there were serious elements of immoral practice on the part of the medical profession and of other health care professionals, with more doctors than were needed and with a weak organization of primary health care. People’s desire for something better in the health sector was obvious according to Walter Holland, a member of the committee: *“There was a popular desire for change, and especially in England we have a saying about how public opinion is best represented by what your taxi driver says to you. And the first thing that the taxi driver asked me heading from the airport towards the centre of Athens where the meetings of the committee were being held, was whether or not I, as a physician receive, informal payments (fakelaki).”*

According to the committee’s report (Abel-Smith, Calltorp et al. 1994), there were several suggestions for improving the Greek Health Care System:

1. Emphasis on public health information and prevention
2. Establish a unified single health insurance fund
3. Introduction of family doctor service
4. Reimbursement of consultants should be based on fee-for-service.

In addition to this, reimbursement of university doctors should be higher, as compensation for quitting private practice

5. The unified sickness fund should allocate resources to each Regional Health Council, according to population needs
6. Introduction of managers in hospitals
7. Hospital employees should not be civil servants
8. Introduction of restricted positive list of drugs

9. Special and intensive training of administrators, public health physicians of public health, and general practitioners, to help with the implementation of the reform

10. The additional cost of these measures could be covered by reduction of waste in the dispensing of drugs and ordering of diagnostic tests

The reaction of EINAP and President Dr. Christina Papanikolaou was that the suggestions of the committee were inappropriate to the Greek context: she argued that she would not hesitate to ask her colleagues to fight any of the suggestions that had not yet been made public.

Walter Holland (member of the expert committee) was amazed by the fact that hospital doctors expressed opposition towards even the committee's presence in Athens, since the committee was there only to receive evidence, and argued that from his experience "*...the Greek medical profession seems extremely powerful, and I am sure that this is also true for the university doctors. And I would have thought that the Greek medical profession is also crucial in the process of formulating or implementing a reform...*" The report's conclusions also pinpointed the role of the various interest groups and vested interests that blocked reforms or made them more difficult to implement, it seems that most of the members of the committee shared a similar view to Prof. Holland.

Doctors were not the only ones who opposed and severely criticized the report. Criticism came also from a leading section of the medical community which was attached to National School of Public Health. They described the report as a cruel neo-liberal plan against the Welfare State and the health sector, mainly obeying Maastricht guidelines (Venieris 1997b).

Minister Kremastinos, as key informants from several perspectives mentioned, wanted to work on building his own academic career and did not want to harm the vested interests of his fellow university and hospital doctors. He even once tried to support his colleagues in the Onassis Cardiac Surgery Centre (not for profit private legal entity, which was build by Onassis Benefit Foundation, and in 1992 was donated to the State. Since then, it has and still is supervised by the Ministry of Health), when they were accused by public hospital doctors of getting better salaries and having more clients. He

then withdrew support from his colleagues when the public hospital doctors criticised his position and threatened they would not back his plan for reform. Some key informants felt that he just wanted to have a painless ministerial period, avoiding all possible conflicts and without the responsibility of implementing a new health reform. They even argued that the two expert committees delayed the time for decisive reforms.

#### 9.4 Conclusions

Overall, the 1990s might have started with a reform in health care, but for reasons discussed in the beginning of this chapter the Conservatives did not have the general support of the public in pursuing reforms in the general public sector domain, and as a consequence in the health sector. This was mainly because they were accused of implementing blunt instruments of cost containment without planning for the long term. As a result, their policies were short-sighted and many academics, policy experts and politicians predicted an early end to their government. They lost their Parliamentary majority in 1993. An important contribution at least in terms of producing a detailed account of the Greek health care system, focused on its weaknesses, was the report published by the overseas Committee of Experts (1994). The report could have initiated a process of planning for reform, according to the experts' suggestions, but in the end it was shelved due to a lack of political will to change the *status quo* in the health care sector.

The next important reform was Papadopoulos' reform plan 'Health for the Citizen' announced in the summer of 2000. In the meantime, the only attempt to reform the Greek Health Care System worth mentioning was carried out by Minister Gitonas. Further details about Gitonas' attempt and a detailed history of Minister Papadopoulos' reform are offered in the next chapter.

## Chapter 10: The Papadopoulos Reform

### 10.1 Introduction

This chapter firstly contains a detailed account of the third sub-case study this thesis examines, the 2001 reform, and an additional summary of the important policy episodes in health care of the years leading up to these reforms (1994-1997). Secondly, it describes the patterns of influence and power exercised by the key players at the different stages of planning, discussion in Parliament, and voting of Law 2889/2001. The key actors of this narrative are the different segments of the medical profession (hospital doctors, university doctors and IKA doctors), the health insurance funds, employees of the Ministry of Health, and the two biggest Greek trade unions ADEDY and GSEE. Finally, as this is the third in a series of narratives which completes the analysis of the Greek health care system in three distinctive periods (1980s, 1990s and early 2001), an appraisal of what has or has not changed during the last decade is offered at the end of the chapter. Table 10.1 provides schematic information on the provisions of Law 2889/2001, their degree of implementation and the main actors involved.

<i>Law/Plan Provisions</i>	<i>What happened?</i>	<i>Main Actors</i>
-decentralization of the System by establishing 17 RHS	-implemented with lots of managerial and administrative inconsistencies	<b>-Hospital Doctors</b> <b>-University Doctors</b> <b>-Health Insurance Funds</b> <b>-Private health sector</b> <b>-IKA doctors</b> <b>-ADEDY and GSEE Trade unions</b> <b>-Ministry of Health Employees</b>
-introduction of hospital managers	-implemented, but with 'restricted' responsibilities, NHS hospitals remain medically dominated	
-afternoon private practices	-initially implemented, but not very popular or successful	
-university doctors have to choose between private practice and exclusive NHS practice	-never implemented in reality	
-the institution of 'clinical professor'	-not implemented	
-appraisal of hospital doctors every 5 years	-not really implemented	
-organisation of PHC <sup>35</sup> -establishment of a Unified Health Insurance Fund	-not implemented -not implemented	

## 10.2 Before the 2001 Reform

In 1994, a committee of international health experts chaired by Professor Brian Abel-Smith of the London School of Economics and appointed by Minister Kremastinos had concluded that the Greek National Health System was ineffective and recommended a ten year plan for reform. Particular problems identified included corrupt practices, overproduction of doctors and weak organization of primary health care.

EINAP (the Association of Hospital Doctors of Athens and Piraeus) strongly opposed the committee's proposals and threatened that if any were implemented, hospital staff would strike. The proposals were shelved in 1996, as Ministerial advisers argued that Greece needed less radical reform (Venieris 1997b).

In July 1997, Minister Gitonas introduced further less radical reform directed at cost containment, including the introduction of managerial personnel in hospitals, development of urban health care centres and changes in the way hospital budgets were devised. But Minister Gitonas also abolished one of the most important provisions of the earlier Kremastinos plan, the objective of establishing a unified sickness fund.

Gitonas' reforms represented traditional, incremental changes regarded as more acceptable to the main actors in the system, especially doctors. Most importantly the government (the Socialists) avoided the political cost of a radical reform. Over two years of discussions resulted in the implementation of the Gitonas reforms in 1999. Major stakeholders, such as doctors, had plenty of time to reshape the plan according to their interests. As a result, the Law included generous increases in hospital doctors' salaries, but the cost containment measures such as changes to hospital management were not realized (Tragakes and Polyzos 1998; Petmesidou 2000).

PASOK was re-elected in 2000 and a non-medical Minister of Health was appointed. Minister Papadopoulos had already gained his reputation as a successful Minister of Finance and of Internal Affairs and he seemed the ideal choice to confront vested interests in the health care sector and manage the likely political conflict that would result. He introduced a health care Bill in the Greek Parliament in January 2001, which was to be part of a wider subsequent reform plan for the longer term, known as 'Health for the Citizen' including not only the establishment of regional health systems, but also the much discussed unification of the insurance funds under a new State body to

be called ODIPY (Organization for the Management of Health Funding<sup>36</sup>) and the establishment of a family medicine system. ODIPY and primary health care were not part of the 2889/2001 Bill, but they were to follow.

### **10.3 The 2001 Reform**

#### **10.3.1 Background to the Reform**

The 2001 reform was another important attempt by the Socialists to implement parts of the 1397/198 Law that for various reasons such as the weakness of the State, ideological resistance, various interest groups' opposition and frequent changes in the Ministry of Health, had not been implemented. It also tried to update the 1983 provisions and to decentralize the administration of the health care system as other EU countries had already done. In addition to this, PASOK had just been re-elected in 2000, and Prime Minister Simitis, already known for his efforts to 'modernize' Greek society and economy between 1996-2000, wanted to emphasize his interest in improving the Greek health care system by appointing a non-medical Minister of Health, a post traditionally occupied by medical doctors. As several key informants commented (3A, 4A, 5A, 6A, 8A, 10MoH/P, 14MoH/P, 18B, 20B, 21B, 22B, 27TU, 28TU34J, 35J, 36J), for this reason Simitis appointed Alekos Papadopoulos to this difficult and not very politically rewarding post.

Minister Papadopoulos had had long discussions with Prime Minister Simitis and convinced him of the importance and political advantages of revolutionizing health care. Success in the health sector had the potential to bolster the government's image and convince citizens of its abilities (Lakopoulos 2000; Lampsias 2000). Prime Minister Simitis, though, had to face the aftermath of Greece joining the Euro, the delays in preparations for the Olympic Games of 2004, and forthcoming reforms in the education sector. This meant, according to key informants from several perspectives, that the lack funds from the preparation for the Olympics and Greece entering the EU zone did not allow for this reform. Their point of view was supported by the inability of Papadopoulos' planning team to provide thorough justification of secured funding for the implementation of the Health for the Citizen plan, and from the EU directives and the Spraos report which strongly supported the idea that Greece should continue cutting its public spending.

Other recurring themes in the interviews were whether Papadopoulos was too ambitious and optimistic about that which he could achieve, whether or not he had the full support of Prime Minister Simitis, and why he did not start his reform with primary health care and the unification of the health insurance funds, instead of decentralization of the system and the establishment of 17 Regional Health Systems (the latter had less contentions). One of the interviewees (11MoH/P) added that “.....it does not matter if you have good intentions, but what really matters is what you have done and if someone will say in the future that this happened during Papadopoulos term.....”, and a couple of others agreed (10MoH/P and 21B). Prime Minister Simitis knew that health sector reforms could be a very difficult task that could destroy the government’s appeal to the public yet he had just won the general election so he had four years ahead of him to open all the difficult issues and to produce decent results by the end of his tenure. In addition to this, a possible success in the health sector could increase the government’s image and convince citizens of its abilities (Lakopoulos 2000; Lampsias 2000; Tsoulea 2000; TO VIMA 2000a; TO VIMA 2000b). However, a different view was voiced by interviewee 33UD, a well-known university doctor, saying that Papadopoulos was appointed Minister because it is a very convenient post for any Prime Minister who wants to ‘burn’ his political opponents.

Again the people’s dissatisfaction with the health system was obvious in various EU Barometer polls (Mossialos 1997), but there were no specific groups demanding a change in the health care system. Papadopoulos introduced Law 2889/2001 (establishment of the regional health systems, etc.) in January 2001, which was part of a wider reform plan for the longer term<sup>37</sup>. The reform plan announced in summer 2000 had also included the much discussed unification of the insurance funds under a new State body to be called ODIPY (Organization for the management of health funding), the establishment of a family medicine system, and an updated and complete version of the a dynamic public health map of Greece.

### **10.3.2 The ‘Health for the Citizen’ Plan and the Production of the 2889/2001 Law**

PM Simitis eventually gave the Minister Papadopoulos permission to present the plan to the other ministers involved and to the public in summer 2000 (Tsoulea 2000). During his press conference he declared his willingness to proceed with the reform by

saying that *“there is no spare time for the system to remain static”*, and argued that *“the reform is a debt of the State towards the Greek citizen who seeks everyday satisfaction through health services”* (TO VIMA 2000a)

Discussions about the reforms started on August 25<sup>th</sup> 2000 and went on for about a month. Many interest groups had already expressed their opposition, and many people who were close partners of the Minister argued that *‘discussion over the plan was more pretentious’* and that in fact he had no intention to make any concession to the original plan. He did not expect serious opposition, as he had already *‘sugared the pill’* for the major interest group in health care, the hospital doctors, by allowing them to have private afternoon practices within public hospitals, and had also established the post of *‘clinical academic’* for them. In addition to this, medical associations and trade unions had not yet held meetings within their organizations to discuss the plan. Nevertheless, the Minister decided to proceed with the production of Bill 2889/2001 (Fyntanidou 2000b).

Minister Papadopoulos was one of the few Ministers to publicly acknowledge the role of medical associations. Not only was he probably the only Minister that visited the headquarters of the biggest medical society in Greece, ISA-Athens Medical Association, but he also declared that *“...The Doctors’ view on what is happening in the health sector is very important. As a result, there can be no reform without the support of their medical societies...”* (TA NEA 2000)

He deliberately compromised at this stage when drafting the Bill and did not include the proposals to introduce a single insurance fund which could develop into a national purchaser of services, or establish primary health care, as there were vested interests opposing the unification, and there were not enough resources for financing primary health care. Instead, he focused simply on decentralization of the public hospital system, through the establishment of seventeen Regional Health Systems (RHSs). The core of the eventual reform, law 2889/2001, included several structural changes:

➤ Development of decentralized regional structures - 17 Regional Health Systems (each of the 17 public bodies was administered by a nine member committee. 5 members of the committee were directly appointed by the Ministry of Health).



- Establishment of a dynamic 'Health Map', which would give details about the health care needs of the Greek population. Data collection would be initially carried out in each of the 17 RHS.
- Establishment of new managerial structures within the public hospitals- new managers appointed in all the public hospitals.
- Modification of the terms of employment of NHS doctors - University hospital doctors were not permitted to have private practice if their university clinic was located in an NHS hospital (private afternoon practices within NHS hospitals).
- NHS doctors employed in the future would achieve permanent tenure only after three successful appraisals. This meant that newcomers to the NHS would be appraised every five years and only after fifteen could enjoy permanent tenure.
- Creation of the title of 'clinical teacher'. A committee set up by the Ministry of Education and Ministry of Health would nominate clinical directors of NHS hospitals. Procedures and privileges were to be the same as the ones that university doctors enjoyed.
- Public hospitals to be open on a 24-hour basis, with afternoon outpatient clinics, where doctors could treat patients on site on a fee-for-service basis. Hospitals' status was also altered to quasi-private legal entities in the sense that they would not be part of the core central government, but rather accountable to the appropriate Regional Health System (Fyntanidou 2000d; Greek Parliament Minutes 2001).

### 10.3.3 Opposition from the Trade Unions

The biggest Greek trade unions, such as GSEE and ADEDY, plus the medical trade unions (OENGE, EINAP, POEDHN) publicly expressed their opposition to the plan on the grounds that "*it promotes the private health sector and damages the social and public character of the system*"<sup>38</sup>. The President of EINAP, Mr. Tsoukalos, argued that the plan gave the impression that up to now there had been total chaos in the Greek health care system, though Greece had scored high on a recent WHO ranking of systems (14<sup>th</sup> place in 2000) (WHO 2000). He also warned the Minister that although legislation had been passed previously, many of them had remained 'dead letters' "*....there are many examples from the recent history of the NHS where a minister has introduced various Laws but none of these were implemented.....*" (Tsoukalos 2000). He and Mr.

Eleutheriou, member of the administrative committee of EINAP and treasurer of ISA, argued that hospital doctors would not accept any kind of change to their working conditions, and would expect a generous rise in the health care expenditure in return for the implementation of any reform (Fyntanidou 2000c).

In addition to this, according to other Ministerial key informants, further opposition was expressed to several aspects of the proposals for hospital doctors' labour relations. Although Papadopoulos had introduced the 'clinical teacher' role for the ESY doctors, they decided to strongly oppose it because they would have had to be appraised by university doctors. And as several key informants pointed out, ESY doctors and university doctors had never got along very well. This is because, in most cases, university doctors took advantage of ESY doctors and patronized them. In other words, a lot of high quality and publicly acclaimed ESY doctors had tried in the past to become university doctors, because they were not part of the personal network or clientele of the senior university doctors. It is also true that in various university or ESY clinics, or a mixture of them, ESY doctors could never become the director of the clinic, as long as a university doctor was practising there.

POEDHN argued that the economic burden of financing the system would be transferred to patients, as the State would not raise health care expenditure, and patients would have to pay out-of-pocket in the private afternoon practices. Representatives of POEDHN also disagreed with the potential establishment of the new organization, ODIPY (Organization for the Management of Health Funding) as part of the 'Health for the Citizen' plan, the hospitals' new legal status, and the fact that the Law did not improve the working conditions and wages of most people working in the health sector. The fact that contributions from employers and employees would be gathered in a single non-governmental legal entity and not in a public legal entity, would encourage private health care spending POEDHN argued. According to Minister Papadopoulos' plan, ODIPY would be an independent organization, supervised by the Ministry of Health and the Ministry of Labour and Social Security. ODIPY represented the Greek adaptation of the separate provider and purchaser of the health services model. The idea was that ODIPY would be able to find the most efficient way of providing health services, even if that meant purchasing health services from the private sector. In addition to this, the fact

that hospitals would no longer be public legal entities meant that employees (80,000) would be accountable to the Regional Health Systems (RHS), which would have the authority to transfer employees between posts and hospitals according to the needs of the system. As a result, the health sector employees would be directed by (or 'captured' by) each RHS, a situation that did not please either ADEDY or GSEE, two of the biggest and most powerful trade unions in Greece that protected the rights of doctors and other health care sector employees (Mpouloutza 2000a).

Most of the key informants also mentioned the strong opposition by OENGE and EINAP because public hospital doctors would lose immediate permanent tenure. Instead, they would have to be appraised successfully twice in ten years to get a permanent post. Key informants representing the hospital doctors' trade union argued they could not allow appraisals in such a highly politicized and party-influenced system. Doctors had to be protected from the deficiencies of Greek society and party politics.

Interviewee 26TU, a member of the boards of OENGE and EINAP trade unions, strongly argued that the true intentions of the minister were not to decentralize the system or to make it more efficient. In that case, he would have tried to reallocate resources according to the needs of each region, he would have hired more doctors, and he would have not insisted on introducing managerial staff and other administrative staff in the 17 Regional Health Systems, which would dramatically increase the cost of the whole system<sup>39</sup>.

Ministerial key informants (8A and 18B) also added that most of the hospital trade unions were also not very fond of the idea of 'afternoon private practices', because the fees that doctors could charge would be set at a very low rate by the health insurance funds. What was the point of working from 9 am till late in the evening, when by getting informal payments during the day from patients, they could earn double or triple what that they could earn from official private practice?

During September 2000, it became quite obvious that all the major trade unions in Greece, including the bigger and most powerful ones, like ADEDY and GSEE, the health sector-related ones, like OENGE, EINAP, and POEDHN were against the reform plan that Minister Papadopoulos had announced (Mpouloutza 2000b; Greek Parliament Minutes 2001).

Representatives of the most important medical associations (OENGE, EINAP, ISA) were particularly against the introduction of professional hospital managers, arguing that managers were not doctors and that they did not have the esoteric knowledge and authority to judge doctors (one MP who was also a doctor argued that “*doctors should be judged only by doctors*”) (Greek Parliament Minutes 2001). Thus, in January 2001, a few days before the discussion of the Bill in the Greek Parliament had started, the medical trade unions announced their decision to go on strike and invited doctors to participate and resist the forthcoming plan for reform (ELEUTHEROTUPIA 2001e; ELEUTHEROTUPIA 2001k).

The various medical associations and trade unions decided to take action against Papadopoulos’ plan for different reasons. OENGE, for example, demanded the unification of the health insurance funds under a public institution and not under ODIPY (private independent legal entity), as the plan had suggested. OENGE representatives also demanded an increase in health care spending, closures or merging of hospitals and the better organization of primary health care and unification of the services. PIS, on the other hand, generally opposed the Law and asked the government to take measures to reduce the increased number of doctors (IATRIKO VIMA 2000; ELEUTHEROTUPIA 2001m). President of PIS, E. Kalokairinos, argued that the forthcoming reform would isolate the medical profession from the decision making of health care. RHSs and the decentralization of the system would abolish most of the power and influence of doctors as none of the nine-member administrative committees that Papadopoulos planned to introduce came from PIS. Kalokairinos argued that, although the minister had asked for PIS’ proposals, in the end he did not include any in the version of the plan introduced to Parliament (ELEUTHEROTUPIA 2001n). POEDHN also asked for increased health care funds, the preservation of the public character of hospitals, the abolition of the clause permitting private afternoon practice in public hospitals, and finally for the downgrading of administrative and nursing employees to stop (mainly these are the public health sector employee categories that POEDHN represents) (Mpouloutza 2000a). In addition to this, ISA emphasized the negative effect that private afternoon practices would have on patients’ budgets, as they would have to pay out-of-pocket, and eventually doctors would be divided into privileged and non-privileged. Unfair competition between hospital

doctors that practised privately inside the hospitals and out-of-hospital doctors would create a dispute between the members of the same profession and weaken their demands for more benefits (ELEUTHEROTUPIA 2001i). ISA's opposition to more organized primary health care demonstrates their hidden aspiration for the failure of Papadopoulos reform. ISA and PIS represent the interests of all doctors, but they are mainly dominated by the power and influence of the private sector doctors (more than 25,000 in Greece) whose interests would be mainly harmed if an organized public primary health care system were to come to existence. For exactly opposite reasons, EINAP also opposed the reform and argued that the government should invest in public health care, and not promote privatization of hospitals, plus it demanded increased pay and permanent tenure for all hospital doctors (EINAP 2000a; EINAP 2000b; EINAP 2000c; EINAP 2000d; EINAP 2000e; EINAP 2001)

Health Ministerial informants (9MoH/P, 15MoH/P) added one last important reason of why hospital doctors opposed the reform. Various ministers of health had tried hard to establish a dynamic mapping of the health system, monitoring the real needs for resources across the country. It was the first time that a public health map had been drawn and the preliminary results were devastating in terms of identifying the misallocation of health care human resources. Small rural areas in particular, presented an overrepresentation of doctors against nurses (i.e. a village in Crete that had ten doctors and only one nurse). This meant, firstly doctors who had better connections to influential State officials could be appointed wherever they wanted, and secondly after this map took its final and online form, the Minister could reallocate doctors according to the needs of the region and the hospital rather than the personal interests of its physician. As a result, not only the medical profession strongly opposed this map, but so did all the politicians who were involved and indulged in clientelistic relationships. Papadopoulos knew that it was difficult to change the civil servant status of NHS employees (including academic doctors), the opposition from ADEDY, one of the biggest trade unions in Greece for the civil servants, would be unbearable, as ADEDY would argue that what would be enforced for the hospital doctors would be expanded in the future for the rest of the civil servants. The minister intended to abolish the legal status of each individual and make them accountable to the RHSs. That way personnel could be placed in the right position

according to the health care needs of each region (a feature that was never realized due to regional directors' inability to implement the Law). However, the Confederation of Public Servants (ADEDY) opposed the possible redeployment of publicly employed doctors in line with the needs of the 17 RHSs, as this was not included in the civil servants' code<sup>40</sup>. ADEDY, the superior trade union of the Greek Civil Servants (EINAP was part of it), was afraid that if the Minister of Health managed to redeploy hospital doctors according to the needs of the system, this measure could easily be expanded to the rest of the civil servants.

As a result, during the implementation stage of Law 2889/2001, regional directors could not enforce the Law, and hospital doctors refused to move even within their region. Hospital doctors also had vested interests within the hospital where they practised, as some of them had established their own undercover network for treating unofficial private patients that they did not want to lose. These common tactics within the NHS resulted in circumvention of waiting lists or even inducement of phantom waiting lists to encourage illegal private practice and informal payments (Davaki and Mossialos 2005).

According to MoH statistics, participation in the strikes announced by EINAP and OENGE did not exceed 6.8% in Attica and 6.2% in the periphery. However, OENGE announced that these figures were not true, and according to them the average percentage of doctors striking in Athens was approximately 35%. Some might say that these figures prove that doctors were not in favour of their representatives' views. Another interpretation is that the majority of doctors did not worry about the forthcoming law, as they knew that they could render it a 'dead letter' at the implementation stage if their interests were harmed (Kouklaki 2001; ELEUTHEROTUPIA 2001j).

#### **10.3.4 Political Opposition**

The Conservative Party generally opposed the Health Reform Plan proposed by Minister Papadopoulos. During the Parliamentary discussion, Dr. Kaklamanis (Conservative MP, University Doctor, Trade Unionist and Minister of Health with the Conservative government from 2004 to 2006) argued that the plan introduced two types of university doctors: privileged ones working in academic hospitals (as they would still

be able to practice privately), and non-privileged ones that would work in university clinics inside NHS hospitals<sup>41</sup>. However, the opposition to the reform from the Conservatives was not unanimous. Ex-Prime Minister Constantine Mitsotakis, a respected and important figure in Greek politics, applauded the part of Minister Papadopoulos' speech where he argued that doctors should stop being civil servants. He carried on "*..... if we want to have a proper health care system, we need to end this ...*" (TA NEA 2001a).

Dr. Kaklamanis also argued that there were many disagreements even within the government, and a typical example of this was the different suggestions for change that the president of IKA had for ODIPY before the MoH had announced his plans for ODIPY (as part of the 'Health for the Citizen' plan in July 2000) (Greek Parliament Minutes 2001). The president of IKA, Mr. Nektarios, had announced that he would be present at the Minister's press conference regarding the plan, but he did not appear. This confirmed the bad relations that existed between the MoH and the junior Minister of Social Security, Mr. Pharmakis, and the president of IKA, Mr. Nektarios, who were fighting about who was going to run the unified insurance fund (ODIPY). The establishment of ODIPY under the two ministries would leave Mr. Pharmakis without a role, and the fact that IKA, the biggest insurance fund, would have to merge with four others into a unified fund, would also prevent Mr. Nektarios from fulfilling his ambitions of upgrading IKA (Mpouloutza 2000b; Greek Parliament Minutes 2001).

Papadopoulos also had to face a strike of Ministry of Health employees which had started in November 2000. Papadopoulos argued that although he did face some problems convincing MoH employees to fully support the 2001 reform, these were soon tackled and were unimportant. This was slightly different from what other representative key informants of the Ministry of Health said. They acknowledged that within the ministry there were several problems surrounding the role and expectations of the employees. For example, bureaucrats demanded that the Ministry of Health and its employees should be more involved in the forthcoming reform and utilize the already existing human resources in the ministry. They argued that Ministry of Health should be the central organizing institution responsible for strategic planning and implementation of the reform. Civil servants in the Ministry of Health expressed their dissatisfaction at relinquishing power to

the Regional Health Systems. They felt neglected by the way the Minister was trying to decentralize the system with the establishment of the RHSs and the extra skilled human resources that the RHS were about to employ (ELEUTHEROTUPIA 2001c; Mossialos and Davaki 2002).

### 10.3.5 University Doctors

University doctors were one of the major interest groups that strongly opposed the proposed Law during Parliamentary discussion, as well as after its enactment because it forced them to choose between public and private practice. As nearly all the key informants argued, university doctors did not want to leave their ESY public clinics and the privileges that they had. By privileges, a health policy academic/consultant of the Greek government (8A) referred to the large number of clients they treated during the morning in hospital, who they then referred to their private practices, in addition to the junior doctors who did all the hard work for them in their every day hospital practice. He continued by arguing that the strongest opposition came from the medical schools of Athens and Thessalonica, where the number of university doctors is was largest and where the competition in terms of securing patients was greatest. This never happened in university hospitals in any other Greek region, as most of the university doctors in the district university hospitals monopolized a very small market.

The President of the medical school of Athens, Mr. A. Koutselinis, argued that Minister Papadopoulos was biased against university doctors, blaming them for all the inefficiencies of the health care system. He also argued that the Minister treated university doctors unfairly compared to other university teachers, and that the reform was indicative of his personal hostility towards them. He disapproved of the Minister's attitude towards university doctors arguing that "*the clause relevant to university doctors' working conditions is against the fundamental principles of academic freedom of the Greek Constitution and it will never be implemented*" (ELEUTHEROTUPIA 2001b; TA NEA 2001c). The Minister replied, "*University doctors who practise in the public and private sectors simultaneously are immoral*" (ELEUTHEROTUPIA 2001b). University doctors, on the other hand, claimed that even if they wanted to practise within the hospital during the afternoons, they did not have the necessary infrastructure. The Minister promised the infrastructure would be ready according to the time limits that the Law set.



Former Minister of Health and MP, Kremastinos (who was also a university doctor), suggested that both sides should reach a consensus, yet because it was doubtful that the infrastructure for the private afternoon practices would be ready by 01.01.2002, he proposed that university doctors should quit their private practices only *“when the infrastructure is ready and a presidential decree is published”* (TA NEA 2001c).

Furthermore, the strong opposition was even more obvious after the plan had become law according to several interviewees told me (2A, 6A, 8A, 15MoH/P, 18B, 34J). Every time that the Regional Health Systems asked for a university doctor representative to participate in their meetings, university doctors did not even bother to reply, as by attending the meetings they would have acknowledged RHS' jurisdiction over them. In addition to this, the 2889/2001 law could only dismiss doctors in ESY hospitals who were not practising exclusively, meaning that the doctors who also had private practices. In response university doctors obtained certificates, for example from the Dean of University of Athens, which indicated that they were relieved of their clinical duties (treating patients in the ESY hospitals) so that they could keep their teaching posts in the university in addition to their private practices. According to the interviewees, it is common thing for university doctors to try to avoid any kind of law that forces them to lose any of their privileges, and in any case who is practicing where and for whom could not be observed. *“We cannot be the policemen/policewomen that chase around university doctors...can we? ... (Interviewee 15MoH/P)”*

University doctors also opposed the new 'clinical teacher' title. They argued that the Minister of Health had created this title in order to deal with a possible mass exodus of university doctors from NHS clinics, and in addition to this they claimed it was unconstitutional, because university teachers had to be elected by university teachers. The newly established 'clinical teacher' posts would have nothing to do with academia, as they would be appointed by the MoH. Thus for the first time, medical schools would not be the institution to award a title that was supposed to be the equivalent of a university teaching post (Klamaris 2001; TA NEA 2001a).

Parliamentary minutes of the discussion of the plan show that the debate between MPs who used to be university doctors and Minister Papadopoulos was lengthy and hard-fought. Most of these MPs challenged the authority of the Minister to judge their

profession and their working conditions, on the grounds he was not a doctor<sup>42</sup>, and they even disputed the view of the Scientific Committee of the Greek Parliament which suggested that the clause complied with the basic principles of the Greek Constitution. The report produced by the Scientific Committee was based on the Supreme Court of Appeal's verdict that *"university clinics established in NHS hospitals are the responsibility of the MoH and not the Ministry of Education"*, meaning that the MoH had the right to determine the labour relations of university doctors. However, university doctors still argued that they could not be judged by, or be accountable, to RHSs and their managers (Greek Parliament Minutes 2001). Even Prof. Kremastinos, a Socialist MP, ex-Minister of Health, who supported the reforms, expressed doubts about the articles on university doctors' labour relations. He argued that *"no one in this Parliament knows that a University doctor receives the same salary as an academic professor in Theology"*. That is to say that the status and the importance of a university doctor is not appreciated by the State, which does not categorize academics according to the importance of their expertise. His implied conclusion was that university doctors should be given higher status by the Greek State (Diakogiannis 2001).

Opponents of the reform also argued that Minister Papadopoulos was promoting the private sector which wanted to employ the brightest and most skilful university doctors in its clinics, as university doctors would prefer not to comply with the new law. Athanasios Gianopoulos, Conservative MP and well-known university doctor, repeated that the government was hounding university doctors and not other academics (Greek Parliament Minutes 2001).

The power and influence of the university doctors was exposed in a series of articles written by a well respected Greek journalist of daily newspaper 'H KATHIMERINI' called Antonis Karkayannis. Karkayannis exposed the way university doctors in Greece, and especially university doctors of the two most important and influential medical schools in Greece, Athens and Thessalonica, had established their privileges under the protection of university autonomy and how they exploited their high status and authority to the detriment of their patients and their students. The majority of university doctors combined multiple posts in public hospitals, private hospitals, private diagnostic centres and private surgeries with university teaching. As a result, they treated

their obligations towards public hospitals and the university as a sideline to their main source of income which was treating patients in their private afternoon surgeries or private clinics. Moreover, in most cases, they built their clientele through their daily job in public hospitals, transferring patients directly to their afternoon private surgeries. In addition to this, and although they were obliged by the State to pay taxes according to their income from these private afternoon practices, the majority were paid in cash and issued no receipts. Karkagiannis also argued that even in terms of their teaching obligations, university doctors scarcely fulfilled their formal obligations. He mentioned an incident where the cynicism of medical academics was revealed. Medical students asked their university teacher to change their examination time as they did not want to miss a clinical class which coincided. He replied, *"...And who is going to pay me the money that I am going to lose by not doing my private practice..."*?

Although it seemed that university doctors were opposing Minister Papadopoulos' Bill because it restrained their academic freedom, in reality, they saw their freedom threatened not inside the university, but outside in their private practices. It is within this context that university doctors argued that their academic title in the university (i.e. being a professor of pathology) was a private title and they could do whatever they wanted in their 'spare time'. Karkagiannis reached two conclusions: firstly, the fact that university doctors generally fulfilling their duties in Athens and Thessalonica was one of the most cynical and immoral actions that Greece had ever experienced; and, secondly, that the strongest opposition towards the Papadopoulos Bill came from university doctors in Athens and Thessalonika, where there were plenty of university doctors competing for patients illegally. University teachers in other Greek cities, like Patra, Alexandroupoli and Ionina were not so numerous and so do not have to compete with each other. As a result, they took their private clientele for granted and continued to practice privately and illegally even if the Law forbade them as they were not in danger of being reported by their competitors. This is more likely to be the case in Athens or in Thessalonica (Karkayannis 2001a; Karkayannis 2001d; Mpouloutza 2001d). University doctors are one of the biggest groups in Greek academia accounting for almost 25% (2000) of the 6000 academics. Out of the total of 1500 university doctors, 700 have posts in the medical school of Athens. As a result, they are interested not only in protecting their

labour relations from any kind of reform, thereby influencing the MoH or even Prime Ministers, but also in competing with each other for patients' attention (Papamathaiou 2000; Karkayannis 2001b).

University doctors continued the debate and went to the Constitutional Court claiming that their human rights were being violated on the basis of the European Convention of Human Rights. Professor Lila Asteriou, President of teaching and research staff in the Medical School of Athens Society, argued that the Society was more than willing to cover all the legal expenses of any academic opposing the 2889/2001 Bill in the courts. That way even more academics were prompted to take the State to court about the violation of personal freedom (Mpouloutza 2001e). In total, ten university doctors from Athens and Thessalonica were fired from their posts by the management of their hospitals because they did not comply with the articles of the 2889/2001 Bill. But academics did not rest their cases. They decided to take the managements of their hospitals to the Constitutional Court demanding reinstatement. According to their applications to the Constitutional Court, the reasoning behind the cancellation and postponement of the orders, was that they were illegal and against the Greek Constitution. In addition to these points, they made clear that these orders could damage the health of their patients.

Under this pressure, the Suspensions Committee of the Constitutional Court ruled in their favour and allowed them to go back to their posts temporarily. The final decision was to be made by the plenum of the Constitutional Court on October 2002. This meant that the Law could not be implemented in its entirety as long as one of its most important parts was postponed. For this reason, the Ministry of Health appealed to the Court for an earlier decision. However, the final decision was made in March 2002, where the court ruled in favour of the constitutional correctness of Papadopoulos' law (Karamanoli 2001; Mpouloutza 2001c; HMERISIA 2002).

After the Court had ruled against the ten academics, all academics stopped university teaching, and later on, even when they went back to their teaching, they threatened that they would not pursue any clinical work inside the NHS and that they would only attend to their private practices and teaching (Mpouloutza 2001a; Karkayannis 2001c; Mpouloutza 2001e). The medical school of Thessalonica even

refused to submit a list with the names of the university doctors and where they practised to the Regional Health System. In Athens, it was estimated that around 300 university doctors continued to practise both in the NHS and in private clinics, even after the passage of 2889/2001. In some NHS hospitals that hosted university clinics, and especially in pure university hospitals, there was a time during their abstinence from clinical work when there were no doctors present to treat patients or patients were only treated when urgent. In addition to this, a new university hospital, built in 2000 to accommodate most of the university clinics that were scattered all over Attica, was still not fully functional as the majority of university doctors did not want to take their clinics to a hospital run by managers and not by themselves (TA NEA 2001b; Mpouloutza 2001f).

The most recent verification of the important role of the university doctors was in an LSE lecture given by Thanos Veremis, president of an independent committee for the education reform on 14 March 2006. Prof. Veremis explained the difficulties of reforming the education sector and reinforced something that is already widely known, the power of the university doctors, especially the ones in Athens. He argued that their power derives from their status and wealth, and the fact that they have very good connections with the politicians, especially Prime-Ministers. In several cases university doctors were appointed Ministers of Health, namely, in 1994, 2002 and 2004. In addition, they exert their power in manipulating health reforms.

### **10.3.6 IKA Doctors, Primary Health Care and Health Insurance Funds**

Problems with the implementation of 2001/2889 and the opposition of the 'noble' insurance funds towards a single insurance fund, the opposition of IKA administration to relinquishing its clinics and urban surgeries to the NHS, and most of all opposition of IKA doctors (they had already started to strike) to enrolling in the NHS, forced the minister to delay the next steps of the reform process. Indicative of the importance of the IKA doctors' conflict and IKA's subordination to ESY under the unified health insurance of ODIPY is what Minister Papadopoulos once stated: *'One big conflict was between me and the university doctors in my effort to abolish their immoral public and private practice, and the other one was in my effort to subordinate IKA to ESY, in order to*

*create a single health care system instead of two separate ones, plus the basic institution of the family doctor that eventually would lead to an organized primary health care system. But at that time, the conflict was to the death....and I do not mean the system's termination I mean the end of my career as a Minister of Health ...'*

Minister Papadopoulos argued that the summit of the reform of Greek health care would be the establishment of a primary health care system. He claimed that primary health care scarcely existed as most patients went directly to hospitals to be treated. In addition to this, each health insurance fund ran its own health care system, which was not organized, administered or accountable to the Ministry of Health. For example, IKA health formed a separate health system with over 5,500,000 members and around 9,000 salaried doctors, whereas the NHS had 10,400 doctors. One of the main aims of the 'Health for the Citizen' plan was to introduce general practitioners. The plan envisaged the financial and administrative independence of the 200 rural surgeries from the central government (e.g. NHS-MoH), and the foundation of several urban surgeries within big cities. That way primary care could be the cornerstone of the new system that already contained 200 rural surgeries and 240 IKA multisurgeries. In order to support the idea of primary health care, Minister Papadopoulos also continued to support ODIPY as a single insurance fund established from the unification of five health insurance funds (supported by the Junior Minister of Labour and Social Security, Mr Giannitsis). Funds would be collected by ODIPY and would then be directly channelled to the hospitals and to the primary health care units (Karelías 2001).

There was an alteration to the initial plan, as opposition from trade unions and insurance funds had forced Papadopoulos to create ODIPY as a public legal entity and not a private one. He also argued that it would be better for the NHS if the health services delivered by IKA and the other four insurance funds were administered through the RHSs (Petropoulou 2001; TO VIMA 2001).

In fact, ODIPY as a unified health insurance fund, was also cancelled in practice, as the 'noble' insurance funds would not give up their privileges. In fact, 'noble' funds' policy since 1983 (see Alevras incident, Chapter 8-section 8.3.2) has not changed at all. It is not a coincidence that even today the board of administration of IKA is occupied by GSEE (General Confederation of Working People) and SEV (Federation of Greek

Industries) members. And as an academic and health policy expert and consultant added (6A), after the empowerment of GSEE in 1983, no suggestion of a unified health insurance has come into being.

At the same time, President of IKA, Mr. Nektarios, close friend of Prime Minister Simitis, also hoped to be the one to unify the primary health care services of the health insurance funds under the management of IKA. He suggested that each insurance fund should purchase and provide health services, but in the end IKA should carry out central planning. The clash of the ambitions of both men (Minister Papadopoulos and IKA President Nektarios) was obvious to the point that Nektarios said that *“the person who is going to solve the problem of primary health care in Greece should be awarded the Nobel prize”*. The clash was also focused on the issue of which Minister was going to be accountable for running ODIPY, an organization that Papadopoulos suggested should be co-supervised by Ministry of Health and Ministry of Labour and Social Protection (Petropoulou 2000; TO VIMA 2001; Petropoulou 2002a).

IKA doctors were another segment of the medical profession that did not agree with the forthcoming law for primary health care and went on strike (June 2001). They wanted the Minister to abolish the plan and start discussing with them a future plan, to be co-written by them and the Ministry. They also wanted IKA to be the core institution providing primary health care, and the IKA doctors to receive permanent tenure with preferential labour relations. They also demanded that the IKA doctors already practising not to be subject to assessment, and that a better salary scheme should soon be introduced. While they preferred permanent tenure for all the doctors working in IKA, they did not want to quit their private practices (ELEUTHEROTUPIA 2001f).

Papadopoulos, under the pressure of the IKA doctors' strike, and the personal mediation of Prime Minister Simitis, invited POSEIPIKA (the Pan-Hellenic Federation of Health Scientists of Social Insurance Institute) to his office and he reassured them that the plan for primary health care would be discussed in Parliament no later than autumn 2001, that he had not taken any final decisions about labour relations, and that he aimed to absorb the majority of the IKA doctors into the new system. According to the daily newspaper ELEUTHEROTUPIA, the Minister wanted to offer permanent tenure to IKA doctors hired between 1985 and 1993, and not after 1994, as the recent Constitutional

Reform did not allow permanent tenure to newly contracted employees (ELEUTHEROTUPIA 2001a; Megas 2001b; ELEUTHEROTUPIA 2001g; ELEUTHEROTUPIA 2001h).

POSEIPIKA decided that it was necessary to inform its members of the government's intentions and then its plenary administration would decide its next steps. IKA doctors decided to continue their strike until August 3<sup>rd</sup>, 2001 (with a participation percentage that exceeded 85%), forcing the government to take stock of the political cost of this action, as approximately 5.5 million people received health care services from IKA. According to a new government plan, the new primary health care system would hire 2,500 doctors, from the total of 5,500 contracted doctors, a figure that did not satisfy POSEIPIKA (H KATHIMERINI 2001).

ELEUTHEROTUPIA speculated that the inability of the government to deal with the issue of IKA doctors derived from the gap in communication and lack of consensus between Ministers Papadopoulos and Giannitsis and their consultants, such as the president of IKA, Mr. Nektarios. Mr. Nektarios argued that he was willing to hire all the contracted IKA doctors, while Minister Papadopoulos wanted to avoid that (Petropoulou 2000; TO VIMA 2001; Petropoulou 2002a).

The administration of IKA decided to take IKA doctors to court in order to prove that their strike was 'illegal and harmful to the public interest'. This action united the medical profession in support of IKA doctors, and the majority of the medical associations condemned IKA's administration. The general secretary of GSEE pronounced that "*if Papadopoulos announced that all the IKA doctors will be hired by the new primary health care system, then the strike will be immediately postponed.*" He also mentioned that when Ministers Papadopoulos and Giannitsis met the Prime Minister to discuss a possible solution to the problem, Papadopoulos was determined to resign if he had to step back from his initial plan (ELEUTHEROTUPIA 2001d).

The court's verdict forced IKA doctors to go back to work after four weeks on strike, and although IKA doctors working in Athens-Piraeus voted 800 to 1 to continue their fight, they decided to postpone their strike and invite Ministers Papadopoulos and Giannitsis and the president of IKA, Nektarios, to a negotiation on the basis of good will - a movement that divided the IKA medical trade unions into two parts, as POSEYPIKA



made clear that the strike should continue and that IKA doctors were being manipulated by the government. The government admitted only SEYPIKA Athens-Piraeus (Health Scientists of Social Insurance Institute in Athens-Piraeus) to the discussions on 20<sup>th</sup> July and agreed to the following. First of all, the forthcoming Law for primary health care would be planned with the equal and energetic participation of IKA doctors, thus the majority of IKA doctors would work for the Greek primary health care system, under labour relations that both doctors and the State would decide on September 2001. During August, the government would make the necessary amendments in order to satisfy disputes about IKA doctors' pay scales and the final and improved wages would be determined by the administration of IKA and medical trade unions. According to Mr. Stathias, member of SEYPIKA and POSEYPIKA, *"IKA doctors are willing to work in the public interest, but unless the government fulfils its commitments they are ready to start a new strike in September 2001"* (Stathias 2001; Mpouloutza 2001b).

On November 2001, IKA doctors went on strike again as they argued that the government had manipulated them and had not met their expectations. The Minister of Labour, Mr. Repas, invited IKA doctors for further discussions, acknowledging that the July committee did not have the necessary authority to take steps towards the final solution of the doctors' problems (Terzis 2001). ELEUTHEROTUPIA argued that this resulted from the inability of the government to put forward a plan for primary health care, but also from the opposition of several trade unions to the idea of giving up around 240 health insurance fund surgeries and poly-clinics to the MoH. Parallel to this, Minister Papadopoulos, after a three hour-discussion with GSEE, and after the admonition of the President of GSEE, Mr. Poluzogopoulos, promised not to include the 240 private surgeries and poly-clinics of health insurance funds in the NHS, unless trade unions agreed (Megas 2001a; ELEUTHEROTUPIA 2001).

However, at the same time newspapers argued that according to people close to the Prime Minister, Simitis was not satisfied with the inflexible way Papadopoulos had handled the reform and the extent of progress. Papadopoulos argued that this was not true and that *"The Prime Minister was probably the only one that still supported the reform"*. He attributed these rumours to *"the mafia that rules the Greek health care arena and would like another reform to be shelved."* According to the Minister, *"some vested*

*interests cannot stand the fact that health care funds, that in 2001 approximated 12 billion Euros, will be distributed in a rational and meritocratic way*". Finally, the Minister once again expressed his commitment *"to establish a primary health care system, which is the cornerstone of a health reform"*, and announced that *"if my plans are not implemented I will resign"* (Stassinou and Galanopoulos 2001).

IKA doctors stopped the strike on the assurance of Minister Reppas that he would work to resolve their issues. This did not last, as IKA doctors started five day strikes on February 19<sup>th</sup>, 2002 dissatisfied with the government's persistence in not offering permanent tenure to contracted doctors. Prime Minister Simitis advised his minister to quickly tackle the issue of IKA, as over 5.5 million people were affected by the strike. On 18<sup>th</sup> February the administration of IKA went to court against the strike, saying that it was against the public good. However, Minister Reppas offered a new package of measures that included a pay rise of 180 Euros monthly and immediate hiring of 1000 IKA doctors in full time and exclusive posts. That way, Reppas argued, NHS reform could be preserved, and doctors were offered all the necessary guarantees that they had had when they were working for IKA within the new primary health care plan. The government would not accept to having doctors that were public servants practising privately (ELEUTHEROTUPIA 2002a; TA NEA 2002a). According to the daily newspaper TA NEA, in 2001, IKA employed 350 doctors on a full-time and exclusive basis, 3,000 doctors with permanent tenure, but also with the benefit of having private practices (they also demanded the same benefits to be given to public servants that worked full-time and exclusively), and 5,500 contracted doctors (Megias 2002).

Representatives were not satisfied with the Reppas suggestions and the president of POSEIPIKA announced, *"even if the court rules against our strike we will continue our fight under the protection of ADEDY"*. ADEDY was the superior trade union of civil servants and could offer legal coverage to the strike of the 3,350 IKA doctors who were public servants. However, the 5,500 IKA doctors who were not civil servants would have to return to their jobs if the court ruled against the strike. Under pressure from the public, the Prime Minister and the court verdict against the strike, Reppas agreed to secure the posts of all the 5,500 contracted doctors and to offer 1,500 of them permanent tenure. IKA doctors announced that they were satisfied by the Minister's suggestions and

postponed their strike. According to ELEUTHROTUPIA, the solution to the problem was achieved because Minister Papadopoulos was not involved, a precondition that IKA doctors had demanded. Doctors knew that Papadopoulos did not intend to include all of the IKA doctors in the new primary health care system, and that in certain cases he had declared that he should not interfere with the resolution of the IKA doctors' issues as he was the least relevant Minister (Petropoulou 2002b; TA NEA 2002b).

#### **10.3.7 Law 2889/2001**

The Greek Parliament passed law 2001/2889 despite the opposition from various stakeholders in the health care system. As a result, various delays and obstacles occurred in the implementation of parts of the 'Health for the Citizen' plan that Minister Papadopoulos had originally introduced in the summer of 2000. Seventeen RHSs were established and presidents appointed. However, managers were not appointed, and problems appeared in the financing of the reform and the improvement of the infrastructure. The dispute between the Ministry and university doctors had reached the point that neither side would accept any compromise; a situation that damaged the image of the Minister and the government in general. The pressure expended by the university doctors moved from Minister Papadopoulos to Prime Minister Simitis, who had been a respected academic economist. He was reluctant to see his minister clash with university doctors. In addition to this, Simitis did not support his own Minister of Health over the idea of unifying the insurance funds under ODIPY and the introduction of a family medicine system, which were the next two important Laws that the minister wanted to put forward. Papadopoulos wanted to pass the two Laws through the Parliamentary process by April 2001 (H KATHIMERINI 2002a).

With the continuation of the dispute with the university doctors, Minister Papadopoulos was replaced by Professor Stefanis, a well respected retired mental health professor. New legislation was introduced under pressure from the civil servants' union to enable its president to become a member of the committee which oversaw the Regional Health System directors and hospital managers, a movement that signalled the granting of more powers to the civil servants' union and the reduction of State influence and control over the new system.

#### **10.4 Conclusions from the Narrative History of the 3 Health Care Reforms**

The ESY was started on the basis of a common belief that an organized public health care system should be established, but with a lack of consensus on its goals and means, and limited support for the idea that all Greek citizens should have equal and free access to health care. The role of the medical profession, in terms of planning and implementing the 1397/1983 reform, was crucial and it seems that although in theory various groups of physicians had different interests (hospital doctors, university doctors and IKA doctors), in reality they all took advantage of the Law to maintain or in some cases expand their privileges and used institutions either to protect themselves or even exclude themselves from regulations that might harm their interests, against the interests of the rest of the Greek society.

According to the narratives in Chapters 8, 9 and 10, since the establishment of the NHS in 1983 up until the 2001 reform, four pieces of reforming legislation, three plans for reform and thirteen Ministers of Health had tried to improve access to, and the quality of, the health services provided to the Greek people. In addition to this, around ten task forces had been established involving scientific researchers and health care experts to promote effective reform. However, the OECD published a survey in 2002 that showed that nine out of ten citizens in Greece were very disappointed with the services that the Greek NHS offered. All the ministers had tried in different ways to reach the high health care standards of other developed countries, but none had succeeded. The most recent Papadopoulos reforms were no different in that, almost six years after the *'Health for the Citizen'* plan had been announced, several parts of it had not yet been implemented.

Yet, this recent and most important reform after the establishment of the Greek National Health System had three main characteristics that distinguished it from the other two sub-case studies. The first one was the political will of the minister. In the beginning he was supported by Prime Minister Simitis, but later on old party politics, clientelistic patterns and mistrust from the members of PASOK and the employees of the Ministry of Health transformed the attitude of Simitis towards Minister Papadopoulos, making the reform vulnerable to the vested interests of university doctors, hospital doctors, IKA doctors, health insurance funds, etc.

This situation describes the second characteristic in which various interest groups, once they identify themselves as the losers of a forthcoming reform, try to alter the legislation according to their interests, not caring about what is best for the public (Olson, 1971). But in 2000/01, the opposition from the interest groups was more intense (university doctors were involved in a series of court fights trying to prove that the Law was not constitutional), and several 'new' stakeholders were added to the list of protesters against Papadopoulos' plans (IKA Doctors, Ministry of Health employees and Socialist Politicians).

University doctors were asked to quit parallel private and public practice, IKA doctors were asked to be part of a unified and homogenous primary health care system, health insurance funds were asked to merge under the unified insurance fund of ODIPY, new NHS hospital doctors were asked not to give up permanent tenure, and 'old' hospital doctors were required to stop receiving informal payments or have 'underground' relations with private diagnostic centres and private clinics. As a result, all these interest groups had motives to stop the reform or render it a 'dead letter' in the future, and it seems that at least they delayed implementation. This was despite the third characteristic of the reform: in order to avoid delays or various interest groups exploiting institutions to make the Law a 'dead letter', for the first time, the Ministry of Health did not produce any presidential decree. In earlier reforms, such as 1983, Presidential decrees had demonstrated the inability of the State to overcome pressures from interest groups, such as university doctors, hospital doctors, and health insurance funds. In 1983, the Ministry of Health had decided to reform university doctors' working conditions with the prospect that this was an issue for the Ministry of Education to tackle by a presidential decree. The same presidential decree was not issued again in the case of Surlas' reform in 1992. Furthermore, although the initial plan for the 1983 reform included the establishment of a unified health insurance fund, in the end the Act allowed voluntary merging of the existing numerous health insurance funds in 1988-1989 under relevant presidential decree. On the other hand, Minister Surlas did not initiate any discussion about the establishment of a unified insurance fund in 1992.

RHSs were included in the first law that Papadopoulos submitted to Parliament. Parts of Law 2889/2001 and the notion of decentralization were also included in the 1983

and 1992 reforms. The decentralization of the system has begun; presidents of the regional authorities and managers of hospitals were appointed, though in the face of opposition from several PASOK representatives of the old clientelistic party politics and of MoH employees who feel that they had lost power. However, without the unification of health insurance funds and the establishment of primary health care, decentralization of the NHS could not achieve its aims and objectives

As far as primary health care is concerned, Doxiadis was the first minister to want to introduce GPs, but his plan was barely discussed in the Greek Parliament. Later on, organized primary medical services were included in the 1983 reforms and in the 1992 reforms carried out by Sourlas, but were never implemented. Chapters 8, 9 and 10 (especially the 2001 reform in Chapter 10) demonstrated that the lack of organized primary health care system is one of the most important and troublesome aspects of the Greek health care system, as it is the result of a combination of opposing interests that cater to the maintenance of the status quo of *'tactful disorganization'* (Minister Papadopoulos) that dominates the Greek health care sector. Health insurance funds want to protect their interests and their insurees' interests. 'Noble' insurance funds like those of the bank, telecommunication and civil service employees want to protect their established privileges. IKA and its administration (9,000 IKA doctors and over 5.5 million insurees establishing almost a second National Health System) want to protect the interests of working people, and the majority of IKA presidents after 1974 did not want to lose their power and status by allowing a possible merger under ESY. And last, the majority of hospital doctors and university doctors do not care about primary health care or else do not want to see a successful organization of primary health care, as they fear they will lose part of their formal (university doctors) or informal (hospital doctors) earnings.

Things are no better in terms of the unification of sickness funds. The establishment of a single fund was included in the 1983 reforms, and was also mentioned in 2001, but even now no progress has been made towards the unification of the funds. Papadopoulos argued that it was necessary for the NHS to have a single insurance fund and for this reason he intended to establish ODIPY. Opposition from political parties,

trade unions and health insurance funds deterred him from introducing the necessary legislation.

The narratives have shown that a variety of interests have contributed to the preservation of the 'tactful disorganization' of the Greek health care system, but what is also very apparent is the importance of the role of the medical profession in how the doctor-centred system has evolved in the past 20 years, as many changes relevant to their labour relations have been legislated, but only a few have been implemented. According to the 1983 law, university doctors were not allowed to practise privately, NHS doctors were expected to practise full-time and exclusively, and they were not allowed to have private clinics or private diagnostic centres. In 1992, Sourlas obliged university doctors to choose between the NHS and academia, and enabled NHS doctors to work part-time or full-time in the NHS. Working part-time meant that they could also practise privately. In 2001, the dispute between the State and university doctors continued without the strict implementation of the relevant clause in the 2889/2001 Law, with NHS doctors working full-time and exclusively in the NHS only on paper, since an important majority continued to receive informal payments and work privately. In the end, the dispute between the Ministry of Health and the university ended with the Minister's resignation. Another Minister of Health, a prominent representative of the 3,000 university doctors in Greece, took his place and reversed the 'injustice'.

The Greek medical profession offers a big paradox. In most Western Societies, the role, influence, power and autonomy of doctors have been substantially challenged; in Greece they have not, as many medical trade unionists have declared in the interviews. According to the Alfordian theory of Structural Interests (Alford 1975), the dominant interests of a health care system (i.e. doctors), can only be challenged if strong structural interests of bureaucrats and/or consumer groups are formed. In Greece, under the specific pattern of political, historical, economic and societal evolution, the latter two of these structural interests are weak and cannot challenge the interests of the medical profession. Furthermore, the Greek medical profession claims that it still has unique esoteric knowledge, expertise, and autonomy (Freidson 1993; Coburn and Willis 2003) which rank it amongst the most important, influential and powerful professions within Greek society, especially towards Greek patients. Of course, this kind of power relationship

between doctors and patients is not unique, but what makes it unique in the case of Greece is the fact that this kind of archetypical physician-patient relationship stereotype has not yet been challenged, and is combined with institutional exploitation of the public by the medical profession. This has resulted in a system that is planned, created and implemented in the interest of a very influential guild which then has vested interests in maintaining the status quo (Immergut 1992; Hall and Taylor 1996; Immergut 1998).

That is why Dr. Doxiadis, Minister of Health from 1977-1981 and a respected figure for his efforts to reform the system at a very early stage, described the medical profession, as “ *the only living creature that autonomously creates its own food*” (Doxiadis 1989). Doxiadis argued that without control over the work of doctors, there is no hope for the Greek Health care system, especially when this is combined with a weak medical culture, an over-developed sense of self-esteem and arrogance among doctors (as a result of the overproduction of doctors), and the peculiarities of the Greek society. The deep-rooted feelings of superiority and the untouchability of their guilds which some of the hospital doctors’ trade unionists admitted, can also be found in a recent report about the internal procedures and norms followed by the medical profession in the case of complaints from patients of medical malpractice or absenteeism. The report was issued by the Greek Ombudsman (Independent Authority) in November 2004 and it accused hospital doctors and medical societies of “*a lack of objective, unbiased, factual and, most of all, reliable investigations*”. In most of the cases, the Independent Authority noticed that accusations against doctors were waived, and no further disciplinary action was taken, not even by their medical societies. It ended by stressing that practices like these shake the foundations of the public health care system and in particular increase the mistrust of the citizens in the system. This enhances the view of the people that doctors have a network of esoteric guild protection (Paparrigopoulou and Fitrikis 2004).

Overall, policy change seems to be very hard to achieve in Greece. Sotiropoulos recently commented on this and concluded that “*no one can say that due to the growing integration of Greece into the EU, reform has prevailed over the institutional legacies in the way social policy is formulated in all policy areas*” (Sotiropoulos 2004a). Health policy is constrained by the main actors of the system that do not want lose what they have already gained (Olson 1971). In order to bring about major change, there needs to be



a high level of consensus or at least the ability to compromise among the groups/interests whose support is necessary to implement reform and who potentially stand to lose. Unfortunately, no consensus was ever achieved in 1983 and there has been none since in favour of significant health sector reform. In addition to this, external pressures for institutional change, such as EU directives, have tended to be represented by opponents as policies of cost containment which are generally unpopular. Since 1974, Greek Welfare State reform has been influenced by the complex interplay between internal politics and EU influences. The EU's impact has been felt in specific areas of public policy such as employment, vocational training and regional development. In other important policy fields, such as education, health and old age pensions, institutional settings have enabled the main players to act in their own self-interest and resist the impact of EU directives (Sotiropoulos 2004a). This 'path-dependence' (Mahoney 2000) is highlighted below in Table 10.2 ,which summarizes the extent of change in the years 1983-2001 against the objectives of successive reforms.

<b>Table 10.2- Extent of planned versus actual change produced by Greek Health Care Reforms, 1983-2001</b>		
	<b>Law/Plan Provisions</b>	<b>What happened?</b>
<b>1980's</b>	<b>1397/1983: Avgerinos Plan</b>	
	<ul style="list-style-type: none"> <li>-Universal Coverage</li> <li>-Equity in delivering and financing health services</li> <li>-Organization of Primary Health Care</li> <li>-Unified Health Insurance Fund</li> <li>-Hospital Doctors full-time and exclusive practice</li> <li>-University Doctor choosing private practice or NHS exclusively</li> <li>-banning of the opening new private clinics</li> <li>-Decentralization of the System under Regional Health Systems</li> </ul>	<ul style="list-style-type: none"> <li>-95% population, only in theory (Sissouras, Karokis et al. 1999)</li> <li>-regressive financing and unequal distribution of the quality and quantity of health services</li> <li>-180 rural health centres, no urban health centres, focus on outpatient hospital health services</li> <li>-Never implemented, distinction between 'noble' and 'other' health insurance funds</li> <li>-Only on paper</li> <li>-article excluded, Ministry of Education responsible for regulating academics' terms of service</li> <li>-ban implemented, and as a result lots of small clinics closed down, but a few powerful survived and expanded</li> <li>-not implemented</li> </ul>
<b>1990's</b>	<b>2071/1992: Surlas Plan</b>	
	<ul style="list-style-type: none"> <li>-State acts as a guarantor of the citizen's right to seek care, in accordance with his/her freedom of choice</li> <li>-hospital doctors in the NHS may practise full-time or part-time</li> <li>-university doctors had 1 year to decide whether to practise privately or in the NHS exclusively</li> <li>-restrictions regarding private clinics, etc. withdrawn</li> </ul>	<ul style="list-style-type: none"> <li>-only in theory</li> <li>-only 492/8,300 took the opportunity</li> <li>-not implemented</li> <li>-numerous private diagnostic centres established, in 1996 they were 403 in total, and 67% in Athens (Fyntanidou 2000a)</li> </ul>
	<b>2519/1997: Gitonas Plan</b>	
	<ul style="list-style-type: none"> <li>-managers in NHS hospitals</li> <li>-non permanent posts for new NHS staff</li> <li>-better career prospects within NHS, better salaries for hospital doctors, abolition of 'nominal overtime' for NHS doctors</li> <li>-urban health centres</li> <li>-family doctor service</li> <li>-global budgeting and Greek version of hospital payment by outputs</li> </ul>	<ul style="list-style-type: none"> <li>-not implemented</li> <li>-not implemented</li> <li>-better prospects for junior doctors to become seniors, increase in their basic salary, 'nominal overtime' was not abolished</li> <li>-not implemented</li> <li>-not implemented</li> <li>-not implemented</li> </ul>
<b>2000's</b>	<b>Papadopoulos' 'Health for the Citizen Plan' and Law 2889/2001</b>	
	<ul style="list-style-type: none"> <li>-decentralization of the System by establishing 17 RHS</li> <li>-introduction of hospital managers</li> <li>-afternoon private practices</li> <li>-university doctors have to choose between private practice and exclusive NHS practice</li> <li>-the institution of 'clinical professor'</li> <li>-appraisal of hospital doctors every 5 years</li> <li>-organisation of PHC<sup>43</sup></li> <li>-establishment of a Unified Health Insurance Fund</li> </ul>	<ul style="list-style-type: none"> <li>-implemented with lots of managerial and administrative inconsistencies</li> <li>-implemented, but with 'restricted' responsibilities, NHS hospitals remain medically dominated</li> <li>-initially implemented, but not very popular or successful</li> <li>-never implemented in reality</li> <li>-not implemented</li> <li>-not really implemented</li> <li>-not implemented</li> <li>-not implemented</li> </ul>

Policy makers and especially Ministers of Health are incapable of resisting existing powerful interests that do not let them pursue their plans for change. In fact, Minister Avgerinos stated that he was more than happy to leave the ministry and its difficulties and the stress that he faced during his ministerial period.

There was, however, a strong argument made by most of the interviewees that the actual Minister of Health is the Minister of Finance. They assert that he/she in fact determines the budget of the MoH and every minister of health has to consult him before he proceeds with a reform plan. However, this does not explain the medical profession's and sickness funds's resistance. As most of the trade unionists said that the Greek health care system is underfunded, they also argued that hospital doctors are responsible for implementing health policy in Greece, meaning that they are the dominant and only powerful stakeholders within the public hospitals who cannot and should not be controlled by managerial personnel. The independent overseas experts' committee commented that even if health care expenditure in Greece were drastically raised, the health care system would not improve unless there was a simultaneous organizational change (Abel-Smith, Calltorp et al. 1994).

In conclusion, the way the State and the various interest groups handle reforms in health care reveals the peculiarity and uniqueness of the Greek health care system. Former Minister of Health Paraskevas Avgerinos (1983/1397) has shown the Greek system's peculiarity and 'uniqueness' with a historical review of the Ministers of Health between 1920 and 2000. In that period, 118 Ministers passed through the MoH and among them, 19 stayed for only a few days (under 20 days), 26 stayed close to three months, 25 lasted under six months and 20 lasted under one year. As a result, of the total 118 Ministers, 90 did not even have the time to familiarize themselves with their duties or the organizational chart of the Ministry. In these circumstances, it is not surprising that they could not organize and most importantly implement 'successful' reforms. Only one Minister managed to stay for a whole term of four years. This dynamic process shows what an unattractive post Minister of Health is and reveals the importance of interest groups in health care policy. "*When the status quo in the Greek health care arena is threatened, they (the threatened interests) fight back with passion to preserve it*" said Dimitrios Thanos, Deputy Minister of Health in the 2001 reform during a Parliamentary

speech (Greek Parliament Minutes 2001). As a result, no matter how well handled the Parliamentary process is, it is very difficult to get laws implemented.

The Greek medical profession is certainly not the only stakeholder in the GNHS, but according to all of the in-depth semi-structured interviews with key informants, it is one of the most important influences on the system.

But are there specific patterns that the main actors of the Greek Health Care System use in order to exploit the system? Are these patterns related to the specific peculiarities of the establishment of the Greek State and the evolution of the Greek Welfare State and the history of health insurance in Greece? And finally what are the specific patterns of influence that the medical profession has pursued, and how have these been exercised throughout the period that this thesis examines (1983-2001)?

These are core questions for this thesis, but are very difficult to answer. However, information from the construction of the three narratives and practical examples of specific patterns of influence exercised by the major interests groups in the Greek Health System will shed some light on these questions in the next chapter which tries to explain the pattern of reform observed.

## **Chapter 11: Thematic and Explanatory Analysis**

### **11.1 Introduction**

This chapter provides a thematic analysis of the data, which were used to construct the three case study narratives of the 1983, 1992 and 2001 reforms. Firstly, it describes the main themes that emerged from the data collection. Secondly, it contains a combined analysis of the themes within the context of the three narratives presented in the previous three chapters, with a particular focus on the establishment of the Greek National Health System. Thirdly, based on the themes which emerged from the document and interview analysis, it provides an overall explanation of health care reforms in Greece, looking at the relative importance of each of the health care reforms examined in this thesis. In particular, it focuses on whether the 1983 reform was a 'window of opportunity', and whether 'path dependency' is suitable for explaining the 1992 and 2001 reforms. The international literature has shown that the medical profession is usually the main source of opposition to any health care reform. This chapter focuses on the origins of the power and influence of the medical profession and the patterns of influence and power that medicine practices, and how these were institutionalized within successive health care reforms, and how once they were established through the 1983 reform, they have been maintained or even expanded.

### **11.2 First Theme: Health Reforms in Greece and their Degree of Uniqueness and Importance**

It is difficult to argue that the Greek health care arena is unique in Greek public policy, especially when other studies (from an institutionalist perspective) have shown that broader policy arenas tend to influence sub-systems such as health care (Immergut 1992; Tuohy 1999; Mahoney and Rueschemeyer 2003). Like other spheres of Greek public policy (e.g. education and social security), the Greek health care system represents a field of dynamics where a range of protagonists compete to maintain or extend their interests (e.g. via clientelistic practices, informal practices and access to the 'black' market or informal economy). Health care professionals, health insurance funds, the private health sector, pharmaceutical companies and the State are the main players in the Greek health sector. Each of them has proved to be very important in terms of decision-

making and implementation of various aspects of the three important attempts at health care reform since the 1980s.

Although difficulties in changing the educational or pension system are common, just as in health care, because of the inherited salient characteristics of Greek society when the Greek State was born, the Greek health care sector demonstrates an extreme example of how these characteristics favour the main stakeholders of the system. But this thesis is about more than the opposition demonstrated by the main stakeholders such as the medical profession.

The fundamental reform of the Greek health care system was the establishment of the National Health System in 1983. The 1397/1983 Law was very important for later reforms for several reasons. Firstly, it was the first piece of legislation to introduce an organized health care system, ostensibly following the principles of the British NHS. In reality, though, it was a piece of legislation which mainly satisfied the demands of the medical profession and its most vocal segment, the junior doctors, in order to persuade them to join the system. The NHS was not a formal demand of the Greek citizens, as interviews with key informants and newspapers of that era revealed, because the majority of Greek society did not know what a National Health System was. However, it had been promoted by PM Papandreou as the cornerstone of the 'reform' in the Greek society he envisaged.

The second reason is based on the fact that although the medical profession seemed to be divided into two segments, representing two different ideologies (see Chapter 8 - section 8.3), the outcome of the implementation of the reform provided benefits for the medical profession as a whole, mainly because the medical elite that was dominant in the late 1970s (senior doctors of conservative origin) was joined by the new medical elite (junior doctors who had just entered the system, the majority of whom belonged to progressive political forces, like the Socialists, the Communists or the Greek Left). This did not mean that senior doctors were excluded from the NHS.

The third reason relates to the specific socio-political conditions of the Greek State and society in the early 1980s. A majority socialist government was in power, the profession was fragmented (junior doctors in favour of the NHS and senior doctors against specific articles of the plan), but its representatives supported the plan for the

NHS in principle, and a general notion of change<sup>44</sup> was the slogan that dominated society. These conditions could be seen as potentially forming a 'window of opportunity' for change, but the subsequent implementation process proved that these conditions were not sufficient for the implementation of the reform.

2071/1992 reform was not as important as the 1397/1983 reform, but it adds important information on the development of the Greek NHS in early 1990s. After almost 11 years that Conservatives were back in power. They had opposed the NHS since its establishment, and thus they had their chance to change the system according to their neo-liberal ideology using the Maastricht Treaty (1991) as a pretext in order to implement their strict cost-containment policies not only in health care, but also in other parts of the public sector (education, social security and economy). However, the Conservatives had to face other important issues, including in foreign policy and their weak Parliamentary majority. In addition to this, the majority of Greek society opposed most of the government's efforts to reform the public sector. In the end, the Conservatives realized that they could not proceed with fundamental changes in the NHS, as hospital doctors working for the NHS had created a strong interest group 'independent' of any party politics. Doctors in the NHS had a variety of ideological perspectives (Conservatives, Socialists and Left) and would not agree with the government's intention to abolish their permanent tenure. Although the 1992 reform in the end focused on changes in the medical profession's employment status, (part-time hospital doctors were proposed by the government), it was resisted by the majority of doctors (see Chapter 9 - section 9.2).

The turbulent political environment resulted in a short-lived Conservative government. As a result, the proposed changes to the 1983/1397 legislation were not taken into serious consideration and the interests of the medical profession were not harmed. Almost everything that the Conservatives had proposed was reversed in 1994 by the Socialists, except that part of the legislation about the right to establish private clinics and private diagnostic centres.

The 2001 reform represents the second most important reform that Greek health care experienced after 1974 because of its level of ambition. The 2889/2001 reform was part of the major health reform plan that Papadopoulos had envisaged when he first took his position as Minister of Health. The dissatisfaction of Greek citizens with the NHS had

peaked in 1997 (Mossialos 1997), which then added to the political ambition and will of Papadopoulos to reorganize the health care sector, as he had already done elsewhere as minister of finance and of internal affairs. Public dissatisfaction and Papadopoulos' ambition were the two main driving forces of the reform. The reform plan was comprehensive and included changes regarding hospital doctors' labour relations, the decentralization of the system, the introduction of organized primary health care and a unified health insurance fund.

However, the political will of the minister and the general dissatisfaction of the people were not enough for the success of the reform. Parts of the reform plan went through the Greek Parliament, but even the parts that became, such as 2889/2001, faced the opposition of university and hospital doctors.

Overall, the Greek health arena represents an arena of public policy in Greece where institutional arrangements play an important role in terms of how the key stakeholders perceive their interests, in a similar but more intense way than other sectors, such as education. The Greek Constitution does not allow specific interest groups, in this case senior hospital doctors, private doctors, private sector clinics, 'noble' health insurance funds and university doctors, any formal 'veto points' during the Parliamentary procedure of passing a law. But it does provide fertile terrain for the use of formal or informal practices in order to delay implementation of a Law or make it a 'dead letter' at the stage of the implementation.

According to the interviews and the documentary analysis, one of the most crucial periods, determining the fate of the Greek Health System, was when Law 1397/1983 was being implemented in 1985-1986. Within this two-year period, the State proved to be incapable of protecting the institutions that the reform had introduced in 1983 from the medical profession's demands concerning their labour relations.

Although several key informants argued that, at least in the early planning and implementation of the 1397/1983 reform, leaders and members of the medical profession involved in the reform, had supported the principle of the NHS for idealistic reasons that were synonymous with their progressive political identity, this changed later on with the detailed implementation of the plan.



During the implementation period, the medical profession used its position to negotiate doctors' participation in the NHS, and during the 1980s managed to achieve most of the demands of their societies or trade unions during the 1980s. As a result, their wages were doubled, even if this meant that the Greek economy was potentially in jeopardy. They also managed to avoid any oversight of their work from non-medics, maintained or even enhanced their clinical autonomy and avoided any form of accountability, audit or restriction of their clinical work. In other words, they established a new ruling medical elite that would not jeopardize its vested interests by accepting any future reforms that could possibly harm its privileges. Concessions and compromises made during the 1980s towards doctors' demands created a specific trajectory limiting future attempts at reform and made them path-dependent.

### **11.3 Second Theme: Capacity of the State**

The State's capacity to implement the health care reforms is an important issue raised by the three reform periods. No matter how efficient or inefficient the planning of the reforms was, the Greek State had always experienced problems in its capacity to implement them in their entirety.

The State's lack of capacity, and, as a result, lack of ability to audit and ensure the implementation process of the health care reforms can be seen in several ways: first of all, planning of the reforms was not always according to the needs of the Greek health care system – for example funding had not always been secured in advance (2001), or when it had been secured its size jeopardized the Greek economy (1983). Secondly, dual party politicization of the general political system (Conservatives and Socialists) was prominent throughout the 1980s and the 1990s, and influenced the political institutions and their role within Greek society (political parties, government, bureaucratic elite). Concerns about the political cost of reform and the desire to establish a bigger voting clientele had always been the target of the two major political parties that dominated the governance of Greece after the restoration of democracy. This situation made the State vulnerable to the demands of the privileged groups of Greek society such as the medical profession and the 'noble' health insurance funds. The lack of permanent bureaucratic elite, in particular, is very important, as most of the senior civil servants change every time there is a change in government. As a result, there is no continuity in State policies

in relation to crucial aspects of public life such as health, education and social security. In addition to this, senior civil servants do not have the political will to implement or audit reforms, as they might challenge major interests and in turn, might jeopardize their posts. Party politics have also been used as an excuse by doctors and civil servants to avoid formal appraisals of their work by the State. Various medical trade unionists turned down the idea of any external audit of their work on the basis that non-doctors could not appraise doctors, and that party politics was so dominant that any kind of appraisal would be biased along party political lines.

Thirdly, the historical narratives showed that the reforms were altered during the discussion of plans in Parliament or were not implemented according to the specific arrangements that the reform had dictated, because of the interference of interest groups, or because of the inability of the State to safeguard or monitor the implementation process. Of course the manipulation of reform required the cooperation of both the State and key interest groups, such as the medical profession. Typical examples were the 1983 and 2001 reforms. The reform plans included conflicting issues such as changing the employment status of university doctors and the unification of the health insurance funds. The State included these conflicting issues in the legislation, but the enactment of the specific articles was left to be dealt with at a later stage by presidential decree. The institution of presidential decrees is a very common way for the Greek government to avoid direct conflict with interest groups. That way the interest groups of the medical profession or the 'noble' insurance funds were kept satisfied that although the legislation did pass, it did not include the detailed specifications that would harm their privileges. They hoped that by the time the government decided to issue the presidential decree, its priorities might have changed or the specific government might have lost power, or their lobbying against the legislation might have been successful.

The fourth element of the State's incapacity to implement health care reforms was confirmed by all the interviewees: it was and still is the relatively low proportion of funding paid for health care by the State, which resulted and still results, in reform failure. The strongest supporters of this argument were the medical trade unionists. As one typically said "*....the real Minister of Health is not the politician that the Prime Minister appoints for this position, but is actually the one that he appoints as Minister of*

*Finance.....”(25TU). What they meant was that the Minister of Health is powerless without sufficient funding from the Ministry of Finance. This represents the standard argument of the medical trade unionists, followed by their demand for better salaries for hospital doctors, but, interestingly, this comment also came from Ministry of Health officials who were concerned about the insufficient funds that the Ministry of Health received from the Ministry of Finance. This way both sides, medical trade unionists and bureaucrats working for the Ministry of Health, can avoid responsibility for the possible failure of reform. Trade unionists argued that reforms failed because they were insufficiently funded, and MoH officials blame the MoF for not meeting their financial demands rather than accepting blame themselves for poor planning of the reform. Overall, the level of finance has been used by both sides as an excuse for the failure of successive reforms.*

Ideological issues were the fifth factor influencing the State's capacity to implement the reforms. These were specifically present in the 1983 reform. During the 1980s, there were two main streams of opinion expressed through the Parliamentary process: The Conservatives who were against an NHS, and the Socialists who were in favour of an NHS (during the 1980s, the Communists and the Greek Left also supported the idea of an NHS). The Conservatives not only believed in a more liberal health care system, but they also aligned themselves with the senior doctors, who represent a significant electoral force. The senior doctors could not be seen to submit themselves to the restrictions of an NHS. On the contrary, the Socialists appealed to their growing electoral base among the junior doctors, who saw the NHS as a unique opportunity to obtain permanent posts, work their way up the hierarchy, and receive stable and high wages. The only negative reaction to the 1977/83 Law came from the opposition party at that time, ND, and the well established senior doctors of the pre-1983 system. The reasoning behind their disagreement lay in the ideology behind the new system, and in the fact that patients' freedom to choose their physician would be restricted, and doctors' freedom to practise in both the public and private sectors would be ended. As result, many senior hospital doctors of the pre-existing 'non-system' decided that they would be better off having only their private surgeries or practices in private clinics (see Chapter 8).

#### **11.4 Theme Three: Medical Profession: Patterns of Power and Influence**

The Greek medical profession played an important role in the establishment of the Greek NHS and in its later development. Medical trade unionism was almost universally recognised by the key informants as a very influential and determining factor of Greece's health policy in the late 1970s and early 1980s, to the extent that politicians argued that an emerging part of the medical profession (meaning the junior doctors) had established its identity and its rights because of the new NHS. Apart from these, many senior doctors who had clearly resisted the idea of entering the NHS and simultaneously stopping their private practice realised, as time passed, that no serious measures of control or regulations had been enacted to audit or control their practice. As a result, they could continue their private practice, knowing that although they were breaking the Law they would not be penalized. In the end, medical trade unionism had succeeded in keeping the medical profession united on the basis that all of its different segments, such as junior and senior doctors, and Socialist or Conservative doctors, would find a way of profiting inside or outside the NHS. The following section provides specific examples of patterns of influence and power of medical trade unionism. It will be prefaced by a general description of the distinctive nature of trade unionism in Greece.

Trade unions in Greece have a different organisational structure to all other European Trade Unions. According to Sotiropoulos (1996) and Triantafillou (2007) trade unions in Greece are organized in a three-tier system. The lowest tier consists of sectoral, firm-level and general trade unions. The next tier includes sectoral federations from the same trade, and from the same local labour centres<sup>45</sup>, of all the first-level trade unions of a specific region (EINAP is the federal trade union for the public hospital doctors of Athens and Piraeus). The third and last tier is also the most senior and powerful one, and it includes confederations of the second tier unions and 'labour centres'. The most important ones are GSEE and ADEDY. OENGE is the confederation of all second level trade unions of public hospital doctors, such as EINAP. However, because all public hospital doctors are both civil service doctors, and public hospital doctors of Athens-Piraeus, they are simultaneously members of three different trade unions, EINAP (regional), OENGE (confederation of public hospital doctors), and ADEDY (confederation of all civil servants).

The structure of trade unions in Greece is characterized by favouritism in terms of pension schemes and health insurance benefits, shown in the way the trade unions are represented, and the way they negotiate policies. As Mavrogordatos puts it, although GSEE is supposed to represent the interests of private sector workers, in reality it represents the interests of public sector employees (civil servants and public utility employees). In addition to this, ADEDY only represents the interests of civil servants, which leaves the private sector employees repressed and generally not well represented (Mavrogordatos 1998).

The proportion of workers who belong to a union as a percentage of the total workforce is a little lower than the European average (EU-15 is approximately 38%). However, the trade union density of civil servants (including public hospital doctors) is high, reaching as much as 80-98% (European Foundation For The Improvement Of Living And Working Conditions 2003).

Triantafillou (2007:109) argues that trade unions in Greece are considered to be weak because of State patronage, and the absence of a strong Left representation. Yet she strongly supports the idea that “...*the numerical weakness of the Greek unions does not mean that unions lack mobilizing capacity. Indeed, unions have organized massive strikes in recent years contradicting the ‘weak’ unions argument*”.

The way Greek trade unionism has evolved shows that Greece belongs to a specific variation of State corporatism called ‘disjointed corporatism’ (Lavdas 1997). According to Triantafillou (2007:109), this type of corporatism means that the State has corporatist, differentiated and uneven relations with selected powerful social groups, leading to an uneven and unfair distribution of rights, opportunities and privileges to middle or upper class social groups and rarely to working class employees.

#### **11.4.1. Medical Trade Unionism and its role in Greek Health Care Reform (1983-2001)**

As argued by a respected senior academic in health policy and key informant, (6A), the ‘non-organized’ system that existed before 1983 was neither friendly to the user nor to the employee. (Objection to this view was expressed by Conservative key informants, who are in now power. However their opinion is contradicted by the fact that in 1980, Doxiadis produced a similar health reform plan that was opposed by his fellow

Conservative party members). Labour relations were taken into consideration in an *ad hoc* fashion, different doctors enjoyed different salaries and patients quite often faced difficulties in accessing health care services. Yet, at that time the health care arena was dominated by a part of the medical profession - the so called senior and university doctors – that had privileges and exploited junior doctors. Things were about to change, though, since the rise in popularity of PASOK during the late 1970s coincided with the growth of the institutionalized representation of the medical profession in Greek society and politics. Medical trade unionism from the late 1970s to the late 1980s was synonymous with EINAP. Founded in 1974, it started as a very powerful trade union that represented the interests of junior doctors whose interests had been previously suppressed by senior doctors. EINAP at that time was governed by a progressive coalition of PASOK, the Communists and the Greek Left. Numerous representatives of this powerful medical trade union had a dual identity as hospital doctors and prominent members of the Socialist Party. Several of these representatives had already produced a first draft of the Greek NHS prompted by Papandreou, which was also part of PASOK's manifesto for future reforms in Greek society under the general motto of 'change' (Allagi). The final draft of the Bill for the establishment of the NHS which reached the Greek Parliament in 1983 was very similar to the one that Socialist EINAP representatives had proposed in the late 1970s. This meant that EINAP took the opportunity to address its members' needs by taking advantage of the policy gap (the government had not produced its own reform plan) and by becoming the key influence on the implementation of the NHS reform in 1983.

Although EINAP appeared to be the main supporter of the Avgerinos plan in 1983 and of the idea of the establishment of some kind of system in general, this was not the case two years later when the implementation process had started. EINAP was concerned about the details of the implementation process that focused on doctors' labour relations. Its members participated in long term industrial action provoked by the unholy coalition of the Conservatives and the Communists, a coalition that, although opposed by PASOK, the vast majority of hospital doctors seemed to support by participating in the strikes. In 1985-1986, under the threat that the establishment of the Greek NHS, (i.e. the cornerstone of the Socialist pre-electoral promises about 'change' in Greek society) would become a

fiasco and prompted by the Socialist representatives of EINAP, Minister Gennimatas decided to pass additional legislation (Law 1579/1985) that satisfied most of the concerns of hospital doctors about their salaries (including overtime), their obligation to work in the countryside (a dispute that obliged Minister Avgerinos to disagree with EINAP and resign in 1984), and the number of hospital doctors. The original number of hospital doctors for the NHS had been only 3200, but with Gennimatas' revised plans it exceeded 7200. In addition to this, Minister Gennimatas sent to each hospital doctor a personal letter, starting with the greeting 'Doctor My Friend....', praising the importance of the hospital doctors as an institution, and the fact that hospital doctors should and would be paid very well in the NHS (including a nominal overtime payment). The negotiation between EINAP and Gennimatas ended in Gennimatas making many concessions to the medical profession and later on acknowledging that many of the junior doctors had become part of the newly formed system, with established interests, which were not different from the ones that senior doctors had exercised in pre-NHS years. Junior doctors and EINAP in the end wanted to protect their own interests, neglecting the initial argument about the overall improvement of the system and of the health care of the population. (H KATHIMERINI 1984a; H KATHIMERINI 1984b; H KATHIMERINI 1984d).

Although many scholars have commented on how Greek society and the public sector has been seriously affected by the party politics and party clientelism (Mouzelis 1978; Mavrogordatos 1993; Sotiropoulos 1996; Mavrogordatos 1997; Mouzelis 2005), there are indications that this was not always the case even for the medical profession. In 1983, the medical profession as a whole (EINAP, PIS<sup>46</sup>, ISA<sup>47</sup>) supported the idea of establishing a health care system. Furthermore, most of the political parties linked to the medical societies and trade unions were in favour of the NHS<sup>48</sup>, since it was planned by a committee most of whose members came from ex-EINAP doctors and Socialists. Disagreement within the medical profession with the NHS lay in specific aspects of the Law, which became more apparent as the debate developed and as the implementation stage was about to start, and did not concern the idea of establishing an organized health care system. It is true that EINAP became more demanding as soon as it was governed by the coalition of the Conservatives and the Communists, but their demands were

applauded by the majority of the members of the trade union and there was a high level of participation in the industrial actions.

EINAP – a trade union which has been influenced by party politics during the last two decades, like most trade unionism in Greece – has, at crucial moments, managed to mobilize its members to undertake industrial action across party lines (1983, 1985-6, 1994, and 2001 reform) when important aspects of its status, power and influence within the system were under threat. Hospital doctors are particularly concerned with every attempt of the State to restrict their clinical autonomy or abolish their permanent positions. That is when hospital doctors become strongly loyal to their trade unions, and with the help of the ‘supreme’ civil service trade union (ADEDY), are willing to fight collectively for their interests (e.g. the 2001 reform). The opposition of EINAP was even more apparent in 1994 when suggestions for improvement of the Greek health care system came from the foreign expert committee. EINAP directly challenged the committee’s findings and warned the government not to proceed to any reform based on the committee’s suggestions. What is interesting in 1994 is that the president of EINAP was Socialist and the Socialists were also in power, which demonstrates that at critical moments (when their interests are being threatened) the medical profession acts as a strong and decisive guild putting aside party politics.

Papadopoulos’ reform was another plan which challenged all the vested interest groups in the Greek Health Care System. However, powerful MPs (even from the opposition, such as the ex-Prime Minister, Mitsotakis) thought that it was a good start for tackling the disorganised health care system. On this occasion, EINAP and OENGE were not responsible for the reform plan collapsing. However, they were certainly against it and when Papadopoulos tried to abolish their members’ permanent status as civil servants within the ESY and make them accountable to the 17 Regional Health Systems in order to allocate human resources more efficiently, ADEDY stepped in and backed EINAP and OENGE in their effort to resist the change. ADEDY has interfered periodically in favour of the interests of public doctors, as ADEDY representatives knew that if doctors became subject to regional authorities this would set a precedent for other civil servants and weaken ADEDY.



As far as the rest of the major medical stakeholders - ISA and PIS - are concerned, they have not been under the influence of 'progressive' political parties since the early 1980s<sup>49</sup> (Kamara 1984; H KATHIMERINI 1985). As a result, they supported the idea of a National Health Service. However, according to various articles in newspapers and interviews with key informants (e.g. EINAP trade unionists), various local medical societies had expressed their strong opposition to the details of Law, and there was speculation about manipulation of the results of ISA's General Assembly, to support the NHS. Their later opposition to the NHS derived from the fact that the majority of their<sup>50</sup> members had dedicated themselves to private medicine<sup>51</sup> (there are about 54,000 doctors in Greece today and only 10,900 of them are NHS hospital doctors (This figure does not include 2,200 university doctors)) and that since 1983 they have never been affiliated to the Socialist Party. On the contrary, the Conservatives have dominated PIS and ISA and have expressed through their representatives their belief in changing the NHS, arguing that doctors should be able to practise medicine freely in the private or in public sector, and that patients should be able to choose their doctor, an ideology dictated by their belief in the free market and the premises of the liberal professions. Part of ISA's and PIS's agenda was addressed by 2071/1992 (Minister Sourlas' Law). It satisfied the conservative origins of their representatives and the majority of their members who wanted to be free to work part-time as hospital doctors and get access to a new kind of private clientele. However, this did not necessarily mean that hospital doctors (EINAP and OENGE) complied with the demands of the medical societies. On the contrary, EINAP and OENGE declared their opposition to the Law and emphasized the part of the Law that categorized doctors according to their employment status (part-time or full-time), aiming to weaken the medical profession by fragmenting it and provoking conflicting interests.

#### **11.4.2 Patterns of Medical Power and Influence**

This section describes ways in which hospital doctors exercised their power and influence. The three historical narratives provide several examples of the emergent categories of the power and influence of the medical profession.

##### **11.4.2.1 Hospital Doctors' Salaries and Informal Payments**

Key informants mentioned a variety of reasons for doctors' power and influence over the health care system. The emerging issues from the thematic analysis underlined the importance of NHS doctors receiving informal payments and the fact that NHS doctors are generally indifferent to salaries from the State since they tend to compose only part of their total income.

The Greek medical trade unionism is synonymous with EINAP. It suffered from all the typical party-clientelistic features that most of the Greek trade unions experienced, 1983-2001. EINAP was powerful and represented the progressive part of the medical profession during the 1980s, but nowadays the demands articulated by its board mainly focus on the labour relations of doctors in public hospitals without any involvement in the wider development of the NHS. The gains for the hospital doctors that EINAP achieved during the 1980s, with the tolerance of, or cooperation of the State, were remarkable, but after that, the medical profession realized that the State was not willing to offer anything more. That was the critical moment when members of EINAP realized that instead of participating in futile strikes demanding salary increases, it would be more effective to shift the weight of their increasing wage demands to patients. It was easier for them to succeed in this task for several reasons:

1. They had an excuse (at least in their eyes) for their actions, since their salaries (which had doubled when the NHS was established) did not increase subsequently at the same rate as they had at the start of the NHS;
2. they were not asking for additional resources from the State, but they were getting their additional income from patients;
3. their status and power were and still are unchallenged, compared to other Western European countries, which meant that they could use their power and influence to extract informal payments from their patients; and
4. The financial status of the Greek State was not ideal for further increases in their salaries, but, at the same time, the Greek State did not have the necessary capacity to challenge their informal ways of earning additional income.

The medical profession often claims that the health care system in Greece is under-funded, mainly referring to expenditure from public funds. However, the existing funding accounts for 10% of GDP (public 4.3%-private 5.7% in 2005, OECD 2007), but

is not used efficiently through the existing institutions and resource allocation patterns. The major stakeholders - doctors, funds, and pharmaceutical companies - play an important role in the allocation of resources. The pharmaceutical industry in Greece supplies the Greek drug market with over-priced products, compared to the majority of the EU-15, and a large proportion of the medical profession practise under-the-table economic relationships with pharmaceutical companies regarding prescriptions, prosthetics, participation of doctors in international conferences and gifts (Papadopoulos 1999; Papadopoulos 2004).

Most of the doctors interviewed recognised that picture, but argued that only a minority of the medical profession received informal payments and reasoned that these practices were due to the poor payment of these doctors. This was an issue that dominated the semi-structured interviews. Medical trade unionists argued that spending from the public purse was quite low, and that the State's income policy has not followed the rate of increase that was initially agreed in 1985. This is true, because when the NHS was introduced there was a need for increased salaries in order to attract doctors to a new system. However, what is also true is that although low physician salaries were quite high on the agenda of hospitals after 1985, the main strikes that EINAP organised after 1986 were not very successful. This means that hospital doctors have found other ways to augment their income, especially by targeting citizens directly. That way a significant majority, especially consultants who treat people, and not laboratory doctors, secure an important extra income that it is quite hard to estimate, as there are no official statistics, and the State is happy not to have to pay higher public salaries.

A university doctor (33UD) who refused to join the NHS in 1983 argued that this is how doctors satisfy their need for acknowledgement of their work. He also argued that personal payment seals a pact between the patient and the doctor. The doctors would do everything they could to save the patient and the patient in return has to express his gratitude by handing over some kind of payment. Of course, the (33UD) professor condemned his/her colleagues who received informal payments while practising in a public hospital as he was one of the few private doctors who provided a receipt for consultations in his private practice and had refused to join the NHS.

The Professor's (33UD) argument provides us with the epitome of how the medical profession perceives reimbursement, and at the same time underlines the aspiration of doctors for additional payments on the basis that practising medicine is superior to other jobs or professions. However, NHS hospital doctors do have better pay than many other public sector workers and their accountability is outside the general civil service code. According to Law 3205/2003, the basic salary of an Assistant Professor in the Greek universities (1,245 €/per month) is still lower than the salary of a Senior Registrar (1,381 €/per month-Εμμελητής Α', in Greek) (Ministry of Finance and Economics 2007). Overall, hospital doctors' salaries are at the top of the salary scale of civil servants, and if their overtime payment is taken into account, which in many cases is nominal, then the hospital doctors are very well paid civil servants. However, it is also true that the pay rises that they received in the 1980s when the NHS was being established (increases of almost two times their salaries) were unique and were not reflected in later increases.

Annual private health expenditure equates to what Greece spent in organizing the Olympics of 2004, approximately 7 billion Euros; the 'black' market economy accounts for 1793 million Euros, which accounts for 26%-29% of the total payments of patients and 12%-13.5% of total health care expenditure. Of the total health care expenditure coming from the 'black' economy, only 11% (194, 5 million €) is informal payments to public hospital doctors, and the rest is unreceipted payments made in the private sector (i.e. to private doctors, private diagnostic centres, etc.) (1598, 5 million €). As a result, it seems that the resulting tax evasion is much bigger in the case of the second category (Siskou 2006).

However, if we take into consideration the fact that only 10,900 doctors are NHS hospital doctors, then the amount of cash received by them is comparable to the rest of the 41,500 members of the medical profession receiving 1598 million € (Liviakis 2006). Furthermore, what is particularly interesting is that according to ISA archives and the journalist Elena Fyntanidou (Fyntanidou 2005), there have been no patient complaints against doctors receiving informal payments for the past four years. This suggests that the institution of informal payments to doctors is deeply rooted in the mentality of Greek society and also reflects the individualism that dominates the Greeks. They prefer to hand

informal payments to doctors and that way make the doctor accountable for their personal care rather than paying for private health insurance. In addition to this, taking a case against a doctor is a very delicate issue, because it means that a patient would be willing to make an official accusation, which is unlikely when the patient has received successful treatment or when he/she has to continue visiting the same doctor. The patient is dependent on doctors, and afraid that if he/she makes an accusation he/she will be mistreated. Apart from that, even if someone makes an official complaint to the disciplinary council of the Athens Medical Society, for example, it can take years until the case is resolved and, during this time the accused doctor practises without any kind of restrictions.

It is true that most of the complaints of the doctor trade unionists about low public health expenditure are correct. It was 43% of the total in 2005 (OECD 2007), but at the same time they do not take into account the extent of private health care spending (57% in 2005), which includes informal payments to NHS doctors, and the fact that, compared to other similar employees in the public sector, (e.g. academics) they are mostly better paid.

There was, however, a parallel to the previous emerging theme in the shape medical trade unionists, politicians, ex-Ministers of Health and bureaucrats of the Ministry of Health's argument that the real minister of health is the Minister of Finance, who decides the budget of the Ministry of Health and every minister of health has to consult him/her before he/she goes on with his reform plan. However, most of the trade unionists who said that the Greek health care system was under-funded, also argued that hospital doctors were responsible for implementing health policy in Greece, meaning that they were the dominant and powerful stakeholders within the public hospitals, who could not be controlled, and should not be controlled by managers. Similarly, according to the independent overseas experts' committee, even if health care expenditure in Greece were to be drastically raised, the health care system would still not improve unless there was a simultaneous organizational reform i.e. money is only a subsidiary explanation for poor performance and corrupt practices (Abel-Smith, Calltorp et al. 1994). In conclusion, public health care expenditure in Greece might be low, but a possible increase in public

health care spending does not mean that the system will improve overall, unless there is a change in the organizational behaviour of the dominant group of hospital doctors.

#### **11.4.2.2 Hospital Doctors' Appraisals, Status and Prestige**

One of the main reasons for the failure of 1397/1983 lies in the fact that the State did not introduce the necessary structure to enforce the implementation process. The detailed narratives of the three periods of recent system reforms show how party-to-person clientelism, absence of political consensus on the type and the character of reforms, administrative and financial weaknesses of the State, institutional fragmentation, and a weak collective culture have all contributed to the unchallenged status of the main stakeholders of the Greek health care system, and especially the medical profession.

According to most key informants, the critical moment for the Greek NHS was the start of its implementation by late Minister Gennimatas. Gennimatas, threatened by EINAP had already changed his attitude towards the Law, mainly because PASOK was not so influential in the medical societies and the trade unions of the medical profession. Senior and other experienced doctors were not joining the ESY. Gennimatas invited the entire Greek medical community to embrace the new system and support it. In return, he had to succumb to the aspirations of doctors for huge increases in their salaries, demands not to be moved to the country side, and not to be accountable for the quality of their practice. It is not a coincidence that although all the doctors of the previous system were dismissed, subject to being appraised to enter the new NHS, the majority of those who were rejected were still entitled to reimbursement. The most controversial aspect of the Law from an outsider's point of view, and significantly interesting for what it showed about the power of the medical profession, was that even doctors that were not part of the old health care system were still compensated for their loss of employment in the new system (Law 1397/1983).

Doctors effectively established the new system and they were satisfied with their position within the system. They were, and still are, the main protagonists in the system, and still do not have to prove their competence and no one has the authority to criticize them. In 1991, one major newspaper *To Vima* and the journal *Oikonomikos Tahidromos*, revealed doctors' immunity to any kind of control, not only referring to the lack of

appraisals of their work for promotion, but also the lack of checks on the conduct of their everyday duties and responsibilities (OIKONOMIKOS TAHIDROMOS 1991; Marinos 1991a).

Evidence, from the semi-structured interviews, Parliamentary archives, medical society announcements and journals, points to the key role of the hospital doctors in supporting the foundation of the NHS. The 1983 reform was mainly about doctors' labour relations, designed almost entirely by doctors for doctors, and it implied the shift of governance from the senior doctors to juniors. However, this did not mean that the government was ruling out the participation of the senior doctors in the new system. On the contrary, PASOK feared that senior doctors might not join the NHS, since they could arrange better labour relations in the private sector, and most of all they could continue make large profits. As a result, and in terms of 'réal politique', no institutions were constructed to safeguard the proper functioning of the Greek NHS. Challenging doctors' work or vested interests (through managers, or an external audit body) was out of the question, and concessions were made to the profession.

A typical example of hospital doctors' non-accountability comes from the 1990s. In 1991, the New Democracy government introduced a group of independent civil servant-auditors responsible for checking on civil service good practice. They decided to audit one of the biggest public hospitals in Athens-Pireaus, the Nikaia General Hospital, and investigate if hospital doctors were doing their 'overtime active duty'. Not a single doctor was on duty when the auditors visited. When the independent auditors were about to finish their investigation, the president of the hospital was notified, along with several doctors. A short while later, a group of hospital doctors arrived and forced the auditors out of the hospital.

The Greek medical profession has not experienced any kind of objective and external assessment, because of the long tradition of party clientelism (Doxiadis 1985; Pipili 1985; Petritsi 1985a; Petritsi 1985b; Petritsi 1985c), the nature of collegiality within the medical profession, and the belief of many hospital doctors that hospitals are their territory and no one can interfere with their administration. As expressed by Mavrogordatos, party clientelism flourished when PASOK came to power and was the successor of family and personal clientelism during the 1980s (Mavrogordatos 1997).

Although declining in Greek society, clientelism still troubles several aspects of public life (Kazamias 2005; Pelagidis 2005). Clientelism, in general, has been a distinctive factor of underdevelopment in Greek society, and has been identified in many aspects of public life. Therefore, several key informants (ex-Ministers of Health, 10MoH/P, 14MoH/P and medical trade unionists, 25TU, 26TU, 26TU, 27TU) identified the importance of clientelism in the doctor-patient relationship. As interviewee (10MoH/P) argued *“there are a lot of Greek citizens who voted for me, but at the same time who were not members or supporters of my party, PASOK. This occurred because I was their doctor and they felt obliged because I treated their children”*. In some cases, doctors who wanted to run for MP treated most of their patients for free to obtain their votes.

There was a key informant consensus as to the high status that doctors still enjoy, although there is an oversupply of doctors in Greece. According to Greek National Statistics, there were 53,943 doctors in Greece in 2004. If we take into account that the 2001 census estimated the Greek population at approximately 10,964,020, then there is one physician for every 203 people; their official salaries have lost purchasing power by more than 50% since 1985, according to a report issued by a member of the General Council of OENGE (Confederation of Unions of Greek Hospital Doctors) (Varnavas 2005), which results in an unsatisfactory level of payment for most of the State hospital doctors. Yet, the majority of the Greek population is still attracted to the medical profession (thousands of Greek high school students study medicine in Eastern European countries, if they fail to get places in Greek medical schools), and specifically to NHS posts. This happens because once doctors enter the NHS, they can practise illegally or receive informal payments. This way they do not depend on modest increases in their public salary, which is also heavily taxed. It is becoming more and more common to see articles in newspapers revealing that a big proportion of NHS doctors practice informally within the public hospitals, and even have their own illegal private practices inside the public hospital or, in some extreme cases, set up their own practice outside the hospital. That way, not only can they use the public infrastructure, but they also avoid paying taxes (E21 1995; Vergou 2004; Fyntanidou 2005).

Other emerging themes from the interviews and written resources include the importance of the Greek medical profession as an electoral consistency as they have



strong influence on patients' voting patterns. In addition to this, Greek governments after 1974 were vulnerable to the medical profession's demands, bearing in mind the political cost of possible voters' mobilization if doctors as a profession were in the end unhappy with the outcome of the reforms. Typical examples were the 1983 and 2001 reforms.

The medical profession also has a very important presence in political institutions, whether this takes the form of being elected to the Greek Parliament or being appointed as Ministers of Health. It was also observed that the higher in the medical hierarchy a doctor is, the easier it is to get into politics and reach top positions like Minister of Health. All of the Health Ministers after 1974 who were doctors, were either successful and respected as private doctors (in their own local community) or were university doctors.

The Greek Parliament has been traditionally dominated by doctors and other liberal professions, with lawyers being the predominant group (48 out of 300 MPs in 1992 were doctors). In addition to this, between 1974 and 2001, according to Sotiropoulos and Bourikos' calculation, almost 42% of Ministers' occupational background before their first ministerial appointment was law, followed by 9.4% in management, 8.6% in journalism and 6.5% in medicine and pharmacy. This means that ministerial elites are dominated by the liberal professions and doctors are a considerable proportion of them (Sotiropoulos and Bourikos 2001).

#### **11.4.3 Theme Four: University Doctors**

All the key informants mentioned the importance, power and influence of the university doctors in term of shaping, but, most of all, in implementing any reform. They argued that university doctors had, and still have, an active role in determining the content of any reform plan, especially when the initial intention of the legislator is to alter their vested and mainly economic interests. Since 1974, no Minister of Health has been able to control and restrict their private practice. The first effort to control them was in 1983, and the opposition was stiff. Minister Avgerinos wanted to avoid a further clash with them and made the necessary changes to the proposed plan, so that the Minister of Education would have to solve the issue of their private practice with a presidential decree in the near future.

The status of the medical schools is rather peculiar in Greece. As with all university faculties, the medical school is under the authority of the Ministry of Education. However, there have been many times in the past when Ministers of Health have tried to legislate for university doctors, arguing that since they practise in NHS hospitals, they should be bound by the same legislation as other hospital doctors; however they have always been exempted from these rules. In 1983, they were exempted on the basis that the subsequent presidential decree was to have been issued by the Minister of Education. This law/presidential decree was never issued in any of the reforms studied. In addition to this, university doctors were satisfied with this reluctance to implement plans, and with the fact that they would have greater opportunity to impede the progress of reform at a higher level of politics within the cabinet.

Lobbying against the reform plans also occurred in 1992 (see Chapter 9-section 9.2.2), but more importantly in 2001, when Minister Papadopoulos faced the opposition of university doctors, mainly from Athens and Thessalonica medical schools. Medical schools at Athens and Thessalonica resisted the reforms because the rest of the medical schools in Patras, Larisa, Irakleion, Alexandroupoli and Ioannina were monopoly markets, and therefore university doctors did not compete with each other. In Thessalonica, and particularly in Athens, university doctors had to compete to gain a good reputation in order to build their clientele. As a result, university doctors from Athens and Thessalonica had much more to lose than university doctors from the other Greek medical schools, so they had more reasons to strongly oppose Papadopoulos' reform.

It was the first time that a Minister had passed a Law which abolished one of the most important privileges of university doctors. As a result, all university doctors had to decide whether they wanted to practise in NHS Hospitals only, or practise in their private surgeries. Regional Health Systems' directors had to implement this article and in most of the cases they had to dismiss university doctors from NHS clinics. This had never happened before and clearly united university doctors, and not only doctors, but academics in general, against the Law and against the Minister. In time, it became quite obvious that the dispute had been transformed into a personal issue between the two parties - the minister and the academics. Apparently, this dispute became more obvious

when Prime Minister Simitis, an academic himself, indirectly withdrew his support for Papadopoulos' reform (Fyntanidou 2002). Nearly all key informants identified that Papadopoulos faced problems with his political party (PASOK), fellow cabinet ministers (including the PM), university doctors and hospital doctors, and lacking the support of his Prime Minister, he decided to not only to resign his ministerial post, but also to leave the political scene.

After Minister Papadopoulos' resignation, Professor Stefanis was appointed Minister of Health. Professor Stefanis is a well-known professor in the field of mental health at the medical school of Athens. He had openly disagreed with the specific articles of 2889/2001 which restricted university doctors' freedom to practise in both private and public settings. He had very good connections to the PASOK cabinet, was a close friend of the ex-Prime Minister Simitis, used to treat Prime Minister Papandreou and had friendly ties with the ex-General Secretary of the Socialists, Mr Laliotis (H KATHIMERINI 2002b). Various daily newspapers pointed out that Prime Minister Simitis' selection as the next Minister of Health was indicative of future alterations of the 2889/2001 statute in favour of the university doctors.

One of the first laws (3204/2004) that Stefanis produced was an alteration of the Papadopoulos Law concerning the right of university doctors to practise in ESY hospitals and at the same time have their own private practice. Not only did he allow for a temporary extension of the period of time during which university doctors could continue to practise in their own private clinics, (justifying his view by saying that the hospitals had not yet met the standards that the university had set in terms of space and equipment), but he also abolished the power of Regional Health Systems and, as a result, of the managers of the hospitals, to expel university doctors who did not comply with the law (Karpouzou 2005). He also addressed accusations by the mass media that university doctors had forced Minister Papadopoulos to resign by saying that "*.....we should not disdain university doctors.....we should not take a boat and put them inside and sink it.....*" He continued in one of his initial speeches when he became the Minister of Health "*.....I am honoured to be a university teacher in medicine and this is because, and by this statement I am referring to all the doctors not only the university ones, medicine is*

*the spearhead for the social policy of each nation or State...*" (ELEUTHEROTUPIA 2002b)

This statement reflects the views of the strong elite of university doctors which had succeeded in blocking the 2001 reforms. Out of the clash between the previous Minister and the university doctors, the medical profession as a whole was the winner, as the new Minister announced his belief that doctors in general, and not specifically in Greece, were, and should be, the cornerstone of the social policy of a country. He reconfirmed, first of all, that doctors are the major stakeholders in the health care system, and second that the State should not challenge their dominant interests. The political cost of a different kind of policy was shown to be unbearable and the alternative, introduced by Stefanis enabled the government to compromise, against patients' interests.

#### **11.5 Theme Five: Health Insurance Funds and IKA Doctors**

The major emerging issue of this section is the interrelation between primary health care, health insurance funds, IKA authorities and IKA doctors. IKA is the biggest and most important insurance fund in Greece. Part of its importance lies in the fact that it has approximately 5.5 million insurees, and its own hospitals. As noted by several key informants, it is more or less like another NHS. It is run by a Board of Administration which is chaired by a government-appointed Governor and is accountable to the Ministry of Labour and Social Protection. The Governor is a member of the Board which includes six members representing workers (trade unions, especially GSEE), three representing employers, and two representing pensioners (i.e. beneficiaries). Within the Board there are also 13 IKA employees responsible for the administrative and financial issues of the fund (Triantafillou 2007). The important issue raised by IKA's complex and multiparty Board, is the difficulty in reaching consensus concerning administrative decisions about its long term planning. That is observed every time central government and the Ministry of Health suggest IKA's merging under the ESY administration. Merging under ESY has always been a problematic issue because of the importance of IKA within Greek society. Its health expenditure is around 2 billion euros per year, it covers almost half the population of Greece, and employs 8,500-9,000 doctors, and 4,500 administrative and nursing staff. IKA has established its own health care system with ESY. As a result, a

possible merging of IKA under ESY affects a number of interests that benefit from this institution (e.g. the president of IKA's influential and powerful role within the Greek health system and society, and the thousands of doctors, or other employees, fear being made redundant after a possible merging under ESY). That is what Zhlidis and key informants meant by arguing that a unified insurance fund established after the merging of IKA and ESY would involve a great deal of redistribution of political power and influence between the State, the President of IKA, its administrative staff and the trade unions represented on its Board (mainly GSEE) (Zhlidis 2005).

When the first attempt at organized primary health care occurred in 1983, Minister Avgerinos envisaged that the unification of the numerous health insurance funds would be the cornerstone of primary health care in Greece. However, this unification was never realized, and primary health care was never implemented as part of a National Health System. Over 24 years have passed, and still the Greek government, politicians, health policy experts, and bureaucrats stress the necessity of a single unified insurance, and still no government has succeeded in that task.

The complexity of setting up a primary health care system within NHS is so great, that even though the fundamental Law 1397/1983 clearly stated the necessity of this institution, it remained on paper. Although the medical profession's power proved to be important, some articles were implemented in a distorted way, but an organized primary health care system, suitable to a NHS was not implemented at all. The interests of the dominant 'noble' health insurance funds in the Greek health sector represent the unequal distribution of power and resources within Greek society itself, and, as a result, the privileged groups of insurees (liberal professions and civil servants) in the Greek social security system maintain their privileges in terms of better access and better quality of health services.

According to fieldwork notes and interviews with key informants, the 1983 reform offers a vivid example of how the privileged part of Greek society protected their interests against the interests of the majority. Minister Avgerinos had to face not only the pressures of the medical profession about its labour relations, but also the opposition of his own political party to the unification of the numerous insurance funds (see Chapter 8-section 8.3.2)

Many researchers (Davaki and Mossialos 2005; Mossialos and Allin 2006) and key informants argue that in Greece, the domination of the 'noble' insurance funds prevents any implementation of an organized primary health care system. They are called 'noble' insurance funds because they represent a minority of the Greek population, mainly liberal professions and public servants; they pay lower contributions compared to IKA insurees; and more importantly they enjoy better access to and quality of health care than insurees of IKA or OGA. A couple of key informants characterized each of the health insurance funds as fiefdoms in terms of funding, organization and management, but most importantly in terms of the quantity and quality of the services they offer. Furthermore, the doctors who practised in or contracted with the 'noble' insurance funds were not audited, appraised or controlled in terms of their everyday clinical work.

Overall, there were, and still are, several interests that preferred a 'handicapped'<sup>52</sup> PHC system:

1. the insurees of the 'noble' funds and their management - the former because they were afraid that they would have to compromise with lower quality of health services delivered by the NHS, and the latter because they would lose their posts, and as a result their power and status;
2. Gennimatas saw the future of the Greek health system in terms of the development of hospital care which would enhance the role of hospital doctors, university doctors and private doctors. It also meant that doctors could continue to exploit patients by treating them on several occasions in their 'illegal'<sup>53</sup> practices, which in many cases were in the everyday practice infrastructure of the hospital that they worked for. The university doctors were also in favour of a non-organized PHC system as they had their own private practices to defend;
3. there were more than 25,000 private doctors who opposed PHC because it could potentially harm their interests.

It is no wonder that primary health care has never been successfully organized in Greece, as various health insurance funds wanted to protect their interests and those of their insurees. An academic/health policy expert key informant (5A) suggested that the biggest problem in terms of the Greek health care system is the inability of the State to unify the numerous health insurance funds.

Issues such as lack of capacity of the State, avoidance of political cost and vested interests of the various health insurance funds were commonly discussed by interviewees, but the degree of influence allotted to each depended on the background of the interviewees. Representatives of the health insurance funds focused on the influence of the medical profession, while medics stressed the difficulty of planning health care policy without the unification of the funds. But again the role of the medical profession within the health insurance funds is critical.

The majority of health care reforms after 1983 proposed the unification of the numerous health insurance funds and the absorption of IKA into the NHS. However, none of the IKA presidents was willing to negotiate any kind of power or status loss after a possible merger with ESY. The opportunity that they were given to run one of the biggest institutions in Greece, was one of a kind. On two occasions, Presidents of IKA not only did not accept any kind of merger with ESY (see Chapter 8-section 8.4 and Chapter 10-section 10.3.6), but on the contrary they demanded that IKA, and, of course, they themselves, should manage the unified health insurance fund. As a result, power conflicts between IKA Presidents and Ministers of Health have been quite common, which is another sign of State weakness.

Interviews conducted with ex-Presidents of IKA (21B, 5A, 19B) also indicated that the role of GSEE in what was going to happen with primary health care and the integration of IKA's infrastructure in the NHS, was very important. They even argued that GSEE (the most powerful trade union and decisive component of the IKA administration) would not discuss the transfer of infrastructure to the NHS without first arranging IKA's compensation for the infrastructure, although some might say that this argument was used as an excuse because they wanted to avoid the integration of IKA in the NHS. IKA Presidents clearly knew that this would be the case if they gave their consent and full support to the government's effort at making the system more efficient. In addition to this, IKA has been a powerful bargaining chip in the hands of the GSEE representatives on several occasions because of its substantial clientele and the importance of the services (mainly health services) that it provides to 5.5 million citizens. The most prominent instance was in 2001 when the clash between the Ministry of Health and IKA Management went public and there was much debate in the mainstream media

on the management's selfishness and its efforts to look after its employees' interests and its own prestige. The open debate between the Minister of Health and the IKA management about the rules and norms of the unified insurance fund (ODIPY) and the establishment of the PHC system, along with Papadopoulos' dispute with university doctors, led eventually to the Minister's resignation.

## **11.6 Theme Six: Path Dependency and Historical Institutionalism applied to the Greek Health Care Reforms**

### **11.6.1 The establishment of the Greek NHS (ESY) during the 1980s-A Window of Opportunity?**

The critical question which this section will address is "*Under what circumstances and why did Greece decide to try to establish a National Health Service system in 1983?*" Tuohy (1999:107) argues for the "*critical importance of the timing of intersections between developments in health care and developments in the broader political arena*". According to this point of view, the absence of a social-democratic party in the United States is part of the explanation for the fact that the USA does not have a national health insurance program (Tuohy, 1999). Similarly, in view of the history presented in Chapter 8, episodes of policy change in the Greek health care arena were brought about by the opening of 'windows of opportunity' as a result of changes in the broader Greek political arena. Institutional theory suggests that reforms can only break out of 'path dependency' (Wilsford 1994) when a 'window of opportunity' or a 'critical juncture' occurs. A seemingly favourable, but ultimately incomplete set of circumstances may explain PASOK's decision to introduce a NHS in 1983. Circumstances such as the consolidation of democracy, the worldwide economic instability (resulting mainly from the two oil shocks), the newly elected Socialist Party with an outright majority, entry into the European Economic Community and the broadly felt public need to correct the discrepancies of the previous system, seemed to offer the opportunity for major structural and institutional change in the health care arena (Immergut 1992; Tuohy 1999; Guillen 2002).

The fact that a new, majority, Socialist government was in power for the first time after the restoration of democracy (1974) is typically invoked to explain the decision to



introduce the proposed National Health System in 1983. The proposed plan and later on Law 1397/1983 was then the product of a complex interaction between ideas and interests groups in the health care arena of the early 1980s, and the agenda of the dominant political actors of that era. Papandreou became the Prime Minister of Greece in 1981 and formed a strong majority government. Papandreou himself was a charismatic leader who then used the popular motto of 'change' to pursue first a reform in health care and then in other parts of the public sector. Papandreou was also unable to pursue his pre-electoral promises of withdrawing Greece from the EEC and NATO, and, as a result, he had to divert people's attention to other aspects of PASOK's pre-electoral programme such as change in the health sector. Furthermore, he already had in his hands the plan for health care reform which PASOK's health care experts (mainly medical trade unionists) had prepared during the late 1970s. However, in order to bring about major change, there needs to be a high level of consensus or at least the ability to compromise among the interest groups whose support is necessary to implement reform and who potentially stand to lose. Unfortunately, no consensus was ever achieved in 1983 and there has been none since in favour of significant health sector reform. In addition, external pressures for institutional change, such as EU directives, have tended to be represented by opponents as policies of cost containment which are generally unpopular (e.g. the 1992 reform), though the EU's impact has been felt in specific areas of public policy such as employment, vocational training and regional development. In other important policy fields such as education, health and old age pensions, institutional settings have enabled the main players self-interestedly to resist the impact of EU directives (Sotiropoulos 2004a). This is what Tuohy (1999:111) means when she says that "*institutions shape policy by establishing the channels through which various interests can exercise their influence - that institutions willy - nilly, bias the policy process*".

As a result, the strong majority Socialist government in 1983 was able to pass its legislation in spite of strong opposition from central actors in health care (as was the case with the passage of the NHS and Community Care Act 1990 in the UK), but still the main actors (hospital doctors, university doctors and 'noble' health insurance funds) had to be accommodated, either during the process of debating the plan within the Greek Parliament, or during the implementation process. The accommodation of their interests

was necessary according to the narrative presented in Chapters 8, 9 and 10 because PASOK could not resist the main driving force behind establishing a National Health Service type system, namely, the junior doctors. PASOK had hoped that junior doctors would be the main interest group supporting this change; at the same time, however, since the junior doctors realized the gains that they could accomplish under further negotiation, PASOK faced the threat that the well established and experienced doctors (mainly senior doctors of the pre-existing system) would not join the newly established system. That was the critical moment when Minister Gennimatas and his think-tank, which mainly included PASOK medical trade unionists, made major concessions, especially with the additional legislation issued in 1985 (Law 1579/1985) in order to establish a National Health Service which ended up as a National Health Service only on paper.

Concessions and compromises were carried out throughout the process of establishing the 1983 NHS, and these were in favour of the medical profession and the government. On the one hand, compromises were intentionally made by the State in order to avoid the political cost of not passing the Law which had already been promoted by PASOK as the cornerstone of the 'change' that the Greek society was undergoing. As a result, the government decided to omit critical articles of the original plan that harmed the interests of university doctors (their private practice) and the 'noble' health insurance funds (establishing a unified health insurance fund). Instead, the Socialists preferred to follow a process very common to other sectors of the public sphere, such as education or social security, through which details of a reform were to be settled with supplementary legislation (e.g. presidential decrees for university doctors' labour relations) or were postponed for a later implementation stage (e.g. unification of health insurance funds).

On the other hand, previously mentioned concessions were made because the State had to produce supplementary legislation in 1985 (Law 1579/1985) for attracting 'good doctors' to the system and for compensating those that had left the system and had gone into private practice. The negotiation process was dominated by the EINAP trade union (which had supported the idea of a NHS, subject to their interests being preserved), the power and influence of the university doctors at all levels of the State (government

and political parties), and the lack of firm political will of the State to implement Law 1397/1983 in detail.

Overall, not only was the presidential decree for university doctors' private practice never issued, but health insurance funds were never unified, and hospital doctors had the opportunity to re-negotiate their labour relations according to their interests, while PASOK gave the impression to the citizens that Socialists had established a National Health System. Even the discourse about the establishment of ESY (mainly referring to investment made in new hospital units and the 200 rural medical centres) and the improvements it brought to their daily access to health services was widespread and believed by the people, and it was used by PASOK (especially during pre-election periods) as evidence of the Socialists' achievements.

In conclusion, all the interests of the main actors of the Greek Health care system (hospital doctors, university doctors, 'noble' insurance funds, and even the State) were accommodated either during the Parliamentary debate of the reform plan or during the implementation period. The 1983 reform was potentially a 'window of opportunity' for a possible successful reform, but the particular characteristics mentioned before (highly politicized system, centralized and fragmented welfare system, reciprocal favours and mutual obligations between patron, the State and client, 'noble' insurance funds and privileged liberal professions) were and still are embedded in the Greek public and societal sphere, giving the opportunity to various interests, particularly the medical profession to block or cancel reforms, thereby preserving the *status quo*. As a result, whatever 'window of opportunity' for health system reform had existed in 1983, it was subsequently shut by the various interest groups and by the lack of capacity of the State to confront them and bear the political cost of conflict. Both sides - interest groups and the State - are responsible for establishing a NHS only on paper. Furthermore, the policy legacy of the establishment of the Greek NHS influenced the trajectory and fate of the future reforms in 1992 and 2001.

#### **11.6.2 Path Dependency applied to the Greek Health care reforms**

Ham (1999) argues that there is continuity between features of the British NHS and the features of the arrangements of the pre-NHS era. This is very obvious in the Greek case: although a new piece of legislation was enacted for the establishment of an

organized system (the Greek National Health System), many features of the pre-existing 'non-system' were transferred in the GNHS. For example the medical profession still remained influential and powerful within the system, although the roles of the different segments of the profession had changed. In the pre-NHS era, junior doctors were suppressed and did not have specific labour relations under an organized system. Within the NHS they were 'promoted' as the most important part of the medical profession that would form the base of the institution of 'hospital doctors' according to socialist ideology. It turned out that junior doctors realised that their prospects of profiting from the fact that they would have a permanent post within the NHS could be enhanced if they negotiated privileges within the system. As a result, the dominant group of senior doctors of the pre-NHS period was replaced by a dominant group of junior doctors within the NHS. Furthermore, university doctors continued to practise in NHS hospitals and in private practice as before, and 'noble' health insurance funds continued to provide better health services to their insurees than the other health insurers such as IKA and OGA.

Part of the analytical framework of Historical Institutionalism relates to how episodes of policy change 'open windows of opportunity' (the Socialists establishing the Greek NHS in 1983) and how these can be 'shut down' because of lack of resources, capacity and willingness of the State to implement a reform and more importantly because of the power and influence of interests groups, such as the medical profession. However, Historical Institutionalism is also about how a specific episode of policy change becomes institutionalized in a specific policy sector, such as health care. This is what Tuohy calls policy legacy or else what other researchers call 'path dependency' (e.g. Wilsford (1994), Thelen (1999), Pearson (2001) and Majoney (2000)).

Although it could be argued that the 1983 reform represented the outcome of the strategic judgement of the Socialists in pursuit of their broader agenda of 'change' (Allagi), the dysfunctional institutional context that resulted has determined to a large extent the fate of the two major reforms since 1983 by providing a secure basis for the stiff opposition of the major interest groups, such as the medical profession, trade unions and insurance funds. Any proposals that were perceived to harm vested interests of the medical profession or the insurance funds were only partly implemented or failed to fulfil their main objectives. Representatives of these interest groups managed in all the reform

periods to use the institutional context to protect their positions and in some cases to enhance their privileges. Thus during the 1980s, the establishment of the GNHS, far from marginalising the medical profession politically, created fertile ground for hospital doctors and their representatives (EINAP), who had close links with ministers and the governing party, to negotiate favourable terms for their participation in the system. They threatened that unless their financial and other demands were satisfied, they would refuse to participate in the new system.

During the early 1990s, hospital doctors were successfully able to reject the Conservatives' requirement that they choose between full-time and part-time practice in the GNHS, thereby maintaining their privileged position and their ability to continue to receive informal payments. They did this by lobbying the relevant Parliamentary Committee and influenced its Report on informal payments in favour of their interests. They also managed to pre-empt any public debate developing on the proposals of the international expert committee convened to provide recommendations to remedy the flaws of the GNHS.

In the case of the 2001 reforms, interest groups - mainly university doctors, and health insurance funds accompanied by IKA and hospital doctors - strongly opposed Law 2889/2001. Papadopoulos managed to pass the Law, but university doctors through their connections and high influence with the government turned the Law into a 'dead letter, since the Minister was unable to convince them to stop private practice. Not only that, threat of university doctors to the Ministry's policies, became personal hostility directed at the Minister in a 'winner takes all' battle, resulting in Minister Papadopoulos' resignation.

The explanation for the failure of the 1992 and 2001 reforms and the role of the main stakeholders including the medical profession is strongly related to the distorted way the GNHS was established during the 1980s, and is supported by Mahoney's version of the theory of 'path dependency'. In short, path dependency is the legacy of the past. In other words, it is what the consequences of the earlier events have for later events, or in the Greek case, the consequences of the 1983 reform and the way it was partly or perversely implemented, for future reforms. Path dependency focuses on the survival of institutions through time. According to Pierson this happens due to self-reinforcing

mechanisms, which Arthur (1994), David (2000), and Thelen (2003) have labelled positive feedback. This means that after each step has been taken in a particular direction, it becomes more difficult to reverse this course (Hacker 2002; Pierson 2004)

Path dependency, or these self-reinforcing mechanisms, has been associated with what Paul Pierson calls 'increasing returns'. The term is adapted from the field of economics and it means that when a specific trajectory has been followed, then it produces a certain pattern of cost and benefits, which create costs to altering the initial trajectory. These cost-benefits include the avoidance of large fixed costs or set up costs that another trajectory could generate, the learning effects (already acquired knowledge leads to high returns from its continuous use), the coordination effects (these occur when benefits from the activity of one individual increase as soon as others engage themselves in the same activity), and adaptive expectations (*"if options that fail to win broad acceptance will have drawbacks later on, individuals may feel a need to pick the right horse"*) (Arthur 1994:24).

According to Pierson, these are the main reasons that a procedure is reproduced. Thelen (2003) uses the term 'positive feedback mechanisms' to explain why institutions reproduce themselves and are path-dependent<sup>54</sup>. Mahoney (2000:508) expands the theory of path dependency from an economist's point of view by arguing that *"an institutional pattern - once adopted - delivers increasing returns with its continued adoption, and thus over time it becomes more and more difficult to transform the pattern or select previously available options, even if these alternative options would have been more efficient"*. Yet economists have not produced an adequate explanation of how the reproduction of an institutional pattern delivers increasing returns. Mahoney argues that behind their argument about increasing returns lies the cost-benefit analysis of the reproduction of the dominant institutional pattern, versus the previous one or an alternative. However, historical sociologists attempt to enrich this economic argument with additional mechanisms that involve reproductive processes, such as functional, power, and legitimation mechanisms. By doing so, they suggest different ways in which institutional patterns that are characterized by path dependency may be reversed.

From a structuralist deterministic account (i.e. Alford's Structural Interest Theory), the outcome of the attempts to reform the Greek health system is neither

surprising nor difficult to explain. The Greek NHS is a large institution, an employer of 10,900 hospital doctors and the main provider of health services in Greece. Like other well established institutions, over its lifetime ESY has also generated a number of active supporters (university and hospital doctors) with vested interests in the institution's continuation in a particular form. The absence of a major crisis or a significant exogenous shock, together with positive feedback effects (accommodation to the interests of the medical profession, 'noble' insurance funds, and the State) and locked-in dynamics of path-dependence made sure that almost all the attempts to reform the 24-year old institution have been incremental and incomplete even in their own terms (Pierson 2004; Skogstad 2005).

However this thesis goes beyond the deterministic structural debate and attempts to focus on the role of individual and collective actors, their ideas, dominant discourse and policy strategies, by adopting Mahoney's theoretical framework (Skogstad 2005). Mahoney adapts Randall Collins' categorization of dominant theoretical frameworks in order to analyze the reproduction of institutions (Collins 1994; Mahoney 2000). The typology includes utilitarian, functional, power, and legitimation explanations, as in Table 4.1 from Chapter 4, reproduced here as Table 11.1.

**Table 11.1 - Typology of 'Path Dependent' explanations of institutional reproduction**

	<i>Utilitarian Explanation</i>	<i>Functional Explanation</i>	<i>Power Explanation</i>	<i>Legitimation Explanation</i>
<i>Mechanism of Reproduction</i>	Institution is reproduced through the rational cost-benefit assessments of actors	Institution reproduced because it serves a function for an overall system	Institution is reproduced because it is supported by an elite group of actors	Institution is reproduced because actors believe it is morally just or appropriate
<i>Potential characteristics of institution</i>	Institution may be less efficient than previously available alternatives	Institution may be less functional than previously available alternatives	Institution may empower an elite group that was previously subordinate	Institution may be less consistent with values of actors than previously available alternatives
<i>Mechanism of change</i>	Increased competitive pressures; learning processes	Exogenous that transforms the system needs	Weakening of elites and strengthening of subordinate groups	Changes in the values or subjective beliefs of actors

[Table from: (Mahoney 2000,p. 517)]

The path-dependent trajectories in the Greek health care sector since 1983 do not perfectly suit any one of Mahoney's typology of explanations, but some characteristics of the utilitarian, power, and legitimation explanations are relevant to the analysis of the health care institutional setting of Greece. The combination of utilitarian, power and legitimation explanations appears to offer the best account of the Greek health care sector, and of the sources of influence and power of the medical profession which were exposed in the three case study narratives in previous Chapters.

The first framework of reproduction of institutions and change is the *Utilitarian* framework. The *Utilitarian* framework is based on rational choice institutionalism. According to rational choice theory applied to the Greek case, doctors will support and protect the formal and informal institutional settings of the 1983 reform and negotiate with the State as long as this does not negatively affect their status. However, the *Utilitarian* framework indicates that the reproduction of the institutional setting (i.e. the establishment of the Greek NHS), is accomplished because the potential benefits to be gained from the alternative institutional settings outweigh its costs. This is to say that if the Greek government were to pursue an alternative arrangement to the institutional setting already established in the Greek Health sector, it would have to keep in mind the costs of this transformation, (cost of audit mechanisms, rise in hospital doctors' salaries, etc). In other words the State and the medical profession have reached a mutual accommodation by the reproduction of the ESY institutional setting because the former cannot afford the additional cost of implementing an alternative institution and the latter because it has self-interest in preserving the status quo or even expanding it by maximizing its profit by capturing a bigger share of the growing private health expenditure (private expenditure was 43% of the total health care expenditure in 2004, and it reached 57% in 2005 according to the recent OECD Health Report 2007) (OECD 2007). As a result, reforms in the Greek health care system have to outweigh what the dominant actors are deriving from the current institutional setting. Only in this case will the actors consider accepting an alternative institutional setting. Thus a new institutional setting is practically inconceivable.



However, increasing returns (e.g. potential benefits through the reproduction the NHS institutional setting), cannot account for the majority of the Greek population, which does not appear to get much out of the *status quo*. For them the current cost-benefit ratio is negative, and as a result the *Utilitarian* framework is incomplete.

Institutional change according to the *Utilitarian* framework may occur when it is no longer in the self-interest of actors to reproduce a given institution. According to market-oriented logic this might happen because of increased competitive pressures, or as Mahoney (2000:518) argues “*learning processes that help rational actors anticipate negative consequences in the future, encourage them to absorb short-term costs and make a change in the present*”.

Although the *Utilitarian* framework sounds convincing in terms of hospital doctors’ behaviour, it leaves a gap in knowledge in terms of further theorizing the ‘lock-in’ effect of specific institutional settings. This is where the contribution of the *Power* framework comes in. The emphasis of the *Power* explanatory framework is on how the institutional setting tends to distribute costs and benefits unevenly across the actors of the system. It also identifies that in the system there are different kinds of actors with unequal power and access to the decision and policy-making centres, responsible for the reproduction of the institutional setting or change. The incomplete version of GNHS persists because it is supported by social actors who benefit from its informal rules and outcomes, and who are sufficiently powerful to promote its continuation. According to Mahoney, it does not matter if the majority of the individuals or groups would prefer to change the specific institutional setting. The dominant group (what he calls the elite) will have the necessary capacity and resources to enforce the reproduction of the institutions it wants (Mahoney 2000).

In the Greek case, the main beneficiaries are the hospital and university doctors. Although they had power and influence in the ‘non-organized’ system before 1983, what was observed in 1983 was the empowerment of another segment of the hospital doctors - the junior hospital doctors - within the new NHS. Fieldwork and analysis of the data then provided an important account of the subsequent role of university doctors in the implementation of the NHS reforms. It is not a coincidence that from the whole community of university doctors, a few, mainly university doctors of Athens and

Thessalonica (this is what Mahoney calls the elite), influenced the outcome of the reforms after 1983, and, particularly, again in 2001. This means that when university doctors find themselves affected by a proposed institutional setting, they will use their power, influence and connections in the government hierarchy to resist change for their benefit, and they will oppose any alternatives. This strong influence, channelled by a particularly powerful university doctors' lobby (based on personal and patient-doctor relations of few well-established university doctors with Greek Prime Ministers), was experienced in 1983, 1992 and most importantly in 2001, when university doctors successfully 'demanded' from their fellow academic, Prime-Minister Simitis, the resignation of Health Minister Papadopoulos. The Minister resigned, and his successor, a Professor of Psychiatry in the Medical School of Athens, Dr. Stefanis, withdrew all the articles of the Papadopoulos Law that aimed to restrict university doctors' private practice.

The limitation of the *Power* theoretical framework comes from the fact that the genesis of the institution may not be attributed to pre-existing power-related arrangements. In regards to the Greek health care institutional setting of 1983, it may or may not be attributed to pre-existing institutional arrangements. This argument is closely related to Mahoney's argument that change may occur in a crisis or when important exogenous factors occur. However, it does offer a convenient explanation of the persistence of the institutional settings after the partial establishment of the Greek NHS.

Institutional change may occur according to the *Power* framework when the empowered parts of the medical profession (e.g. hospital doctors and university doctors) are weakened by the previously subordinate groups. In the Greek case, the subordinate groups might be the Repressed Structural Interests (Alford 1975) of the consumers or patients. Such a change in the institutional reproduction process might be precipitated by an external social or economic change. As a result, change in the *Power* institutional framework happens when a specific power group benefiting from the institutional setting, is outweighed by another group, and not because the beneficiary group choose to change the institution (*Utilitarian* framework).

As far as the *Legitimation* framework is concerned, the reproduction of an institutional setting is based on what the actors perceive as appropriate or morally correct.

According to documentary and interview analysis, hospital trade unionists stressed their legitimately dominant role within the NHS, and how their absence would automatically lead to the collapse of the NHS (*"Everything that it is good for doctors is good for the public health and for the Greek people"* (Evdokimidis 1983)). Other quotes from the medical trade unionists interviewed, highlight this perspective: *"it is about time that the State recognizes the difficulty, the responsibility and high mission of the medical profession and reimburses it with a wage plan specifically tailored to their needs"*(F.Papadelis, medical trade unionist and university doctor)....*" I believe that 'fakelaki' is a crime committed by two sides. There is an individual that gives the money and there is another individual that receives the money. As a result, we cannot put the blame on doctors who receive informal payments...(Dr. Sourlas, ex-Minister of Health and the First (A') Vice President of the Greek Parliament since 2004 )"*...*"...The Doctors' view on what is happening in the health sector is very important. As a result, there can be no reform without the support of their medical societies...(Athens Medical Association-ISA)"*...*".....there are many examples from the recent history of the NHS where a Minister has introduced various Laws but none of these were implemented..."* (Dr. Tsoukalos, President of EINAP, implying that it does not mean anything that a Minister introduces a reform. In any case, Greece is very good at producing laws, but very bad at implementing them) .....*"no one in this Parliament knows that a University doctor receives the same salary as an academic professor in Theology"* (Professor Kremastinos arguing in favour of the superiority of university doctors over any other university teacher).... *"The public has to be sure that our intentions are good and that we are on the right track in pursuing them. There is no other trade union in the health care arena that fights like us for the sake of change, and for full-time and exclusive employment. As a result, the public should be aware that whenever they hear that doctors are on strike, they are fighting against something wrong that affects Greek society in general and not only doctors"* (President of EINAP, Dr. Eleftheriadis in 1984) and *"... And who is going to pay me the money that I am going to lose by not doing my private practice?..."* (A university doctor's reply to his students when they asked him if he could reschedule the exams at a more convenient time, so that they could attend

*another course*). These quotes are indicative of persuasive discourse of representatives of the profession to justify their informal or formal exploitation of the NHS.

Another example of persuasive discourse is their argument that they do not accept external appraisals because the State is influenced by party politics so it will not treat them fairly. They argue against any introduction of managerial control over their work, because their clinical work will be affected and their dominance over their practice will be seriously challenged. They consider themselves the most important asset of the Greek NHS. They have continuously stressed their importance and superiority of their work compared to other guilds, and positioned themselves metaphorically as one level below God<sup>55</sup>. The majority of hospital doctors have successfully convinced Greek patients that in order to treat them they need to pay them informal payments. That way not only do they profit from the 'black' economy, but they have also managed some independence from their State salaries, making their 'main' and permanent civil service post their side-line. In addition to this, they have even convinced Greek society that the higher the payment is, the better doctors they are.

In terms of university doctors, the dominant discourse does not differ from the one for hospital doctors and it relies on the fact that university doctors feel superior to hospital doctors and the proof of that is the fact that a clinical director post will be given to a university doctor and not to a hospital one. In addition to this, their power, status and academic freedom give them the privilege of seeing patients in their afternoon private practices. In extreme, but quite frequent cases, they even prompt their patients to visit them in their private surgeries, and avoid queuing during the morning in the NHS-University clinics. Overall, hospital and university doctors have created a core ideological system of principles which supports and reproduces the 'perverse' implementation of the Greek NHS since 1983.

Mahoney argues that the reproduction of the dominant institutional framework may stop when another framework with contradictory moral codes or ideology which challenges the existing code and as a result makes it lose its legitimacy appears. The dominant institutional setting can lose its legitimacy when a decline in its efficacy or stability is observed, or when new ideas are produced by political leaders (Mahoney 2000).

The last mechanism of institutional reproduction or change described by Mahoney is the *Functionalist* framework. In this case institutions persist because of their consequences for an overall system. According to the functionalist framework the “..the institution serves some function for the system, which causes the expansion of the institution, which enhances the institution’s ability to perform the useful function, which leads to further institutional expansion and eventually institutional consolidation” (Mahoney 2000:519). The *Functionalist* framework is less suited to the Greek case, since the reproduction of the institutional framework of 1983 does provide a function for the overall system, but in reality the reproduction of the way the 1983 reform was implemented resulted in losers (some patients) and winners (medical profession and the State). The mechanism of change in the case of the functional framework comes from an exogenous shock that transforms the system needs (Mahoney 2000).

Overall, Mahoney’s framework emphasizes how an institutional setting can be reproduced through *Utilitarian, Power, Legitimate and Functional* mechanisms (path dependency), but at the same time contributes to the scientific debate about how this institutional dominance can be changed. As previously demonstrated, the Greek case is unlikely to be explicable in terms of a single theory of the persistence or change of an institutional setting. *Power* and *Legitimation* perspectives are likely to be complementary and contribute to the explanation of the path dependency of the GNHS. That is, an empowered medical profession (university and hospital doctors) via the perversely implemented NHS, is able to exercise its dominant core ideology about its powerful and influential legitimate role within the Greek Health system, which is seen as morally correct according to the profession’s code of ethics. Finally, it seems that the great loser in the path dependency of the GNHS is the majority of the Greek population, who according to Mahoney’s *Power* framework are subordinated to the medical profession.

## **Chapter 12: Discussion**

### **12.1 Introduction**

The previous chapter has described and explained the emergent themes from the narratives of the three reform episodes, the documentary analysis, and the interview analysis. It also revealed the peculiarity of the Greek health care arena, and identified the theory that best explains its dynamics.

The final chapter of this thesis begins with the introduction of findings of other studies on the emergent theme of 'health in crisis' and health system reforms in industrialized countries. The reference to other scholars' works is important in distinguishing health care reform agenda setting between Western European countries and Southern European countries during the late 1970s and 1980s. It also contributes to the characterization of the Greek health system as a puzzle or a deviant case within the dominant Western European paradigm. In addition, it provides a detailed account regarding the main contribution of this thesis which is the fact that several theoretical frameworks have been tested in order to explain the unchallenged power and influence patterns of the Greek medical profession, and the Greek National Health Service reform failures. This section concludes that no single theory is adequate to explain every aspect of the Greek National Service. However, the most suitable theoretical framework appears to be Historical Institutionalism, with complementary contributions from the Theory of Professions and Structural Interest Theory.

The next section of this chapter is dedicated to the strengths and weaknesses of this thesis. In-depth analysis of the GNHS reforms based on three case studies, combination of documentary and interview data analysis, high success rate in approaching interviewees and detailed account of the medical professions' role, power and influence, are the strengths of this thesis. The weaknesses of this thesis are first, that it is a study of a single country, second that it is mainly focused on the role of the medical profession and of the governments within health systems, leaving out the voice of patients/consumers, and last that there is no single adequate theory to explain the Greek health system reforms.

This chapter also suggests that the Greek NHS's pattern of implementation created a legacy for future reforms and made them path-dependent. Only minor changes have occurred, and these were only allowed because they did not affect the status quo and the distribution of power amongst the main actors of the system. Therefore, the suggested ways of incremental change via *displacement, layering, drift, conversion and exhaustion* (Streeck and Thelen 2005) are not visible in the Greek case.

Finally, the chapter offers insights on the issue of how the dominant institutional settings in the Greek health system could change under the power and legitimation frameworks of path dependency, and how signs of the latter can already be spotted in patients' attitudes towards claiming their social right to access health care services, and their willingness to challenge the system collectively using modern technology.

## **12.2 The Contribution of this thesis**

### **12.2.1 Health Politics and Reforms**

Health care reform has been top of the political agenda internationally for more than twenty-five years. In industrialized countries, as in Western Europe or Northern America, there have been increasing pressures to make structural and institutional changes in health systems. After the post-War expansion of the Welfare State, and specifically the rise of the health care expenditure, the majority of the nations had to reorganize their health systems following cost containment policies. Since then several scholars have engaged themselves in detailed and rigorous accounts on whether health policy is driven by the need to decrease health expenditure.

Michael Moran (1999:xi) has concluded that health policy making makes no sense if only cost containment is concerned. He argues that health policy making "*must be shaped by something more subterranean than the acknowledged search for cost containment*". That is why he suggests that countries such as the UK, Germany and the United States of America, used cost containment practices used as an alibi in order to ration and regulate their health systems, and at the same time demarcate the medical profession. Health systems according to Moran (1999:17) are quite different from any other policy arena, and for this reason "*we cannot make sense of health care states without placing them in that global division of labour, but the key to understanding a particular health care state will turn on understanding its particular place in the global*

*system*". Within this context he chose to conduct a comparative study between the UK, Germany and the United States of America. Each of these countries offers a good example of the three distinctive ways health care systems organize the delivery and financing of their health services: a) National Health System funded by general taxation (UK), b) Market-orientated system (USA), and c) systems funded by compulsory insurance (Germany). Moran is not however interested in these archetype health systems. He is more interested in their importance within what he calls the "*global state system*". In addition, he acknowledges that each of these countries has evolved their health care systems according to their particular historical trajectories and have differences in the way the medical profession and the State have interacted and created a "*working relationship*". He concludes that health and health care reforms can be understood only by careful research on the power relations between the State, markets, the medical profession and industrial interests. Moreover, he suggests that these relationships are embedded in the historical development of the State of each country and their bureaucratic structures (Moran 1999).

Michael Harrison (2004) is another scholar that has produced a comparative study regarding the genesis and the implementation of health care reforms in the UK, Sweden and the Netherlands. He uses four different frames in order to understand the policy process. The first frame is used to describe policy initiatives and their rationale according to a top-down approach. The second analytic frame is concerned with how policies are implemented from a local point of view, what he calls bargaining and interest group politics (bottom-up approach). The assumption that he makes is that local policy actors may facilitate, inhibit or distort the way a policy is implemented. The third analytic framework is interpretative and focuses on the interaction and dominant discourse observed when the lower policy actors are asked to implement policies from above. Harrison believes that this relationship is complicated and that in many cases the objectives, rationale and desired outcomes set by high level policy actors may reach the target population in a distorted way that does not represent the initial aspirations. The fourth and final analytic frame is Harrison's version of historical institutionalism. According to his account, each country, or within each country, each policy area is structured differently in terms of institutions, political processes, policy precedents,



history and culture. As a result, these characteristics are responsible for shaping each country's policies. The aforementioned framework is then used by Harrison to conclude that the implementation of the market reforms in UK, Sweden and the Netherlands were strongly influenced by doctors and their organizations, since they are the key actors of the systems and shape policy implementation. In addition, he argues that resistance to market reforms comes from strong horizontal professional networks and the principle of clinical autonomy. Following that, he offers a detailed account of market reforms' degree of failure, drawing on examples taken from the three case studies. He argues that all three countries had common problems implementing their market reforms, and the most important were a) difficulties in getting accurate data on services, b) setting accurate charges and prices, and c) monopolistic trends in health care services which inhibited a competitive market. In addition, he strongly supports the idea that the power of the medical profession to block change, and strong and unexpected external economic and political influences, were also important in shifting policy actors' priorities. In all three case studies, rising health care costs led politicians to adopt fiscal measures which improved the level of efficiency of the secondary health sector. However, these cannot be attributed only to the effects of the reforms.

Harrison does observe, changes in the rhetoric about health care delivery, which resulted in changing the way local level policy actors became more cost conscious and managerial. The new discourse which they adopted included power shifting from doctors to managers, and doctors becoming generally more cynical towards the introduction of new health care regulation, especially in the UK.

A third scholar who has undertaken comparative analysis of health politics in Europe, is Richard Freeman. Freeman (2000) starts his analysis of health politics by stressing the contemporary importance of health, and continues by revealing that health care has become an important sector of labour and as a result a very crucial factor of a country's economy. Therefore, it also becomes political.

Freeman (2000:6) strongly criticises the deterministic categorisation of health systems as either national health services or social insurance-based systems. Instead, he emphasizes that European health systems ought to be understood on an "*essentially comparable geology*", sharing common policy objectives, such as adequacy and equity in

access, income protection, a degree of freedom of choice for consumers and autonomy of providers. He also concludes that the health system of any country can be examined as a number of systems, for example public and private, superimposed on each other, sometimes in a complementary way, or sometimes coexisting or competing. Therefore, Freeman does not accept the concept of an integrated model of understanding health politics. Instead he argues that health politics are better understood, as Day and Klein argue (1992:463), if they are taken as *"a complex of different if related arenas, with different if overlapping sets of actors"*. He also takes a historical perspective describing the evolution of European health systems since 1880, reaching the conclusion that the golden period of the Health Care State was during the 1960s and 1970s. By 1980s almost all European countries had managed to guarantee access to health care to the majority of their citizens. However, the increased scope and cost of publicly guaranteed health care did not match the executive authority of the governments. In reality, although health care was sponsored by the State it was not governed by it. He attributes the inability of the State to govern health care to the fact that health care is an industry in which, unlike others, the introduction of new technology does not coincide ultimately with reducing unit costs or saving labour.

He also stresses the importance of the medical profession in European health systems, by saying that health care in Europe is synonymous with medical care. As other social scientists have argued, the medical profession in Europe reached its most powerful position by the third quarter of the 20<sup>th</sup> century. Governments, however, did try to implement cost containment policies in health care, and consequently reduce the power and influence of the medical profession in health care, with measures such as medical audit, clinical guidelines and the introduction of managerialism, but their success has been moderate due to doctors' ability to avoid control. The origins of the power and influence of the medical profession lie in the dependency relationship that the State and the medical profession have demonstrated in the post-war era, a relationship based on mutual understanding and benefits, as the State granted power and status to the medical profession by legitimizing its role, and in return the medical profession offered a fertile terrain for the State to medicalize social and political problems.

The aforementioned studies are part of an ongoing literature about public policy making and health care reforms in Western European countries and North America. The European case studies demonstrate the need of governments to explore ways of getting out of the financial dead end created by the expansion of the Welfare State after WWII and the increase in public health care expenditure. The golden era of the Welfare during the 1960s and 1970s reached an end after countries experienced economic crisis due to the two major oil crises (Skoutelis 1995). The Welfare State then became the central topic in political and academic debate, which resulted in an ongoing effort of the European countries to reform their health care systems. While the majority of the Western European countries got involved in the debate about the 'crisis' of health care systems in the 1980s, health reforms or power of the medical profession, another set of countries, representing the so called Southern European Welfare States were struggling economically and politically with the aftermath of their unstable political regimes and their economic backwardness (Carlos 2001). For countries like Greece, Spain or Portugal the debate was more how to develop a Welfare State according to the expansist mode of the 1960s and 1970s in Western Europe and catch up with their counterparts in the EEC, rather than issues like market reforms, competition or cost containment in financing and delivery in health services. Southern European countries had established their health systems on social health insurance, without reaching universal coverage. Therefore, during the last thirty years, a series of reforms have been enacted in order to achieve more universal access to health care services. According to their pre-existing institutional settings and the degree they allowed the main actors of their systems to influence these attempts, Southern European countries have partly succeeded (Spain and Italy) or partly failed (Greece and Portugal) in their objectives (Guillen 2002). The establishment of the Greek national health service-type system in 1983 was based, apart from the aforementioned 'formal' agenda, on Papandreou's populist discourse in favour of 'change' in Greek society which was one way for the government to obtain support for this 'political vision'.

### **12.2.2 What this study adds**

The scientific contribution of this monograph does not lie in building up a new theory about the role of the medical profession in health care systems. What it does do

though is test already existing theories of health system reforms within the single case study of Greece.

#### **12.2.2.1 The Greek health care system: A puzzle or a deviant case**

The Greek health care system was chosen because it could be characterized as a puzzle or a deviant case. This is because, although a National Health System was established in 1983 according to the 1397/1983 legislation, the way that it was implemented did not resemble the NHS systems of the Western European countries, such as the UK. In addition, the adoption of an NHS-type system was quite late by OECD standards. Most Western European countries had already established their NHI and NHS systems just after WWII, (e.g. the UK, or in the following decades, e.g. Sweden, while Southern European countries did not manage to do until the late 1970s or early 1980s. Greece established a NHS system in 1983, Portugal in 1979, Italy in 1978 and Spain in 1986 (Freeman 2000; Guillen 2002).

The deviant character of the Greek health care system compared to other European National Health Insurance-or National Health Service-based systems was recently confirmed by the OECD Health Data Report (2007) and by the analysis chapter of this thesis. Greece has the highest proportion of doctors/1000 inhabitants (5 doctors/1000 inhabitants) in OECD countries, with a total health care expenditure of 10% of GDP, and what is more striking is that it has the highest percentage of out-of-pocket spending as a share of the total expenditure on health at 57%, a figure that proves Greece has a National Health System only on paper and not in real terms. In addition, the deviant character of the Greek health system is demonstrated in the explicitly self-interested way the main actors of the system (university doctors, hospital doctors and 'noble' insurance funds) treat the Greek NHS. By making use of the inherent socio-political, historical and societal characteristics (pre-1983 fragmented National Health Insurance, party politics, clientelism and lack of capacity of the State to implement reforms) the medical profession has achieved a unique unchallenged status within the Greek health care system, protected even more by the repressed role and individualistic character of the Greek population as patients.

#### **12.2.2.2 Influence patterns of the Greek medical profession**

However, demonstrating that the Greek health care system is deviant compared to other Western European health systems, is only part of the findings of this thesis. The detailed account of the role and influencing methods of the medical profession within the three case studies (1983, 1992 and 2001) adds to what is already known about the Greek health system. Other Greek scholars have indeed produced descriptive accounts of the Greek health care system and reforms (Matsaganis 1991; Kyriopoulos and Tsalikis 1993; Venieris 1997b; Liaropoulos and Tragakes 1998; Liaropoulos and Kaitelidou 1998; Liaropoulos 2001; Mossialos and Allin 2006), and have mentioned the importance of the medical profession within the Greek health care system. However, this thesis provides an explanatory analysis of written and interview data around the establishment of the NHS, and more importantly how the establishment of the Greek NHS shaped future reforms. The interviews in particular, introduced information from an extensive network of 37 key-informants who verified and in some case expanded evidence coming from documents on issues such as the organization of the medical trade unionism, and patterns of influence and power that they have exercised since 1983.

An extensive literature already existed in relation to the 1983 reform (Venieris 1997b; Davaki and Mossialos 2005; Mossialos, Allin et al. 2005) providing a detailed account of the enactment of the NHS legislation. However, researchers focused on describing the legislation without providing detailed information about the opposition or the specific patterns of influence exercised by the medical profession during the reform planning or implementation. Therefore, this thesis not only provides a detailed mapping of the main actors of the Greek health system before 1983, but also describes and explains the implementation process during the 1980s and attempts to describe the legacy of the establishment of the NHS to future reforms. In addition, the legacy of the 1983 reform is not separated from the broader public policy making scene and the fundamental political, economic and societal institutional setting of the Greek State after 1974. Therefore, pre-existing institutional arrangements are interrelated with the way the Greek medical profession managed to maintain or in some case extend its unchallenged status, to the point that after 24 years not many aspects of the Greek health care system have changed.

### **12.2.2.3 Testing Theoretical Frameworks**

The contribution of this thesis is also related to the fact that several theoretical frameworks have been tested in order to find the most suitable to explain the role of the Greek medical profession and the failure of the Greek reforms in general and in particular in health care (New Institutionalism, Theory of Professions or Structural Interest Theory), and finally with the help of the theoretical frameworks to demonstrate the variety of influence and power patterns used by the medical profession to preserve the status quo in the Greek health care system after the perverse implementation of the GNHS during the 1980s. This thesis concludes that there is no single theory which adequately explains every aspect of the Greek health system. Therefore, each theoretical framework contributes to understanding the pattern followed in Greek health system reform.

#### **12.2.2.3.1 Historical Institutionalism: Importation of Western European institutions vs. endogenously inherited institutions of the Greek society ('Path – Dependency' of the Greek health care system)**

The literature review and evidence coming from the qualitative research indicated that salient sociopolitical and historical characteristics of the Greek society are responsible for the empowerment of privileged groups within the society, and especially for the unchallenged role of the medical profession. The origin and the explanation of the power and influence of the medical profession goes back to the rather simplistic and general point of view that 'history matters'; i.e. understanding the Greek health care reforms through the lens of Historical Institutionalism and 'path dependency'. Thus, the explanation of the specific trajectories offered important insights into the role of the medical profession.

Several political scientists have used Historical Institutionalism and path dependency in comparative studies in order to demonstrate how similar conflicts between the State and the medical profession have produced divergent trajectories in terms of the health insurance-based system they implemented (Immergut 1992; Moran 1999; Tuohy 1999; Freeman 2000; Harrison 2004). Each country had different institutional rules and procedures, which provided different opportunities and impediments to both politicians

and interest groups. These institutions established the rules of the 'game' in health policy-making. For example, Immergut (1992) does not give much weight to the influence that medical associations or trade unions have on the political process. She does not correlate the power of a medical society or association with its level of professionalism. What matters is the proportion of opportunities offered by the institutional veto points for blocking or challenging government institutions. That is why interest group power and more specifically medical dominance depend on the veto points within political systems and not with the organizational properties of particular interest groups.

Immergut argues that differences in political institutions of decision making are responsible for different outcomes, something that is confirmed in this thesis. However, Immergut does not engage in an extended discussion about how institutions influence the implementation stage once a law has been enacted. That is a gap that Tuohy addresses with her much more complex and sophisticated analytical framework of *Accidental Logics* (Tuohy 1999). She uses a version of Historical Institutionalism which *"emphasizes the importance of decisions taken at crucial points in time, decisions that become crystallized in the formal and informal rules governing behaviour, and that establish the context in which subsequent decisions will be made. Historical Institutionalism, however, is a house with many mansions: it allows for a variety of emphases regarding the factors that bring about critical moments of decision-making and that shape decisions at those moments"* (Tuohy 1999:107). Within her framework, factors such as political institutions, policy legacies, public opinions and cultural understandings, political culture and parties, organized interests and strategic judgements intersect and contribute to policy outcomes.

This thesis confirms that the establishment of a NHS type system provoked major conflicts between the medical profession and the State in 1983, like in most other Western European countries just after WWII or before the 1980s (Immergut 1992; Tuohy 1999). In the Greek case, conflicts varied from ideological (between the Socialists and the Conservatives), to interprofessional (between different segments of the medical profession i.e. junior versus senior doctors). It also confirmed what Tuohy (1999) Immergut (1992), and Starr and Immergut (1987) have already demonstrated in their studies in Western Europe and North America, about the accommodation of the medical

profession's interests by the State during the Parliamentary discussion of the 1983 reform and during its implementation (1985-1986). In addition, this thesis acknowledges that the most important part of policy making is the implementation of a Law (Tuohy 1999). During the implementation stage of law 1397/1983 political institutions played an important role (Immergut 1992), but at the same time other factors (such as policy legacies, public opinions and cultural understandings, political culture and parties, organized interests and strategic judgements intersect and contribute to a sound understanding of policy outcomes ) (Tuohy 1999), or as Thelen (2003) argues "*the general institutional context*" played a much more important role for the policy outcomes.

In other words forces of the broader political arena had opened a 'window of opportunity' for the establishment of a national health service system in Greece in 1983 because of the political culture (a strong majority socialist party was in government), the public opinion (the majority of the Greek population was agitated by the Socialist leader's vision of change for Greek society), and Greece's commitment to Europeanization and democratic stability (until 1974 Greece was under military junta). However, the resulting change which took shape with the implementation of Law 1397/1983 was crystallized by the existence and combination of the following factors:

1. The 'policy legacy' of the pre-GNHS institutions, which shaped the power and influence of 'organised' interests (medical profession-health insurance funds) in the health care sector during the late 1970s and early 1980s; and
2. The government's 'strategic judgement' in order to get the GNHS initiated was to accommodate the organized interests within the new system. On the one hand, the government was in principle following its preelectoral commitment of 'change' in the health care sector, and on the other the medical profession succeeded in blackmailing the government with its participation or lack thereof in the newly established NHS.

The complexity of the organisation of the Greek health care system (Bismarckian health insurance system before 1983) with many inequalities in accessing and delivering health care services and poor health care infrastructure underpinned the need to reform the system, but at the same time it made any attempt to reform a difficult task. Existing health insurance institutional arrangements had already established an extended network



of 80 health insurance funds for the delivery of health services all over the country, according to the occupational background of the citizens. The introduction of a National Health Service system meant that citizens would access health care on the basis of their fundamental social rights i.e. as citizens, and that a unified health insurance fund should be created (Guillen 2002). In 1982 the three major health insurance funds (IKA, OGA and TEVE) representing the majority of the Greek population (85%) had secured some kind of access to health care for their insurees. However, discrepancies in the level of access, and especially in the health care expenditure per person, were observed amongst the numerous insurance funds. According to Prof. Yfantopoulos' calculations (Yfantopoulos 1988) although IKA, OGA and TEVE spent from 8 to 14 €/person, the 'noble' insurance funds representing 10% of the population spent 26 to 44€/person. In addition to this, the very low outpatient health care expenditure for OGA's insurees revealed that primary health care was not existent for the rural population (see Table 12.1).

**Table 12.1 Insurance Funds' Health Care Expenditure/Person in 1982 (in Euros)**

			<i>Outpatient Care Expenditure</i>		<i>Hospital Care Expenditure</i>		<i>Total Health Care Expenditure</i>	<i>/Person</i>
<i>HI Funds</i>	<i>Insurees</i>	<i>% of Popul ation</i>	<i>Total</i>	<i>/Person</i>	<i>Total</i>	<i>/Person</i>		
<b>IKA</b>	4,250,000	40.5	28,277,456	6,65	30,802,524	7,25	59,079,980	13,90
<b>OGA</b>	3,542,000	33.7	6,763,316	1,90	18,863,390	5,30	25,626,706	7,20
<b>TEVE</b>	985,950	9.4	3,731,950	3,80	3,973,784	4,00	7,705,734	7,80
<b>Bank Employees</b>	75,226	0.7	2,490,306	33,00	845,540	11,25	3,335,846	44,25
<b>Civil Servants</b>	880,000	7.8	17,120,470	19,50	5,807,777	6,60	22,928,247	26,10
<b>OTE</b>	111,720	1.1	2,965,743	26,50	624,450	5,90	3,590,193	32,40
<b>TSAY</b>	98,240	0.9	120,320	1,20	572,270	5,80	692,590	7,00
<b>TAE</b>	202,070	1.9	n/a	n/a	810,580	4,00	810,580	4,00
<b>Others</b>	420,240	4.0	3,460,000	8,20	2,929,112	7,00	6,389,112	15,20
<b>Total</b>	10,504,431	100.00	64,929,561		65,229,427		130,158,988	
<b>Mean Health Care Expend./Ins uree</b>				12,60		6,35		18,95

(Table taken and adjusted in to Euros from Yfantopoulos (1988), p.116)

The establishment of a National Health Service could secure access to all the Greek population, but at the same time one has to take into account that a certain level of health care had already been provided by the pre-existing health insurance system. In particular, OGA offered hospital care to all the rural population, and IKA which was mainly for the urban population had secured free access to hospital care, specialist care, and its own network of clinics for its insurees. The 'noble' insurance funds provided a wide range of quality services to their insurees.

As a result, around 10% of the population – especially civil servants, liberal professions, bank employees and workers for the public utilities – received a very good level of health services. In addition, while the majority of the population did not enjoy the same level of access or quality of health care as the 'noble' health insurance insurees, they did enjoy a satisfactory level of access to health care services, apart from the rural population whose access to outpatient care was problematic. Therefore, although the discrepancies described above justified the plan for reforming the system in 1983, at the same time, it was difficult to convince the population as a whole of the need for radical reform to reduce the inequalities of the system: first of all because there was a general mistrust of government policies; and, secondly, because the 'noble' insurance funds opposed any reform that potentially would reduce their importance and the quality of their health care services.

The discrepancies observed in the pre-1983 Greek health system provided the ground for PASOK and the populist discourse of its leader Andreas Papandreou to justify a reform of the system. Subsequently, the Socialists moved away the debate away from the real issues of the discrepancies in accessing and delivering health care services, by emphasizing the general need of the Greek society to 'change'. The notion of 'change' for the Socialists was not part of a specific plan for reforming several aspects of the public sector. It was based on a vague and indefinite rhetoric about the need for change. The lack of in specific policy initiatives from government was exploited by EINAP which became increasingly powerful and influential, mainly with junior doctors, who, under the

prompting of Prime-Minister Papandreou, played an important role in planning the first draft of the 1983 reform plan.

The Socialists under the pretext of eroding regional inequalities, administrative dispersion of the system, and the discrepancies in accessing and delivering health services, established a National Health Service system which served as way of legitimizing its government, distracting people's attention from other pre-electoral promises (for example Greece opting out EEC and NATO) that the Socialists could not fulfil, and showing how PASOK was 'changing' the Greek health care system, and subsequently the Greek society.

The Socialists in the early 1980s confirm the argument of this thesis that a strong majority government was not enough for a successful implementation of the Greek NHS. The government in 1983 was strong enough to pass the legislation with several concessions to university doctors and the 'noble' insurance funds, but was unable to safeguard it at the implementation stage. Therefore political institutions did matter in terms of the Parliamentary discussion of the legislation (and the process confirmed Immergut's argument about veto points from university doctors and 'noble' insurance funds), but it seems that it was the implementation process that determined the success or failure of the reform, not only in Greece but also in other countries of the so-called Southern European Welfare State model. This part of policy making is the most vulnerable to discrepancies between what the law stipulates and what actually happens (formalism) in most Southern European countries and particularly in Greece (Mouzelis 1978; Sotiropoulos 2004b). There were several manifestations of 'formalism' during the implementation of the Greek NHS, including legislation which obliged university doctors to quit private practice, public hospital doctors to practise full time and exclusively in the public sector, hospital doctors to be properly appraised, doctors to stop receiving informal payments, and health insurance funds to be unified. All these were never realized.

The discrepancy between what the law stipulates and what is implemented comes from the general institutional context of the Greek State, in particular, because of the superimposition of imported political and administrative institutions on a pre-modern society, based on what Mouzelis (1978) calls "*indigenous institutions*", which included a variety of informal workings of all sorts of interests, related to social class, localism and

regional identities. As a result the Greek State, like other Southern European States, was permeated by these interests and functioned in a particularistic and clientelistic manner.

The imported Western European type NHS institutions in Greece in 1983, neglected the indigenous institutions of the Greek State and Greek society, and the existing health insurance system, which had already placed the medical profession (especially the senior part of it and the university doctors) in a prestigious and powerful position within the society and more importantly within the Greek health care system.

As a result, the reform of 1983 and especially the way it was implemented was a typical manifestation of formalism, where various interests groups maintained their hegemony to preserve the *status quo* against the interests of the majority of the Greek population. As Mouzelis (1978) argues that Greek political and cultural life has been dominated by formalism, thereby sacrificing substantive change (which is the real interest of the underprivileged groups) to formal change (debates in metaphysical terms about the general notion of 'change'). In short, the establishment of the Greek NHS did not change the status quo and did not put at its centre changes to the inequities and inefficiency of health services in the pre-1983 era, though it served to maintain the hegemony of the medical profession.

An important institution imported from the British NHS was the fundamental notion of trust between the State and the main providers of health care services, the medical profession. According to Klein (1993), trust towards the providers was essential for the foundations of the British NHS. The Greek State also trusted the doctors who joined the GNHS in 1983, and granted them financial and career rewards, such as a doubling of salary, and the privilege to use public infrastructure and innovative medical equipment and technology that they did not have access to in the numerous private clinics in the pre-1983 era. However, the fact that the notion of trust was decisive in the success of the British NHS, did not mean that it would also have the same effect on the establishment of the Greek NHS. The introduction of trust between the State and the medical profession ignored the institutional context that dominated and still dominates State-citizens relationships in Greece, in which Greek citizens mistrust the State's effort to introduce new institutional settings, but at the same time demand that the State provides them with education, health care and employment, even if this means that the

majority of Greeks try to evade tax and thus not contribute towards the implementation of the policies of the State. These paradoxes lie in the fundamental fact that policy implementation is usually undermined by a number of interests which demand and obtain favouritism from the State. This way the rest of the Greek population argues that the policies are unfair and as a result they mistrust the State (Petmesidou 1991; Sotiropoulos 2004b).

#### **12.2.2.3.2 Complementary contributions from the Theory of Professions and Structural Interest Theory**

A complementary contribution to the explanation of the fate of the Greek health care system came from the Theory of Professions (which combined with empirical proof of Greek doctors' high status, power and dominance contributed to labelling the Greek doctors as key actors in the health care arena), and Structural Interest theoretical framework (which focused on the role of the Repressed Interests, Consumers/Patients, and provided a convincing explanation on why doctors in Greece remain unchallenged.

According to this thesis, the repressed and individualistic character of the Greek population, contributed to, first the unchallenged status of doctors and second to the establishment of personal relations between doctors and patients. This was especially the case in the countryside where the doctor, alongside the priest and the teacher formed the archetypical triad of the local bourgeoisie called 'notables'. The term 'notable' belongs to Theodore Zeldin (1973) who described the power and influence of notables in the French countryside from 1848 to 1945. According to Zeldin a well-known doctors would be the archetypical 'local notable' amongst other social which exercised informal power in French periphery (Worms 1966 cited in; Immergut 1992).

Similarly the Greek physicians are also known for their strong representation within the political system. The history of the 1992 reform in particular, revealed the importance of the strong representation of medical doctors in the Greek Parliament, forming a 'lobby', with 48/300 members. In the most recent election (2004) the same doctors' representation in Parliament appeared again, showing that, after lawyers, doctors form the second biggest and most powerful grouping in the Greek Parliament, with a continuous and powerful representation of their interests. These figures along with fact

that the medical schools in Greece or outside Greece, are very popular with Greek students, demonstrate the unchallenged, prestigious and attractive position of doctors in Greek society. The percentage of medical doctors in the Greek Parliament (14%) is remarkably high compared to the figures of other Western European or North American countries. In more detail, UK has only 6 medical doctor MPs (1%) (Cracknell 2005), Spain has 22 medical doctors in a total of 350 members of the Spanish Congress (6%) (Spanish Congress 2004), USA has 11 medical doctors, 9 of them in the House of Representatives and two in the Senate (2%) (Amer 2006), and Canada has four medical doctors in the House of Commons (1.3%), and two in the Senate (2%) (Parliament of Canada 2007).

#### **12.2.2.4 Conclusion**

The combination of both salient characteristics of the Greek case helped the medical profession enhance and even expand, to a greater degree than in the pre-1983 era, their power and influence within the NHS, by providing them with political and cultural authority. As a result, they also realized their dominance within the division of labour in the Greek health care arena. Since then, the perverse implementation of the institution of the Greek NHS, became an impediment for any future reform (path-dependence).

#### **12.3 Strengths and Weaknesses of the study**

This thesis is a monograph on the Greek health care system based on the description and analysis of the medical profession in a single setting, however it is also more than that since it is built upon three case histories of reforms during the evolution of the Greek health care system after 1974. In addition, it is the first in-depth account in the literature on the Greek health system that attempts to bring together information from archives, newspaper articles and official announcements of medical trade unions and medical societies including previously undisclosed information about the role of the medical profession.

This research also demonstrates a high success rate in approaching key informants for conducting the semi-structured interviews. As described in Chapters 8, 9 and 10, the

processes of health care reform in Greece were heavily dependent on the actions of individuals (politicians, bureaucrats, and powerful members of the medical profession) or specific collective forms of action, such as medical trade unions (EINAP and OENGE), and medical societies (ISA and PIS). Hence, a core tenet of the data collection strategy was to identify and interview key individuals who has proved them selves to be experts in the Greek health care system after 1974, and who had directly or indirectly been involved in the process of reforming the Greek health care system. With that in mind, a list was of drawn in the early stages of the thesis with the names, expertise and period of time they got involved with the Greek health care system. The list was enriched after the preliminary interviews were conducted with key individuals that key informants suggested (snow balling), and by the author's own personal knowledge of the Greek health care system and the people involved in it. A total of 37 interviews were undertaken. The success rate with approaching people for interview was very high at approximately 88%. In most cases where the request was declined an alternative perspective on particular events from another interviewee was possible, in order not to decrease the scope of the interview data generated.

The main phenomenon under research in this thesis has been the health system reforms. Clearly, this represents a challenging task for research regardless of the more specific interests that thesis may have. This extensive and complex phenomenon has been studied from a rather narrow empirical perspective. The selection of a single case study design naturally brings forth many limitations as far as the generalization of the results of the study is concerned. However, the narratives of the three period reforms provide the researcher with a unique opportunity to understand thoroughly the phenomenon of reform in general, and in the Greek institutional setting, and to test the existing theoretical frameworks. By understanding the particularities of a single case study (Greek health system), as a deviant case, we might also be able to learn something about the broader picture and the fact that health system reforms may differ from country to country.

Another limitation of this thesis could lie in the adopted perspective. The common feature of understanding health care reforms in general also includes the perspective of the consumers/patients. Instead, this thesis has focused mainly on the medical profession and mostly on the government. This is because of the 'repressed' character of the

structural interests of the consumers/patients in the Greek society. As mentioned in Chapter 11, the individualistic character upon which the Greek Welfare State was built, did not allow citizens to develop a universalistic identity. As a result, there is no formal expression of the people's view towards policy making and especially towards health policy making as an organized interest group. What is observed from Mossialos' work (1997) and according to well regarded daily newspaper articles is the dissatisfaction of the vast majority of the population with the level of quality of health services received by the NHS, but with no collective means of bringing about change.

Criticism can also be presented concerning the application of multiple theories on the Greek case. The theoretical base of this thesis can be described as being fragmented as it includes a variety of different perspectives. However, the purpose of adopting this kind of strategy in the present thesis has been to strengthen the analytical tools of the researcher. Thus, no single theory presented in this thesis is adequate for explaining and understanding the Greek health care system. As soon as the different theoretical frameworks were introduced from the literature review, their role at the later stage when they were applied and tested within the Greek case, proved that apart from indicating a dominant framework, i.e. Historical Institutionalism, the other two i.e. Theory of Professions and Structural Interest Theory, still had a contribution to make.

Table 12.2-Strengths and Weaknesses of this thesis	
1. In-Depth Analysis of the Greek Health System Reform phenomenon based on three case study narratives. 2. Combination of documentary and interview analysis 3. High success rate in approaching key-experts. 4. Thorough account of the medical profession's role in the Greek health reforms.	1. Single Case study/Monograph. 2. Focused mainly on the role for the medical profession and the governments. 3. Not a single theoretical framework used.



## 12.4 Path Dependency and Change within the Greek Health Care System

### 12.4.1 Current Debates in Institutionalism

During the 1970s and 1980s many institutionalist researchers were concerned to demonstrate how different institutional settings produced divergent policy outcomes, and how this is related to the different policy trajectories that countries followed (Berins-Collier and Collier 1991; Skopcol 1992). Others, like Pierson (1994, 2004) and Weir (1992b) argue that feedback mechanisms are responsible for the reproduction of various institutional and policy trajectories over time.

The theoretical debate about the importance of path-dependence has benefited from the theoretical insights of James Mahoney, who separates the process of institutional innovation from the process of institutional reproduction. Mahoney's view on institutional reproduction and innovation is based on the punctuated equilibrium model of policy change, in which fertile periods for change, are followed by long periods of institutional 'lock-ins' (Krasner 1984). As a result, the institution created is reproduced until it breaks down, influenced by an exogenous factor (a critical juncture or a window of opportunity). In other words critical junctures explain institutional innovation and feedback brings about institutional reproduction.

However, this deterministic approach to the genesis or break down of institutional settings provokes questions about the explanation for change when institutional settings do not break down or when exogenous factors, such as revolutions or wars, are not able to weaken strong and persistent institutional settings. The issue of change in the literature of institutionalism used to be neglected and institutional settings were perceived most of the times "*as the frozen residue of critical junctures or as sticky legacies of previous political battles*" (Thelen 2003:211).

Change is difficult to define, trace and explain, within Historical Institutionalism. Therefore new theoretical insights of Historical Institutionalists emphasize the need to expand or slightly alter Krasner's (1984) and Mahoney's (2003) argument that institutional reform is possible only through rare but rapid change alone, which is caused by exogenous crises. According to Streeck and Thelen (2005), exogenous change cannot explain the different policy paths that various nations have followed, and as a result their

interest has shifted from the influence of exogenous factors to endogenous factors responsible for incremental change. Recent literature has moved forward the debate on the reasons for persistence of institutional settings by focusing on the ‘increasing returns’ effects, which describe the dynamic processes behind the persistence of institutions for a long period of time (Streeck and Thelen 2005). But the contribution of increasing returns lies in the reproduction of the institutional settings and not on the way institutions may change or evolve. In addition to this, the occurrence of important transformations in various nations’ social policy, despite the persistence and resilience of pre-existing institutional arrangements, proves that exogenous factors do not exclusively shape macro welfare State or social policy change. Thus, researchers’ interests have recently been shifted to look at endogenous processes of change and in, particular, how, within a pre-existing institutional setting, small-scale and incremental change can occur. Streeck and Thelen (2005) argue that change of institutional arrangements does not necessarily come exogenously but can be endogenous, provoked by the institutional arrangements themselves. They suggest “*five broad modes of gradual but nevertheless transformative change. These are displacement, layering, drift, conversion and exhaustion*” (Streeck and Thelen 2005:19).

*“Displacement change happens as new models emerge and diffuse and eventually call into question existing, previously taken for granted organizational forms and practices”* (Streeck and Thelen, 2005:19). In particular, political science literature has shown that change through displacement comes from ‘shifts in the societal balance of power’ within the existing interests groups (Berins-Collier and Collier 1991).

The second mode of change is ‘Institutional Layering’. According to Thelen (2003:225) “*layering involves the partial renegotiation of some elements of a given set of institutions while leaving others in place*”. The Layering process of institutional change is demonstrated by Eric Schickler in his example of the United States Congress, where institutional change is achieved through a series of lock-in effects and innovation. In this case Schickler (2001) argues that institutional change occurred with the tensed layering of new arrangements on top of preexisting structures. This is to say that new institutional arrangements may be designed under new coalitions, but “*these coalitions may lack*

*support or the inclination to replace the preexisting institutions established to pursue other ends*”(Schickler 2001:15).

The third mode of change is ‘Drift’. According to the ‘Drift’ process, institutions do not stay entirely stable, and most importantly, they do not rely for stable reproduction on increasing or positive returns. From time to time, institutions need to be maintained in order to remain active. They need to be “*recalibrated and renegotiated in response to the political and economic environment in which they are embedded*” (Streeck and Thelen 2005:24). As Hacker puts it in his empirical work on United States Health Policy, institutions without this kind of tendering can erode or atrophy through drift (Hacker 2002).

Institutional ‘Conversion’, which occurs “*when existing institutions are redirected to new purposes, driving changes in the role they perform and/or the functions they serve*” (Thelen 2003:226) is the fourth method of transformation observed in existing institutional settings. ‘Conversion’ is a different mode of change from ‘Layering’ and ‘Drift’, as institutions are ‘not amended or allowed to decay’, on the contrary, institutions are redirected to new goals, functions or purposes (Streeck and Thelen 2005). The new goals, functions, or purposes may be dictated by new environmental challenges, and it is a way policymakers attempt to meet them. ‘Conversion’ can also occur through change in power relations, where actors who were not previously involved in the original design of the institutional setting, take over and redirect it to new ends. The conversion mode of change entails strong elements of lock-in and stability effects. However, there is a fundamental difference between the traditional ‘increasing returns’ and ‘conversion’ arguments. In ‘increasing returns’ scholars suggest that actors adapt their strategies to existing institutions, whereas, ‘conversion’ mode supporters stress the fact that existing institutional arrangements are adapted to serve the new goals or to fit the interests of new actors (Streeck and Thelen 2005). Although ‘conversion’ might appear to have much in common with the drift mode of change, there is a fundamental difference between the two of them. Although in the drift mode of change institutions “*may retain their formal integrity even as they start to lose their grip on social reality*”, the conversion process is strictly dominated by the fact that “*behaviors invoked or allowed under existing rules operate to undermine these*” (Streeck and Thelen 2005:29)

Finally, the last mode of transformative institutional change is 'Exhaustion'. This last mode of change differs from the previous models because Streeck and Thelen (2005) argue that it represents more or less a breakdown of preexisting institutional arrangements. However, one similarity with the previous models of change exists in the fact that the collapse of the pre-existing institutional setting is gradual and not abrupt (Streeck and Thelen 2005). The origin of 'exhaustion' might be the basic principle of Marxian theory, that "*social arrangements may set in motion dynamics that show the seeds of their own destruction*" (Streeck and Thelen 2005:29).

#### **12.4.2 Has the institutional setting of the Greek NHS changed endogenously?**

Although it is difficult to argue that the Greek health care system has not changed at all since 1983, the pattern of change is more about endogenous than exogenous change. However, endogenous change in the Greek health system represents the introduction of new laws on top of the fundamental 1397/1983 Law, and more importantly it does not mean that the new or the additional legislative items introduced in 1992 or in 2001 were automatically implemented. On the contrary, only minor changes which did not affect the power balance of the main actors of the health care arena have occurred, either because they became 'dead letters' or because they were curbed during the implementation process. According to Table 12.3 the only changes that have been implemented in the Greek health system are the decentralization of the system by establishing 17 RHSs, and the introduction of hospital managers. However, these changes had a limited effect on the overall health system because they were implemented with a profusion of managerial and administrative inconsistencies (decentralization). In fact, hospital managers had, and still have, restricted responsibilities due to the power of the medical profession inside public hospitals and the old style of party politics. In addition to this, neither measure could have been successful as other important parts of legislation, such as university and hospital doctors' labour relations, organization of primary health care, and establishing a unified health insurance fund (in 1983, 1992 and 2001), were never realized.

In conclusion, for over two decades no process of endogenous incremental change had truly transformative results in the Greek NHS. However, this does not mean that potential change in the system can only occur through exogenous factors. In fact, the population's dissatisfaction with the Greek NHS may signal the start of gradual processes

of change, leading to the transformation of the system endogenously or becoming a much wider exogenous force over time (if dissatisfaction reaches a sufficient level so as to be taken up by politicians who could put external pressure on the system). Early signs of the endogenous processes are the growing use of private sector health services, the empowerment of the population rights movement for better health services through the Greek Ombudsman, and the expansion of information technology. Thus, these elements of premature endogenous change may question the dominant GNHS institution (*displacement*); set in motion NHS-altering directions (for example faster growth of the private sector can effect profound change – *layering*); recalibrate or renegotiate GNHS to a new economic and societal environment (a new economic environment may be the result of the stalemate of health care expenditure from the public purse or the dramatic increase of the private health care expenditure, while a new societal environment may be the result of the consumers' empowerment through choice and information – *drift*). In addition, change can also happen when the existing institutional structures of the Greek NHS are adapted to serve new goals dictated by new actors. This process reflects the *conversion* of the existing GNHS institutional structures to the interests of the empowered and informed consumers/patients.

Finally, a gradual institutional break-down in the GNHS may occur through its own *exhaustion*. *Exhaustion* will occur only when the political (governments) and guild (the medical profession) interests which the GNHS served for almost 25 years are challenged by better informed and more pro-choice consumers, and the increased competition between the rising number of doctors (hospital doctors and private doctors already forcefully compete for patients-with the latter accusing NHS doctors of illegal private practicing). As a result, the GNHS will no longer serve as an increasing returns mechanism and will no longer have reason to exist.

**Table 12.3- Extent of planned versus actual change produced by Greek Health Care Reforms, 1983-2001**

	<i>Law/Plan Provisions</i>	<i>What happened?</i>
<b>1980's</b>	<b>1397/1983: Avgerinos Plan</b>	
	<ul style="list-style-type: none"> <li>-Universal Coverage</li> <li>-Equity in delivering and financing health services</li> <li>-Organization of Primary Health Care</li> <li>-Unified Health Insurance Fund</li> <li>-Hospital Doctors full-time and exclusive practice</li> <li>-University Doctor choosing private practice or NHS exclusively</li> <li>-banning of the opening new private clinics</li> <li>-Decentralization of the System under Regional Health Systems</li> </ul>	<ul style="list-style-type: none"> <li>-95% population, only in theory (Sissouras, Karokis et al. 1999)</li> <li>-regressive financing and unequal distribution of the quality and quantity of health services</li> <li>-180 rural health centres, no urban health centres, focus on outpatient hospital health services</li> <li>-Never implemented, distinction between 'noble' and 'other' health insurance funds</li> <li>-Only on paper</li> <li>-article excluded, Ministry of Education responsible for regulating academics' terms of service</li> <li>-ban implemented, and as a result lots of small clinics closed down, but a few powerful survived and expanded</li> <li>-not implemented</li> </ul>
<b>1990's</b>	<b>2071/1992: Sourlas Plan</b>	
	<ul style="list-style-type: none"> <li>-State acts as a guarantor of the citizen's right to seek care, in accordance with his/her freedom of choice</li> <li>-hospital doctors in the NHS may practise full-time or part-time</li> <li>-university doctors had 1 year to decide whether to practise privately or in the NHS exclusively</li> <li>-restrictions regarding private clinics, etc. withdrawn</li> </ul>	<ul style="list-style-type: none"> <li>-only in theory</li> <li>-only 492/8,300 took the opportunity</li> <li>-not implemented</li> <li>-numerous private diagnostic centres established, in 1996 they were 403 in total, and 67% in Athens (Fyntanidou 2000a)</li> </ul>
	<b>2519/1997: Gitonas Plan</b>	
	<ul style="list-style-type: none"> <li>-managers in NHS hospitals</li> <li>-non permanent posts for new NHS staff</li> <li>-better career prospects within NHS, better salaries for hospital doctors, abolition of 'nominal overtime' for NHS doctors</li> <li>-urban health centres</li> <li>-family doctor service</li> <li>-global budgeting and Greek version of hospital payment by outputs</li> </ul>	<ul style="list-style-type: none"> <li>-not implemented</li> <li>-not implemented</li> <li>-better prospects for junior doctors to become seniors, increase in their basic salary, 'nominal overtime' was not abolished</li> <li>-not implemented</li> <li>-not implemented</li> <li>-not implemented</li> </ul>
<b>2000's</b>	<b>Papadopoulos' 'Health for the Citizen Plan' and Law 2889/2001</b>	
	<ul style="list-style-type: none"> <li>-decentralization of the System by establishing 17 RHS</li> <li>-introduction of hospital managers</li> <li>-afternoon private practices</li> <li>-university doctors have to choose between private practice and exclusive NHS practice</li> <li>-the institution of 'clinical professor'</li> <li>-appraisal of hospital doctors every 5 years</li> <li>-organisation of PHC<sup>56</sup></li> <li>-establishment of a Unified Health Insurance Fund</li> </ul>	<ul style="list-style-type: none"> <li>-implemented with lots of managerial and administrative inconsistencies</li> <li>-implemented, but with 'restricted' responsibilities, NHS hospitals remain medically dominated</li> <li>-initially implemented, but not very popular or successful</li> <li>-never implemented in reality</li> <li>-not implemented</li> <li>-not really implemented</li> <li>-not implemented</li> <li>-not implemented</li> </ul>

## 12.5 Conclusion

This thesis has examined the Greek health care system in relation to three distinct health care reforms (1983, 1992 and 2001). It has exposed the dominant role of the medical profession alongside the role of other actors such the State, the health insurance funds and the lack of consumers/patients. It has traced the origins of the power and influence of the medical profession in the salient traits of Greek society and the way the State was built.

The three theoretical frameworks used contributed, each in its own way, to the descriptive and explanatory analysis of the evolution of the Greek health system after the restoration of democracy. In view of the history presented in Chapters 8, 9 and 10, it appears that sociological theories of the professions and structural interest theories are unlikely to offer a complete explanation of the particularities of Greek health care reform.

The theory of the professions can explain the professional dominance of doctors at the clinical and related levels. It is also useful in explaining the success of some of the profession's tactics in resisting reform (e.g. their status and control over esoteric knowledge enabled them to claim successfully that non-medical managers could not and should not have any jurisdiction over how they worked). The theory of professions also stressed the important role of the medical profession as an important political elite, in terms of the status and class of the profession, and as an important occupation within the health care arena. Within this context, the medical profession has traditionally exercised significant power in relation to health policy because of its special knowledge and authority, form of organization, and its legally granted occupational monopoly, and its position at the top of the occupational hierarchy in health. In addition to this, several scholars have argued that its cultural authority, was and still is, powerful regarding the ability of the profession to define issues as technical and scientific - i.e. what constitutes health and illness and who is in need of health services - and, therefore, outside the purview of political decision-making (Illich 1975; Maier 1987; Starr and Immergut 1987).

However, in general, comparative studies of health care reform (Immergut 1992) show different trajectories in different countries despite the fact that in each the medical profession exhibits similar characteristics of occupational monopoly and clinical

autonomy. Thus, in order to explain the different impact of medical associations on policy decisions and systems, we need to look beyond the professional dominance of doctors over their working conditions, clinical autonomy, and division of labour to focus on the role of institutions and how these influence the ability of major stakeholders to shape any proposed changes in health care policy (Immergut 1991).

In addition to this, health care reform in Greece appears to deviate from what one might expect in terms of structural interest theory. Alford's theory is that contemporary health policy is shaped by 'corporate rationalizers' challenging the dominant structural interests of doctors. The path of the three reforms in Greece suggests that corporate rationalizers have not developed or are not represented, at least to the same level as in U.S.A. or Western Europe, due to the weak State and non-existent bureaucratic elite. One thing that does match the Greek case is the 'repressed' position of the consumers of health services. Although the majority of the population has expressed its dissatisfaction with the current health care arrangements, it has not developed a formal way of demanding change that favours its interests. Some Greek scholars have attributed this to the absence of a universalistic culture and collective forms of representation. Alford's theory is attractively simple, and as such rather persuasive. However, it is too deterministic and it fails to take into account the role and the impact of individual and collective actors, their strategies and dominant discourse used, on the implementation of a health system reform.

Instead, the thematic and explanatory analysis suggested that Historical Institutionalism provided a better basis than the other theories for an overall explanation of the 1983-2001 reforms. Greece came out of an authoritarian period and entered the 1980s with inherited characteristics of a highly politicised (dual party system), centralized and fragmented Welfare State, where reciprocal favours and mutual obligations between patron (the State or the two major political parties) and client (politically opportunist social groups such as the trade unions of the 'noble' insurance funds and key professional representative organisations, such as the medical profession) were embedded, and where the notion of individualism dominated policy making at the expense of universalism. It is within this broader context that decisions about the Greek health care system were and are made.



Institutional theory suggests that reforms can only break out of such 'path dependency' (Wilsford 1994) when a 'window of opportunity' or a 'critical juncture' occurs. A seemingly favourable, but incomplete set of circumstances may explain PASOK's decision to introduce a NHS in 1983. Circumstances such as the consolidation of democracy, the worldwide economic instability (resulting mainly from the two oil shocks), the newly elected socialist party with an outright majority, entry into the European Community and the broadly felt public need to correct the discrepancies of the previous system, seemed to offer the opportunity for major structural and institutional change in the health care arena (Immergut 1992; Tuohy 1999; Guillen 2002). However, in order to bring about major change, there needs to be a high level of consensus or at least the ability to compromise among the groups/interests whose support is necessary to implement reform and who potentially stand to lose. Unfortunately, no consensus was ever achieved in 1983 and there has been none since in favour of significant health sector reform. In addition to this, external pressures for institutional change, such as EU directives, have tended to be represented by opponents as policies of cost containment which are generally unpopular. Since 1974, Greek Welfare State reform has been influenced by the complex interplay between internal politics and EU influences. The EU's impact has been felt in specific areas of public policy such as employment, vocational training and regional development. In other important policy fields such as education, health and old age pensions, institutional settings have enabled the main players self-interestedly to resist the impact of EU directives (Sotiropoulos 2004a).

The institutional context has determined to a large extent the fate of the three major reforms since 1983 by providing a secure basis for the stiff opposition of the major interest groups, such as the medical profession, trade unions and insurance funds. Any proposals that were perceived to harm vested interests of the medical profession or the insurance funds were only partly implemented or failed to fulfil their main objectives. Representatives of these interest groups managed in all the reform periods to use the institutional context to protect their positions and in some cases to enhance their privileges. Thus during the 1980s, the establishment of the GNHS far from marginalising the medical profession politically created fertile ground for hospital doctors and their representatives (EINAP), who had close links with ministers and the governing party, to

negotiate favourable terms for their participation in the system. They threatened that unless their financial and other demands were satisfied, they would refuse to participate in the new system. During the 1990s, hospital doctors were successfully able to reject the Conservatives' requirement that they choose between full-time and part-time practice in the GNHS, thereby maintaining their privileged position and their ability to continue to receive informal payments. They did this by lobbying the relevant Parliamentary Committee and influenced its report on informal payments in favour of their interests. They also managed to preempt any public debate developing on the proposals of the international expert committee designed to remedy the flaws of the GNHS.

At other junctures, they focused their efforts on being exempted from reforms (e.g. by obtaining presidential decrees excluding them from the scope of changes) or by turning the law into a 'dead letter' at the implementation stage. Typical examples of the latter were the failure to establish a unified insurance fund and the inability to prevent academic doctors continuing private practice, which in 2001 became a 'winner takes all' battle between the university doctors and Minister Papadopoulos. In this way, the status quo was largely preserved, and by no means in the interest of citizens.

Gambetta (1988) and Pelagidis (2005) take the argument of path dependency one step further and argue that these groups of people belong to the category of 'rent seekers', and are against of any kind of change in the way institutions are embedded in Greek society and are able to be exploited by themselves. In addition to this, it is within their scope to oppose any notions of trust, cooperation, universalism or meritocracy that at various times have been promoted by either academics influenced by Western European political culture or directives coming for the European Union.

The plethora of reform plans and legislation on the Greek NHS versus little or no change that has occurred in the Greek health system (Table 12.3), means that the broader institutional arrangements of the Greek State and society have created an 'unhealthy' or 'path-dependent' public policy-making. Although the 1980s political scene and dynamics may have been characterized as a unique 'window of opportunity' for change in the Greek health care system, instead any notion of change in favor of the majority of the population was neutralized at the implementation stage. This is indicative of the influence

that broader institutional patterns of the evolution of the Greek Welfare State have had since the establishment of the Greek State in the early 19<sup>th</sup> century (Thelen 2003).

According to advocates of the path dependency explanatory framework applied in the Greek case, there are several ways to accomplish an institutional change and avoid path dependency. *Utilitarian* perspective scholars argue that change on the dominant institutional setting will occur when the actors responsible for the reproduction of the current institutions, no longer wish to reproduce it. This may happen when competition comes high in the agenda and pressures are made to the medical profession. However, the competition patterns in the Greek case deviate from the classic definition, which makes it more possible that the overproduction of doctors will strengthen more their negotiation patterns towards the satisfaction of their interests in terms of salaries working relations and general influence. It is not a coincidence, that although Greece has one of the biggest ratios of doctors per citizens, doctors still determine their working patterns and reimbursement. The explanation of this phenomenon may lie on their high status and influence on governments, as the result of the important voting pool that the influence of voting patterns of their clients.

Thus, competition does not appear to be the optimal choice of dealing with path dependency in the health care sector institutional reforms. That is why suggestions from the second explanatory of path dependency might offer a new perspective in dealing with increasing returns. The *power* explanatory framework suggests, that one solution to the problem could be the empowerment of a subordinate group that 'suffers' under the exercised power and influence of dominant group, which in the Greek case it is the Greek medical profession, and more specifically the university doctors. A crude adaptation of the *power* explanatory framework would mean that the empowerment of consumers, for example patients, could stop the reproduction of the institutional settings in which the medical profession-the university doctors rely their power and influence. Although, as previously mentioned Greek consumers groups practically do not exist, as the Greek individualism overrules any kind of notion of universalism.

Finally adopting Prof. Spraos's suggestion (Spraos 1997)<sup>57</sup>, a reduction in the cash flows from the EU would provoke a serious economic crisis and could pressure actors in the Greek public sector to accept reform, more specifically in the Greek Health

Care System. The Professor's suggestions are under the functional explanatory framework, which underlines the reproduction of the current institutional settings because it serves a function for the overall system, and the mechanism of change lies in an exogenous shock that transforms the system's needs.

This thesis argues that a possible change is more likely to occur by changing the *power or legitimation* framework. The subordinate and repressed majority of the Greek population could realize its interests and challenge either the power of the medical profession or their legitimate role within the Greek NHS. Technology in this case could play an important role, (e.g. the Internet), and could be used to awake consciousness and raise awareness. A recent incident has mobilized an important part of the Greek population against the role of the medical profession and the State in the preservation of the imperfections of the current NHS. The protagonist was a young woman who eventually died after a long term fight with cancer. Her case had an enormous appeal to mass media and internet subscribers. She documented through her blog<sup>58</sup> her everyday relationships, treatment and interaction with the main actors (medical profession and Ministry of Health bureaucratic agencies) of the system. She argued in favour of patients' rights and against the perverse and immoral but 'legitimate' moral code that had guided doctors in her case (informal payments, malpractice and authoritarianism), and blamed the State for its apathy towards patients' rights to decent health services and towards the profession's dominance within the system.

Although this blog is not indicative of general attitudes in Greek society, -i.e. challenging the medical profession or the State's behavior in accommodating the profession's interests, - it is an important start (or as Streeck and Thelen (2005) argue this could be an early sign of incremental change) which spread the message that it is time for Greek people to realize that their individualism has provided a safe and unchallenged environment for an oligarchy which preys on the interests of the majority of the society. This kind of analysis could eventually help in realizing the importance of changing the status quo, and could contribute to a re-evaluation of how the principles, aims and objectives of the Greek NHS are to be realized, which could lead gradually lead its transformation.

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# APPENDIX 1

## Understanding Public Policy Context

1. Situational factors - impermanent or idiosyncratic events
  - A. Violent events, e.g. wars and other catastrophes
  - B. Economic cycles (depression, recession and inflation)
  - C. Natural disasters
  - D. Political events and conditions, e.g.
    - Political status change, e.g. achieving independence, to join or leave an international association
    - Political regime change, e.g., revolution, election of a radical party etc.
    - Change of government, e.g. electoral shift from conservative to socialist government
    - Political reform, e.g. extending suffrage
    - Political corruption or scandal
    - Change of strong political leadership
  - E. Technological change
  - F. Policy agenda: competition among policy issues and their proponents for the time, attention, and resources available
2. Structural factors are relatively stable societal factors, and include more permanent features of a system, e.g. economic bases and political institutions
  - A. Political structure
    - Type of political regime, e.g. socialist or non-socialist, competitive or non-competitive party system
    - Type of government, e.g. federal or unitary system
    - Form of government, e.g. parliamentary, presidential, non-democratic
    - Group activity, number, e.g. strength and legitimacy of interest groups
    - Political process, e.g. legislative-executive relations, budgetary process, nature of bureaucracy
    - Policy constraints, e.g. incrementalism, prior policy commitments
  - B. Economical structure
    - Type of economic system, e.g. free market, planned or mixed economy
    - Economic base, e.g. industrial etc.
    - National wealth and income, e.g. size of GNP, distribution of wealth
    - Complexity of economic organisation, modern or traditional economy
  - C. Social, demographic, and ecological structure
    - Population structure, e.g. age structure, geographical distribution, migration rates, level of education
    - Degree of urbanisation
    - Natural resources
    - Geographic location
3. Cultural factors is concerning political values and culture
  - A. Political culture
    - National heritage
    - Political norms and values: concerning the role of the individual and the State
    - Formal political ideology, e.g. democratic
  - B. General culture
    - Traditional values, e.g. in relation to social institutions and arrangements such as marriage and family
    - Religion
4. Environmental factors - factors that exist outside the boundaries of a political system but at the same

times influence the system.

A. International political environment

B. Policy diffusion, e.g. emulation and borrowing of policy ideas and solutions from other nations.

C. International agreements, obligations and pressures

World public opinion

International affiliations

Participation in international conferences and agreements

International financial obligations

D. International private co-operations

Taken from Howard M. Leichter, p. 41 - 42

## APPENDIX 2

### Interview Topic Guide

**Interviewee's Name:**

**Position Held:**

**Other Details (date, place etc.):**

#### **Topics for Discussion**

1. *How you are related to the Greek health care sector?*
2. *An academic argued that during the 1974 - 1981 era, the sentence that epitomized the attitude of the medical profession towards the Greek health system was, "whatever is good for doctors, is also good for the public health of the Greek citizens". Can you please comment on this phrase? Do you agree/disagree?*
3. *People coming from the medical profession trade unionism argued that "the medical profession was empowered in early '80s because political parties had not yet formed a specific health policy. As a result, doctors' trade unions took the initiative to cover the gap and mixed politics with ideology. A mixture that resulted in a two way problematic relationship." Do you agree with that?*

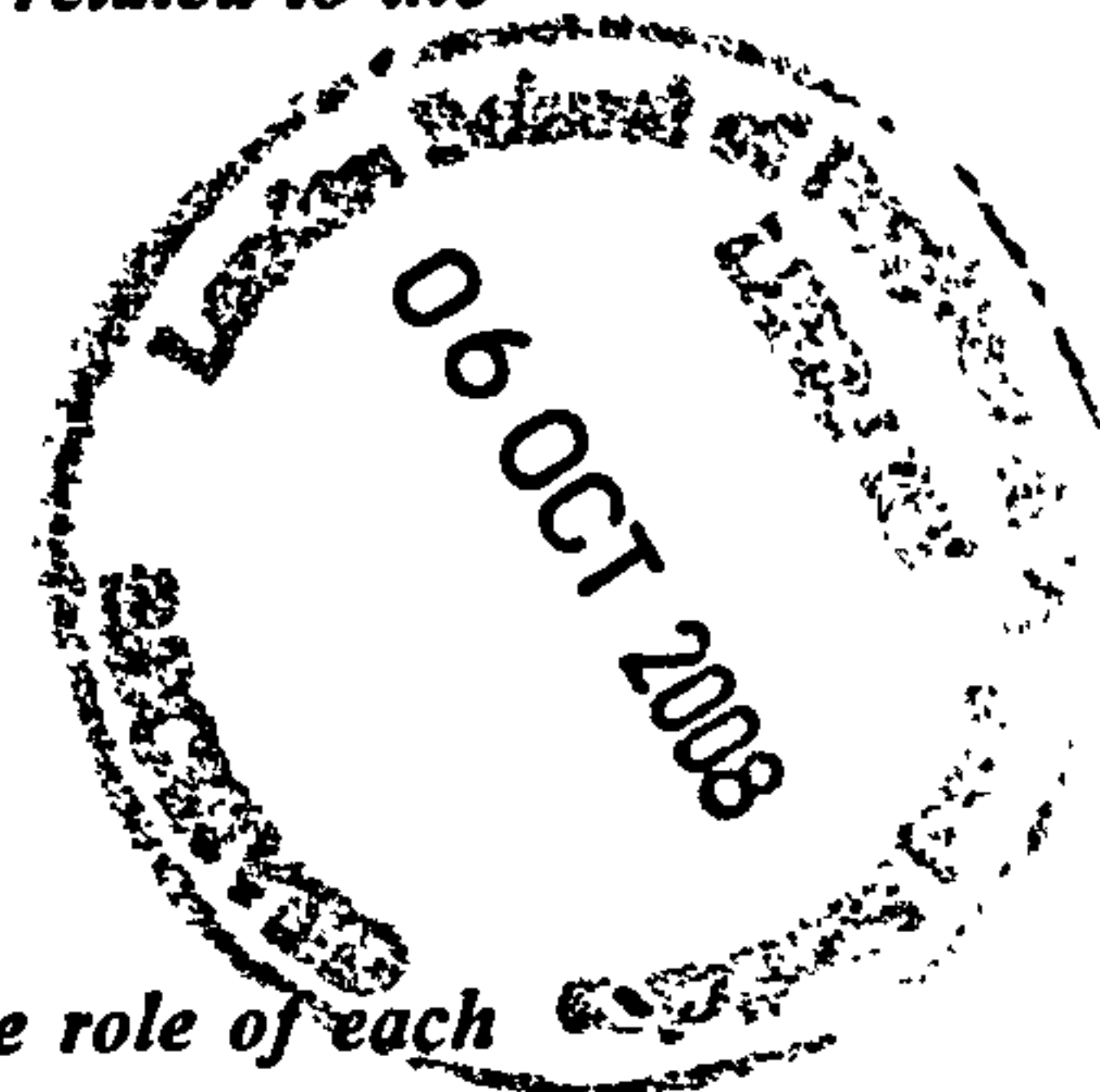
#### Health Care Arena During the 80's

4. *What was the need for the establishment of a National Health System? Who wanted the ESY (ΕΣΥ)?*
5. *Can you recognise any vested interests in the 1983 reform? If yes what was the role of each group before the ESY statute and during its implementation? (For example the president of LAIKO Hospital of Athens argued in 1988, that "ESY reform has failed because there a lot of groups inside and outside of the government that wanted it to fail, or at least they did not want it to progress.")*
6. *What was the role of party politics within the medical profession? (in order to examine Venieris' separation of doctors to Socialists and Conservatives) Where there powerful medical trade unions at that time? I have the impression that even if the medical trade unions are surpassed by political parties, in the end they tend to support their guild interests.*
7. *What was the role of the medical trade unions in the 1983 reform?*

8. *What was the role of the health insurance funds in the 1983 reform? Is it close related to the establishment of primary health care?*

9. *Academic Doctors and their exemption from the 1397/1983 Law.*

10. *Was the reform financially feasible and well planned?*



#### The 1990's Reforms

11. *Can you recognise any vested interests in the 1992 reform? If yes what was the role of each group before the 2071/1992 Statute and during its implementation?*

12. *What was the role of party politics within the medical profession in 1992? (with reference to: 1) the initiatives that the government took in order to "reward" a number of conservative doctors that had chosen not to join the NHS in 1983, 2) the report prepared on informal payments (received by hospital doctors) by medical trade unions and guilds with the collaboration of doctor's Parliamentary lobby, and 3) the exclusion of military hospital doctors from the reform.*

13. *The role of the medical trade unions in 1992?*

14. *Health Insurance funds*

15. *Academic doctors (discussion about the 3 member directorate of Athens Medical School Academics and their role on excluding academics from the reform)*

16. *Was the reform financially feasible and well planned?*

#### The 2001 Reform from Papadopoulos

17. *Can you recognise any vested interests in the 2001 reform? If yes what was the role of each group before the "Health For the Citizen" Reform Plan, during its implementation.*

18. *Hospital Doctors - Comments on the following issues: 1) afternoon surgeries inside public hospitals, 2) permanent tenure of the hospital doctors, 3) every 5 year appraisal, 4) ability of the RHA to transfer the doctor according to the needs of the region.*

19. *IKA doctors - What was their role towards the establishment or not of primary health care. Why Greece has not yet established primary health care?*

20. *Academic doctors and their personal debate with Minister Papadopoulos (with the reference of the incident in Thessaloniki, where university doctors agreed that they should all sign a "protocol of honour" that would bind all university doctors to continue their abstention from their work. A journalist argued that the government serves the interests of the private hospital sector, as with their law a lot of the finest university doctors would opt out NHS and work in private)*

21. *Official reaction of medical trade unions and health insurance funds.*

22. *Was the reform financially feasible and well planned?*

#### Provocative Statements For Further Discussion

-Overall the Greek society gives the impression that it was founded and developed, and continues to develop on the existence and ruling of specific privileged professional or guild groups.

-As a result, a possible reform is doomed to fail, especially when this reform is about the puzzled and dynamic sector of health care, where various sub-guilds of the medical profession are not willing to lose any of their privileges. On way of getting out of this trap is granting some kind of privileges to the most powerful guild and have its members support the reform.

- Overall, Greece had around 118 Ministers of Health in a period of 80 years (1920-2000), of whom only 28 survived more than 1 year.