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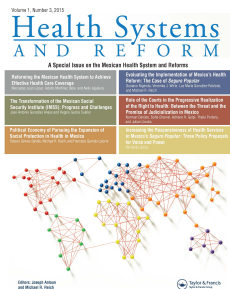
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Explaining the persistent dominance of the Greek medical profession across successive health care system reforms from 1983 to the present

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Abstract

The Greek medical profession played an important role at the start of the Greek NHS (National Health System) in 1983 and became intrinsic to its later development. In particular, junior hospital doctors firmly established their position and rights as a result of the new NHS. Using archival sources and interviews with elite participants, this article investigates the specific patterns of power and influence that Greek NHS doctors have exerted from the establishment of the Greek NHS through the latest major attempt at reform in 2001 to the present. Hospital doctors, in particular, have been able consistently to resist any health care system reforms that might affect their dominant position. Their unchallenged position in the system derives from both the particularities of the Greek state and society (in particular, the former's founding institutional arrangements and the latter's clientelistic social relations), and the key role that junior doctors played in the early stages of the Greek NHS. As a result, the system is highly 'path dependent' in that the initial implementation of the NHS during the 1980s ensured that subsequent reforms consistently favoured medical self-interest. While challenges to the unaccountable power of the medical profession have emerged in Greece following the financial

crisis of 2009, including the beginnings of a popular critique of the medical profession, it is too soon to tell whether these will succeed in bringing about significant change.

Keywords: Greek NHS Doctors, Medical Profession, Trade Unionism, Health Politics, Power and Influence

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Introduction

Greece has embarked upon three major health care system reforms since the restoration of democracy in 1974: in 1983–1986¹, 1992-1994² and 2001³. In all three cases, there has been a large gap between the goals of the reforms and their implementation in practice.

In 1983, key provisions of the socialist PASOK (Pan-Hellenic Socialist Movement) government's reforms under Health Minister Paraskevas Avgerinos (i.e. setting up a system of primary health care, establishing a unified health insurance fund, hospital doctors' full-time and exclusive practice in the public system, the requirement for university doctors to choose either private practice or National Health System (NHS) (public) practice and decentralization through regional health systems) failed to be implemented.

In 1992, the Conservatives, under Health Minister Georgios Sourlas, focused on individual responsibility for health care, a shift from public to private provision and from public to private finance of health care. Elements in the Conservatives' plan were dedicated once again to reforming labour relations with the medical profession, such as introducing non-permanent tenure and part-time posts for public hospital doctors, and requiring university doctors to choose between university employment and full-time work for the Greek NHS. In addition, the Government attempted to tackle the issue of informal payments from patients to doctors, especially within the public hospital sector. The majority of the reforms, especially those affecting doctors' labour relations, were never realized in the face of strong public disapproval of the changes and doctors' unwillingness to comply with their new working conditions.

PASOK's 2001 reform plan, under Health Minister Alekos Papadopoulos, established 17 regional health authorities to enable redistribution of resources to under-served areas. However,

without the unification of the health insurance funds, the establishment of a primary health care system and the removal of traditional clientelistic party politics, this decentralization of the Greek NHS could not be implemented. As far as doctors' labour relations were concerned, Minister Papadopoulos attempted to tackle once and for all the lack of medical accountability and related medical dominance, but became embroiled in a fierce clash with the hospital doctors, especially the university doctors over reducing or abolishing private practice, which ended with his forced resignation and replacement by a more amenable minister who reversed most of the reforms in medical labour relations.

The failure of all three sets of reforms indicates that the Greek medical profession was able to resist state influence over matters such as the number and distribution of medical staff in the NHS across the country, and methods of reimbursement and accountability, and highlights their power. Hence, today there are relatively large numbers of physicians per capita in Greece, maldistributed geographically (see Tables 1 and 2)⁴. Physicians continue to receive informal payments and are not subject to any kind of effective external control over the services they deliver. The combination of salary in a budget-limited public system with extensive private fee-for-service opportunities and lack of oversight over their working hours within the NHS, encourages doctors to minimize their effort in the public sector and maximize their time in the private sector contrary to the goals of the public system. The continuing large numbers of doctors, on the one hand, and increasingly restricted NHS resources, on the other, also explain why it has been so difficult to find a method and level of public reimbursement to meet doctors' expectations. This, in turn, has perpetuated and encouraged the receipt of informal payments. Informal payments reflect the inability of the Greek state to establish comprehensive coverage of

the population, the fragmented way health insurance coverage has developed (favouring privileged groups, such as the liberal professions and civil servants, which, in turn, reflects the unequal distribution of power within Greek society), the desire of doctors for supplementary income, and patients' willingness to give doctors informal payments in the expectation that this will ensure that doctors provide them with good treatment. This harms poorer public patients' access to public services, in particular, since they have to pay out-of-pocket for care that should be free out of their limited incomes. The public is generally dissatisfied with the health care system⁴, dissatisfaction which may explain successive governments' efforts to reform the system and their ensuing clashes with various segments of the medical profession⁵.

Though there is already some literature on the Greek medical profession and successive Greek NHS reforms⁶⁻⁸, it dwells on the detail of reform legislation and is reliant on secondary sources. In particular, little attention has been given to explaining precisely how the medical profession has been able to block or limit each set of reforms when these threatened to weaken its dominance and privileges.

By contrast, the current analysis uses extensive primary data, informed by insights from structural interest theory (in which the health care arena and its dynamics are defined by conflicts between the three fundamental-structural interests of the medical profession, managers and the community as -patients)⁹, the sociology of the professions (according to which once the medical profession has established its professional autonomy, it is then uniquely well positioned as a political lobby group to protect its position from challenge)¹⁰ and historical institutionalism (which explains 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) are likely systematically to favor some interests and disadvantage others)¹¹ critically to explain the largely unchallenged position of hospital doctors, in particular, in the NHS.

Methods

This qualitative research uses two primary data sources: analysis of Greek documents related to health care system reforms; and elite interviews with reform participants. Documentary analysis included government documents, parliamentary reports, position papers of medical societies and trade unions, and publications of other interest groups in health care, together with contemporary accounts in newspapers and periodicals. Semi-structured interviews were undertaken to tease out the role and influence of different interest groups on the origins and implementation of the reforms. The interviewees were identified initially from documents and previous accounts of the three major health care reforms, supplemented by those whose names were mentioned in interviews. This identified the main interest groups involved (i.e. academics/health policy experts, ministers of health or interested politicians, health bureaucrats, trade unionists, associations of university and other doctors, and journalists), their interests (i.e. goals, motives, strategies), and their formal and informal alliances¹². The interviewees were mainly former health ministers, former presidents of medical associations and MPs. Interviews were undertaken face-to-face, using a checklist of questions which was adjusted according to the role of each informant. Thirty-seven interviews (12 for the 1983 reform, 11 for the 1992 reform and 14 for the 2001 reform) were digitally recorded and transcribed. Interviews lasted between half an hour, and one and half hours. Interviews took place in informants' offices, homes, or wherever they felt comfortable to speak.

All the interviewees gave informed, written consent to participate in the research. Some interviewees were willing to be identified though all were offered anonymity. Interviewees are described only in terms of their broad organisational affiliation to help reader comprehension. . Whenever it was requested, a copy of the transcribed interview was provided allowing the interviewee to correct any potential misunderstanding of what they had intended to say¹³. Interviews were analysed thematically and quotations are used to encapsulate important themes. These included the roles of collaborating medical representative bodies, of clientelistic relationships, and of legislative or electoral influence in preserving access to informal payments and resistance to external appraisals, that persisted throughout the period from 1983 to 2001. Each key theme (e.g. collaborative medical bodies such as EINAP, ISA, PIS) was then displayed or charted in its own matrix, where every respondent was allocated a row and each column denoted a separate subtopic, such as, their power and influence within the medical profession, their role in each health care reform, their political affiliations, their tactics towards the planning and the implementation of the reforms, and their alliances or their rivalries. The sources of data were used iteratively during the analysis, for example, moving backwards and forwards between the documents and interviews without assuming that either source should be given greater weight but that taken together they could provide a fuller account than a single source. The following sections are organised around the aforementioned themes. The protocol and related documentation were approved by the Research Ethics Committee of the London School of Hygiene and Tropical Medicine (Application Number: 2079, Approval Date: 5th January 2005).

Results

1980s: the early claims of hospital doctors become embedded in the newly established Greek NHS

From the late 1970s to the late 1980s, medical trade unionism was synonymous with EINAP (Athens – Piraeus Hospital Doctors’ Trade Union), established in 1976. During the late 1970s, EINAP rapidly became a very powerful trade union representing junior doctors (hospital doctors in specialist training) whose interests were suppressed by dominant senior doctors (the hospital specialists or ‘consultants’). Junior doctors could become seniors after they had finished their specialty training only if a relevant post in a hospital was created or became available following a decision by the head consultant of a hospital specialty or the management committee of a hospital. Thus, junior doctors were heavily dependent for their future careers on their relationships with their superiors and with the administration of the hospital.

Senior and junior doctors had rival aspirations for the new Greek NHS. The senior hospital doctors wanted to protect and expand their interests by maintaining their right to pursue parallel public and private practice. Junior doctors, who were not allowed to practise privately and were poorly paid without a secure career path, saw the implementation of the NHS as a unique opportunity to avoid the authoritarian control of senior doctors, achieve more secure careers and obtain similarly generous salaries that far exceeded those of ordinary public servants (eventually, they obtained salaries roughly two and a half times greater). The senior doctors wanted to control the new system introduced by the PASOK government, and were against being forced to practise full-time and exclusively in the public hospitals, arguing that this was Marxist totalitarianism contrary to their human rights. For example, Dr. Halazonitis, former president of ISA (Athens Medical Society) (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 financially disadvantaged¹⁴.

Although senior and junior doctors had different aspirations for the new system, they appeared to be united in demanding a more organized system. However, even if the majority of the medical profession (professional societies and trade unions) was in favour of a NHS, in principle, it did not support the specific proposals and did not trust the government. A senior official of ISA (representing over half of the Greek medical profession) vividly described in his interview junior doctors' views at the time: *"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 its needs"*. Another of his colleagues summarized the medical profession's position at the time in one sentence, *"Everything that it is good for doctors is good for the public health and for the Greek people"*.

Behind the profession's support for further improvement of the health care system in the public interest, there lay an agenda focused on advancing the profession's own interests in terms of wages, working conditions and training¹⁵.

During the parliamentary debate on the Greek NHS Bill in 1983, the political opposition was strengthened by the position adopted by the medical associations, which had argued that the transformation of doctors into employees with permanent tenure would create a medical proletariat¹⁶. Unions of specialists and senior doctors affiliated to the Conservative Party-New Democracy strongly criticized *"the way the government promoted one part of the medical profession [i.e. junior doctors], in order to secure its support during the implementation of the NHS"*.¹⁷ The Pan-Hellenic Union of Specialists argued that doctors would have to practise under

a ‘police state’, and that the state was planning to violate doctors’ professional autonomy¹⁸.

Specialists characterized the Bill as “*bossy, tough, inflexible and inapplicable to Greek reality*”.

¹⁷ Former Conservative Minister of Health, Spyridon Doxiadis, argued that the Bill transformed doctors into “*a bunch of checkers that are ruled by the State and possibly by political parties*”.¹⁹

EINAP’s representatives, however, supported the idea of permanent tenure for hospital doctors, but opposed the Bill for different reasons, arguing that the government had manipulated EINAP to isolate, divide and weaken the medical profession. ISA and non-hospital doctors were also concerned about the same issues²⁰.

Nonetheless, the Greek NHS Bill became Law 1397/1983 in September 1983, but there were signs from a very early stage of sabotage by the hospital doctors, as soon as the Minister tried to implement the legislation decentralizing the system and requiring doctors to work in under-doctored regions. To this end, Health Minister Avgerinos attempted to establish so-called ‘institutional hospital doctor posts’. In response, junior and senior doctors went on strike with the support of EINAP, despite the fact that the representatives of EINAP were overall politically aligned with the Socialists, supported Avgerinos, and blamed the Conservatives and the representatives of the Greek Left for trying to undermine the NHS Law for contrasting reasons. On 17th January 1984, Avgerinos resigned, accusing hospital doctors of burying the recent reforms and saying that the strike was illegal, prompting the Administrative Hospital Councils to prosecute the hospital doctors who had participated in the strike. EINAP was outraged by the prosecution of its members, and this action united doctors against Avgerinos. As one of its executive committee members at that time stated in the daily newspaper *H KATHIMERINI*, “*Hospital doctors are the ones that can implement the Law and support the newly born Greek*

NHS".²¹ The doctors were able to use the argument that without their support, it would be impossible for the new Greek NHS to function, in order to pursue their own interests. In addition, EINAP expressed its desire for a NHS that was "*friendly to the patients, but also to the doctors*"²² and, as one of its senior officials at that time stated in his interview, hospital doctors wanted to reassure the public that "*whenever they hear that doctors are on strike, they are fighting against something wrong that harms Greek society in general and not only doctors*". The public was largely convinced by these arguments and supported the doctors' resistance to the government's plans.

Under this kind of sustained pressure, the next Health Minister, Georgios Gennimatas, surrendered to the claims of the hospital doctors. The government feared that doctors, particularly the senior doctors, would not join the NHS and that PASOK would thus not be able to fulfil one of its most prominent plans for the transformation of Greek society.

As a result, Health Minister Gennimatas immediately acknowledged the hospital doctors' demands and declared his opposition to the attempt of Avgerinos and KESY (the Central Health Council) to encourage doctors to practise in the under-doctored countryside, by introducing supplementary legislation to Law 1397/1983 (Law 1579/1983) preserving the freedom of doctors to practise in the big cities (see Table 2). In addition, public hospital doctors who had failed their NHS assessment of competence were eventually allowed to remain in post within the new system despite government plans to the contrary.

The Ministry of Health then resorted to a different approach to tackling the problem of the maldistribution of doctors by employing additional private specialists in the regions, but without any prior appraisal of their qualifications. Law 1579/1985 also increased doctors' reimbursement for

‘active service’ (referred to as ‘nominal overtime pay’ in the Greek NHS)²³⁻²⁷. The government’s actions in this period had an immediate and long-term effect on hospital doctor numbers and their vested interests. First, the number of doctors that entered the Greek NHS doubled (from the 3200 that Avgerinos had initially proposed to over 7000 by 1986), and second, this increase enabled the medical profession to form a solid and powerful interest group within the Greek NHS whose support no political party could afford to lose.

The change in Avgerinos’ plan for the Greek NHS brought about by his successor, Health Minister Gennimatas, was striking. He praised the role of the hospital doctors, saying that “...*hospital doctors in the NHS are poorly paid, and as a result they mistrust [the NHS]. This should change...doctors have to regain their trust in the system*”.²⁸ Unfortunately, Gennimatas did not appreciate the future problems surrounding the control of doctors’ labour relations that this deferential attitude would provoke. As a result, hospital doctors started to break even the diluted NHS Law by continuing to receive informal payments and undertaking private practice when supposed to be working in the public system.

The government might have strengthened its position vis-à-vis the medical profession had it tried to exploit the pre-existing divergence of interests between the medical societies (PIS and ISA, mainly representing private doctors) and the medical trade unions (principally EINAP, mainly representing doctors working in public hospitals in Athens and Piraeus). However, Gennimatas’ strategy made it easy for the different representative bodies of the medical profession to support each other to protect the position of the profession as a whole²⁹⁻³⁰.

The victory of the hospital doctors was also based on the willingness and ability of the majority of the EINAP representatives to put aside their different party political affiliations. The

Conservatives and the Socialists within EINAP united in finding a way of profiting whether they worked inside or outside the Greek NHS. For those inside, EINAP managed to negotiate a NHS moulded to their interests, thereby undermining the Greek NHS legislation that was the cornerstone of PASOK's policy. EINAP and the other medical bodies prevented the transformation of the health care system into a genuinely national system in 1983 through their closeness to the centres of political decision-making³¹.

1990s: evolution of hospital doctors' authority through parliamentary influence on their access to informal payments and their resistance to external appraisals

As in 1983-86, at crucial moments in the 1992 reforms, EINAP mobilized its members to undertake industrial action across political party lines when important aspects of the position of hospital doctors was threatened. In addition, the hospital doctors' main trade union enjoyed public support in their conflict with the government. Hospital doctors became particularly concerned with any attempt by the state to restrict their clinical autonomy or abolish rights to permanent employment. Facing such threats, hospital doctors became strongly loyal to their trade union (EINAP) and, helped by the overarching Civil Service Trade Union (ADEDY), fought collectively for their interests. The experience of this period showed that the medical profession was adept at resisting reforms whether coming from the right or the left of the political spectrum. In 1992, the new Conservative government's neoliberal agenda (in contrast to the previous social democratic reforms) included the introduction of three different levels of employment for public hospital doctors - full-time, part-time, or paid per case - reflecting its support for more flexible terms of service throughout the civil service. This was the Conservative government's route to tackle informal payments, which it saw as a fraud undermining the efficiency of public services. It was argued that part-time and paid per case contracts would enable hospital doctors to earn

additional legitimate income from private practice, replacing dependence on informal payments to supplement their earnings. EINAP opposed the legislation arguing that the reforms risked harming access to decent hospital care. In the event, only 492 hospital doctors (out of 8,300) accepted contracts under the second or third mode, as they were sure that they could continue to work full time while receiving informal payments without fear of sanctions³²⁻³³. When PASOK returned to power in October 1993, 330 of these doctors returned to full-time and exclusive tenure. A senior trade unionist of the period recounted at interview “...*they got a quite bitter taste of what the private sector could offer them and decided to return to their safe and uninterrupted interests within the Greek NHS....*” In the end, the Conservative Minister Sourlas, failed to make fundamental changes in doctors’ working practices. Hospital doctors employed by the state may have had different political affiliations (Socialists, Conservatives or the Left), but they had a strong and shared interest in preserving the status quo transcending party differences and refused to renegotiate their formal (permanent tenured posts, special payments, etc.) or informal (nominal overtime payments, informal payments, corrupted appraisal system, etc.) vested interests.

Furthermore, they successfully exploited the fact that the rate of increase in NHS funding was lower than had been initially agreed in 1985, as justification for continuing or even increasing the frequency of informal payments in the face of measures designed to remove them. In 1992, representatives of the most important medical trade unions and medical societies accepted responsibility to self-regulate informal payments. They also agreed to release the results of their own investigation into informal payments to the Committee on Social Issues of the Greek Parliament which was investigating informal payments in response to public complaints. The

profession's report concluded that: a) the informal economy was a common, accepted feature of Greek society, including the health sector; b) doctors received informal payments principally because of poor salaries; and c) because of the peculiar, personal and very close relations between doctors and patients, some doctors would continue to be given gifts symbolic of patients' gratitude, irrespective of the level of their salaries. According to the Parliamentary Committee's report, informal payments were 'insignificant and within the limits of personal relations'³², and thus not something that should be the subject of further legal regulation. However, an earlier draft of the Committee's report had appeared in the daily newspaper, "TO VIMA". It had clearly stated that most hospital doctors encouraged informal payments. Two weeks later this was changed to state that only a few hospital doctors received informal payments, and that the payments were not initiated by the doctors - rather patients spontaneously offered them, or, as a senior journalist expressed it in his interview, "*patients tempted doctors with them*".³⁴ This was a view widely held outside the medical profession. For example, a high ranking bureaucrat of the period argued at interview that the persistence of *fakelaki* (informal payment) was: "... *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....*".

The Parliamentary Committee's final report was further strongly influenced by the fact that all the members of the inter-party Committee were physicians unanimously supportive of the hospital doctors³⁵. Unanimity among Greek parliamentarians is rare, so it seems that the Greek doctors' lobby had again managed to transcend party politics³⁵.

The Committee's conclusion that patients were to blame for informal payments protected hospital doctors from future accusations of impropriety. The inability of the state to properly implement and monitor regulations regarding doctors' working practices, the exploitation of these dysfunctional institutional arrangements by NHS doctors and the strong representation of doctors in, and their intimate connections to, the Greek Parliament, together explain how the Committee's report was able to be manipulated in favour of the status quo. It was no coincidence that in 1992, 48 of the 300 MPs were from the medical profession and that they were so well represented on the Committee investigating informal payments. As the daily newspaper, TO VIMA, argued, the MPs on the Committee acted first as doctors and only second as representatives of the Greek people^{34, 36}.

As well as successfully resisting any external regulation of informal payments during the early 1990s, hospital doctors were also able to resist any kind of external appraisal of the quality of their clinical work. The roots of their ability to avoid external appraisal lay in Health Minister Gennimatas' plan in the 1980s to build a solid bloc of vested medical interests in support of the institution of the Greek NHS, designed to remove any threat that successor governments might try to abolish the new system. As a result, the state was able to build a strong Greek NHS, at least at the start, but, at the same time, an institution subordinated to the interests of the Greek medical profession. As a result, when the Conservative government tried in 1991 to introduce a system of independent audit specifically to investigate if hospital doctors were fulfilling their 'overtime active duty', this was fiercely and successfully resisted. For example, at one public hospital, not a single doctor was on duty when the auditors arrived. Later, the doctors appeared and forced the auditors to leave the hospital³⁷.

2001: hospital doctors' continuing demonstration of their power and influence

In 2001, the PASOK Health Minister, Alekos Papadopoulos, proposed further reforms designed to challenge vested medical interests in the Greek health care system. As a previously successful Minister of Finance, Papadopoulos was sufficiently ambitious to believe that he could tackle the long standing problems of the Greek health care system. He also believed that it would be possible to transcend old style party politics in pursuit of his reforms. His proposals included the development of 17 decentralized Regional Health Systems, new managerial structures within the public hospitals, modification of the terms of employment of the Greek NHS and university doctors, and 24-hour opening of the public hospitals, with afternoon outpatient clinics, where doctors could treat their private patients on site on a fee-for-service basis so that more of the doctors' private practice would take place where it could be observed and any shirking of public responsibilities would be more visible. In addition, a percentage of the doctors' fees would be shared with the public hospital. Finally, hospitals were to become accountable to the appropriate Regional Health System rather than remaining part of central government and the civil service. Presenting itself as the guardian of the public interest, EINAP opposed the 2001 plan on the grounds that "*it promotes the private health sector and damages the social and public character of the system*", arguing somewhat tendentiously that the introduction of managers in public hospitals, the introduction of a unified insurance health fund, which was intended to be a private not for profit entity and not a public one (ODIPY), and the afternoon private outpatient clinics in the public hospitals, where patients had to pay for the doctor's time, amounted to wholesale privatization. Its President, Dr. Stathis Tsoukalos, argued that the plan gave the misleading impression that up to now there had been total chaos in the Greek health care system, when, in

fact, Greece had scored relatively well in a recent WHO global ranking of health care systems (achieving 14th place in 2000) ³⁸. In addition, as another member of EINAP's executive committee argued at interview, hospital doctors had warned the Minister that, although reforming legislation had been passed previously, much of it had remained a 'dead letter', "...there are many examples from the recent history of the Greek NHS where a minister has introduced various Laws but none of these were implemented.....". Dr. Stathis Tsoukalos and Dr. Giannis Eleutheriou, member of the administrative committee of EINAP and treasurer of ISA, respectively, threatened that hospital doctors would not accept any change to their working conditions, and would expect a generous increase in health care expenditure in return for the implementation of any other reforms to the system ³⁹. Representatives of EINAP were particularly against the introduction of professional hospital managers, arguing that as managers were not doctors they did not have the clinical knowledge and thus authority to judge any aspect of doctors' work (one MP who was also a doctor argued in his interview that "*doctors should be judged only by doctors*"). Finally, hospital doctors opposed the reforms on the grounds that Minister Papadopoulos was attempting to abolish EINAP members' permanent status as civil servants within the Greek NHS and to make them accountable instead to the 17 Regional Health Systems, so that the Regions could allocate the medical work force more efficiently. The civil service union, ADEDY, backed EINAP in its effort to resist this change. ADEDY had intervened periodically in favour of the interests of public hospital doctors, as ADEDY representatives knew that if doctors became subject to regional health authorities, this would set a precedent for other personnel to be moved out of the civil service and might weaken the position of ADEDY.

Public opinion was not uniformly in favour of the medical status quo in this period and the lack of medical accountability was increasing citizens' mistrust of the system, encouraging the view that doctors enjoyed a network of esoteric guild protection⁴⁰. Nonetheless, while public mistrust of the Greek medical profession rose still further during the 2000s, this did nothing to erode the clientelism which marked the doctor-patient relationship (which had its roots in party political clientelism)⁴¹⁻⁴². This continued to be exploited by doctors, for example, to influence their patients' voting patterns in favour of themselves or their political parties. As a senior hospital doctor argued at interview, "*there are a lot of Greek citizens who voted for me, 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 other cases, doctors running for Parliament treated patients for free to obtain their votes.

As far as informal payments were concerned, the representatives of the medical profession continued to downplay their extent, and where they existed, argued that they were due to poor pay and were initiated consistently by patients. As a result, according to Liaropoulos et al.⁴³, the majority of public hospital doctors still receive informal payments (only 4% of NHS hospital doctors denied receiving informal payments in 2008), despite the fact that Law 3745/2009 puts hospital doctors at the top of the civil servants' pay scale⁴⁴⁻⁴⁵. A rough calculation of the additional informal income of each Greek NHS doctor is around 7,300 Euros per year or a third of the official average salary of a public hospital doctor (assuming that there were 27,386 NHS hospital doctors)⁴⁶. There are NHS doctors who do not receive or accept any informal payments and, at the other extreme, cases of NHS doctors whose illegal income far exceeds their official salary⁴⁸.

Discussion

Until 25 years ago, there had been very little research interest in Greece in public policy, including in the health field. During the 1990s, researchers started to look at health policy and reforms⁴⁷⁻⁴⁹. Scholars such as Venieris⁶ and Mossialos⁵⁰⁻⁵¹ evaluated how the reforms of the Greek NHS (1983-2001) had affected funding and service provision. In addition, Carlos⁵² and Guillen⁵³ adopted a Southern European comparative welfare state perspective to explain why countries like Italy, Spain, Portugal and Greece had decided to implement NHSs during the 1980s. They argued that the role of the medical profession was crucial in the implementation of these reforms, but they did not seek to explain in detail using primary data how the profession was able to exert so much influence to frustrate reformers from both left and right wing political persuasions.

This article reinforces the centrality of the medical profession in shaping the Greek NHS, but advances understanding by showing how medical interests were both affected by the establishment of the Greek NHS and at the same time strengthened by the new NHS. In turn, this shaped future medical trade unionism, allowing medical interests to organise working practices and methods of reimbursement to suit themselves rather than the interests of patients or tax payers. The incomplete implementation of the original plans for the Greek NHS, in turn, became an impediment to any future reform - a typical example of path dependency. Mahoney explains path dependency as a situation where *“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”*^{54:508}.

The plans for the establishment of the Greek NHS provoked major conflict between the medical profession and the state in 1983, as in most other Western European countries when tax financed systems were first introduced ^{11,55}. In the Greek case, conflicts varied from the ideological (between the Socialists and the Conservatives), to the intra-professional (between different segments of the medical profession such as junior versus senior doctors). However, what emerged was the accommodation of the medical profession's collective interests by the state during the Parliamentary debates of 1983 and subsequently during the early period of Greek NHS implementation (1985-1986). The government was unable to safeguard the principles underlying the Greek NHS against the self-interest of the various sub-groups within the medical profession. Policy implementation is the most vulnerable part of the policy process to discrepancies between what the law stipulates and what happens in practice (so called 'formalism' (which refers to the tendency to focus more on the form of legislation than its implementation, and to distract attention from substantial to trivial problems) which is prevalent in most Southern European countries and particularly in Greece ⁵⁶⁻⁵⁷). There were several manifestations of 'formalism' during the implementation of the Greek NHS, particularly the requirements in the initial legislation for 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 refuse informal payments and the unification of the health insurance funds. All these remained unfulfilled. As Mouzelis ⁵⁶ argues, Greek political and cultural life has been dominated by formalism, thereby sacrificing substantive change (which would be predominantly in the interest of underprivileged groups) to formal change (generally in the interest of privileged groups). Seen from this perspective, the establishment of the Greek

NHS did not change the status quo in many respects. On the contrary, it served to strengthen the hegemony of the medical profession, including for the first time the junior doctors.

This was highlighted by the maintenance of personal, clientelistic relations with patients and with governments. Clientelistic relations with governments were enabled and maintained through the strong representation of doctors in the Greek Parliament where they formed a coherent lobby, together with their ability to mobilise voter opinion in their favour. Since the restoration of democracy in 1974, successive Greek governments have been vulnerable to the medical profession's demands because of the potential political cost of voter mobilization against the government if doctors as a profession are unhappy with particular policies. This has been reinforced by the predominance of doctors as Ministers of Health and their tendency to be drawn from the ranks of either successful private doctors with strong local community support or prestigious university doctors. Doctors have long been strongly represented in the Greek Parliament. This was particularly evident in the 1992 reform period when 48 out of the 300 MPs were doctors, again in the early 2000s and continues to be the case. For example, in the 2004 general election, after lawyers, doctors formed the second biggest and most powerful grouping in the Greek Parliament. The same occurred in 2009.

The persistence of path dependent reform without change suggests that only a powerful external 'shock' is likely to alter the Greek health care system. The 2009 Greek debt crisis would appear to have offered just such a 'shock'. Between 2001 and 2009 health system reform was off the government agenda. By contrast, the response to the debt crisis included proposed reforms with the potential to challenge the hegemony of the medical profession. However, the incomplete implementation of the first two reform memoranda dictated by the Troika of European

Commission, International Monetary Fund and European Central Bank (the group of international lenders that laid down stringent austerity measures to be followed by the Greek government in return for loans) has shown that, even in a period of crisis, both the government and the lenders prefer more easily implemented changes such as across the board cuts in public spending over structural reforms designed to improve efficiency since such reforms risk disturbing the vested interests of the privileged parts of Greek society.

It is no coincidence that the Troika could only bring about major budget cuts in pharmaceuticals (public spending on pharmaceuticals fell from 5.6 billion Euros in 2009 to 2 billion Euros in 2014⁵⁸), some restructuring of hospital clinics⁵⁹ and some initial plans for a better organized primary health care system (though these are once again yet to be realized at the time of writing in March 2016)⁶⁰. The focus on crude budget cuts has, if anything, reinforced the persistence of informal payments, bribes and the lack of scrutiny of hospital doctors. Two reports, the first by a private polling company called Public Issue⁶¹ and the second by the General Inspector of Public Administration⁶² have both shown that hospitals and hospital doctors are still at the forefront of informal payments and bribes. Senior doctors argue that this is justified by the cuts to their wages since the beginning of the debt crisis. However, this does not explain why informal payments were common place before the crisis. It is also inconsistent with the fact that hospital doctors enjoy relatively high, protected salaries (along with judges, MPs, academics, the military and the clergy) and that just before the debt crisis they had obtained a 40% increase in their basic salaries. This means that the majority of hospital doctors are currently paid at their 2004 level, while the salaries of the majority of civil servants have fallen to the level of the late 1990s due to public spending cuts following the debt crisis⁶³⁻⁶⁵.

Junior doctors who have not secured a post within the Greek NHS have fared less well since the debt crisis and a number have left to follow a career outside Greece. Faced with budget cuts, lower than expected wages, continuing corruption and reliance on informal payments, they feel insecure about their futures. However, there are also more recent signs of contrary trends. For example, starting in 2015, there has been an unexpected return of young professionals, entrepreneurs and even doctors to Greece to seek job opportunities⁶⁶. For example, as large parts of the publicly financed system have collapsed, so opportunities have grown in private practice (e.g. in psychiatry).

So far, it seems that, despite the partial implementation of the Troika's first two reform memoranda, the ability of the state to bring about the necessary structural changes, both more widely and within the health care system, designed to establish a new social contract with the people has been further weakened. Politicians have proved unable to use the crisis as an instrument to limit the prerogatives of the medical profession. This is indicative of the influence of broader institutional patterns present since the 19th century on the evolution of the Greek Welfare State⁶⁷.

However, there are tentative signs that external pressures for change may yet serve to shake up the path dependent nature of the health care system. First, in the summer of 2015, under the pressure of the Troika, Greece signed a third reform memorandum which dictated potentially important structural reforms to social insurance, and increased flexibility and competition in the markets for the services of professionals such as lawyers, notaries and pharmacists. Such developments, if implemented, could have significant implications for the medical profession. Second, there are early signs of a change in public awareness of, and sentiment towards, the

perpetuation of a privileged oligarchy which includes the medical profession, driven by the extreme humanitarian crisis. More than the incomplete implementation of the previous two reform memoranda, the effects of the crisis have forced a growing realization among ordinary members of the public that their individualism and support for clientelism have not served their best interests. Through their novel participation in collective movements outside formal state institutions (e.g. local community medical services, food banks, Third Sector legal assistance, independent local food markets, etc.), the population has begun to organize and act beyond the reach of the hegemonic vested interests of Greek society. These initiatives are based on the principles of participatory democracy and local empowerment. In the health care arena, they can be found in the activities of independent groups exposing hospital doctors who accept informal payments. However, the courts are also beginning to act against tax evasion by doctors, including their receipt of informal payments, and to patients against medical malpractice. Whether these early signs of patient and public empowerment, and maturity in relations with the medical profession become the foundation for challenging the medical profession's hegemony remains to be seen. However, challenging doctors' status and immunity from accountability are important steps towards re-evaluating how the principles, aims and objectives of the Greek NHS are to be realized in practice. They could lead gradually to the NHS' transformation. However, in order to make genuine progress with key reforms, such as a better organized primary care system able to relieve some of the demand for hospital care and contribute to the Troika's demands for curbs on public spending, a high level of political consensus is required, or at least the ability to compromise among the groups whose support is necessary to implement changes, many of whom potentially stand to lose, at least in the short term. In addition, a strong

state, with a politically neutral bureaucratic elite is needed to sustain reform implementation.

Unfortunately, no sustained consensus was achieved in 1983, and there has been no sustained public pressure in favour of significant health sector reform where this affects the prerogatives of the medical profession.

Conclusion

Hospital doctors, in particular, have been able consistently to resist any health care system reforms that might affect the dominant position of the medical profession in the Greek NHS. Their unchallenged position in the system derives from both the particularities of the Greek state and society (in particular, the former's founding institutional arrangements and the latter's clientelistic social relations), and the key role that junior doctors played in the early stages of the Greek NHS after 1983. As a result, the system is highly 'path dependent' in that the initial implementation of the Greek NHS during the 1980s ensured that subsequent reforms consistently favoured medical self-interest. While challenges to the unaccountable power of the medical profession have emerged in Greece following the financial crisis of 2009, including the beginnings of a popular critique of the medical profession, it is too soon to tell whether these will succeed in bringing about significant change.

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Table 1: Personnel employed by Greek NHS Hospitals, 1999-2009

	1999	2001	2003	2005	2007	2009
Total public hospital employment	77,382	80,701	86,157	84,734	84,643	87,085
Physicians	22,698	24,424	24,227	25,573	25,965	27,386
Nurses, midwives, health care assistants and other staff	47,631	51,027	55,216	54,656	55,448	57,474
Administrative staff	7,053	5,250	6,714	4,505	3,230	2,225

Source: (OECD, 2015)

Table 2: Number of doctors by geographical area, 1974 - 1997¹

Years	Greece Total	Greater Athens	Thessalonica	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

¹ Source: Social Welfare and Health Statistics, 1970 – 2001, and National Statistics, 2001, National Statistical Service of Greece. (ESYE)