

**Can existing theories of Professions, Institutions and
Medical Power explain the Greek health care reforms
since 1983?***

Athanasios Nikolentzos

**Department of Public Health and Policy, Health Services
Research Unit, London School of Hygiene and Tropical
Medicine, University of London.**

Athanasios.Nikolentzos@lshtm.ac.uk

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Abstract

Greece has enacted three major health care reforms during the past 20 years since the establishment of a National Health Service (NHS) in 1983. These have been designed to improve the ability of the system to realize its founding principles of equity and efficiency in the delivery and financing of health services. This paper presents an early report of ongoing doctoral research that aims to examine the relative influence of medical professional organizations versus other interests on the 1983 – 2001 reforms of the Greek state health care system.

There are a number of theoretical frameworks for understanding the health care system and the role of the medical profession within it, such as: (1) sociological theories of professions (e.g. professional dominance of doctors over the division of labour in health care, clinical autonomy, etc.), (2) historical institutionalism (where, in conflicts between rival groups for scarce resources, institutions systematically favour some interests and disadvantage others), and (3) structural interest theory (where the structural interests of doctors are challenged by corporate rationalizers). This paper will explore which theories best explain the nature and extent of health care reform in Greece since 1983.

Though each body of theory has something to contribute, historical institutionalism appears to offer the greatest potential to help explain the reforms and their limitations. The Greek health care system exhibits institutional peculiarities which are strongly related to the way the Greek Welfare state has developed in the post-authoritarian era since 1974. Preliminary analysis suggests that a major explanation for the fate of reform efforts since 1983 lies in the fact that these institutional arrangements allow several embedded interests, including, but not exclusively, the medical profession and its trade unions, to benefit from the status quo and resist the efforts of governments to change the health care system.

Introduction

Greece first attempted to establish a universal health care system, free at the point of use, in 1983, when the Socialist Government (PASOK¹) introduced Act 1397/1983 (MoH 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 (NHS from now on) have not been realized in the face of sustained opposition to most of the major changes proposed (Mossialos 1997). 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 (Mossialos and Davaki 2002). As a result, the public is generally dissatisfied with the health care system and many of the major players in reforms appear puzzled at the relative failure of successive well-meaning reform efforts.

Understanding the failure of these reforms means answering fundamental questions such as: why do governments decide to undertake health reform and how are initial decisions and subsequent implementation shaped? The weakness of the Greek State and the complexity of its 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. This article will attempt to elaborate and refine this explanation.

In the next section I offer a brief overview of the main features of current theories of health care reform which are likely to be relevant: sociological theory of the professions, historical institutionalism and structural interest theory. I then describe the current Greek welfare state and within it, the health system, before sketching the three main health system reforms since 1983. I then attempt to assess which of the theoretical frameworks best explains the fate of the reforms and the role of the medical profession within the health care arena.

Theories of health care reform and of the role of the medical profession

The international scientific literature has shown the importance of the medical profession 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. Three main bodies of theory in sociology and political science are relevant.

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

¹ Pan – Hellenic Socialist Movement

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 quite 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 1970; Freidson 1985; Freidson 1994).

Other theorists argue that medicine was once dominant in health and health care, but is now being fundamentally challenged (McKinlay and Arches 1985; Colombotos and Fakiolas 1993; Coburn 1999; Coburn and Willis 2003). Coburn especially argues 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 (Immergut 1992).

Historical Institutionalism (HI)

Historical institutionalists offer explanations as to how, in conflicts between rival groups for scarce resources, institutions² favor 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 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 behavior and drove outcomes (Oliver and Mossialos 2005). 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 situation (Steinmo, Thelen et al. 1992) cited in (Hall and Taylor 1996).

HI is closely associated with a historical developmental perspective on public policy and the state. Its scholars have argued that policy change is '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 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 (veto points, mainly in Western European countries) (Immergut 1992), or can influence subsequent policy implementation; and 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).

² Formal or informal procedures, routines, norms and conventions embedded in the organizational structure of the polity and political economy.

However, Historical Institutionalists do not argue that major policy change can never happen. Radical change can occur, but this only 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 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. 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 Skocpol forthcoming). HI has been used to analyse health politics and health care reform in particular (Immergut 1992; Wilsford 1995; Tuohy 1999).

Structural Interest Theory

Alford’s 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’) 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, medical schools, 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 monopolies. These conflicts occur in an institutional framework that generally prevents the corporate rationalizers from generating enough social power to 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 structural interests of the community population.(white rural and urban poor, lower middle class etc.). Not only are the interests of the community population not represented in the health care system, but they are generally not organised as an interest group. As a result, their autonomous demands are not heard.

Current Features of the Greek Welfare State

The social and economic structures of Greece evolved rapidly to a post-Fordist stage by the early 70s , without passing through a period of full industrialization. This rapid change, without any time for adjustment, resulted in weak working class forms of solidarity (trade unionism) and an absence of universalism in social policy.

The lack of universalistic culture and identity, the clientelistic patterns that Greece has continued to experience since the seventies, slow economic growth, the empowerment of the state apparatus, and the fragmented organisation of the labour

movement, legitimized Greek families and individuals to act strategically in seeking employment from the state, or 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 by developing clientelistic patterns, pushed citizens to demand from the public sector extra revenue in the form of welfare provision³, but at the same time created privileges for politically opportunist groups. (Petmesidou 1991; Petmesidou 1996; Petmesidou 2000). This is what Tsoukalas calls “clientelistic corporatism”(Tsoukalas 1987). 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 expressing their objectives publicly, results in a great degree of dependence of trade unions on governmental support for achieving their goals.

The socio – economic structure of Greece reflects the fact that the country still has a comparatively large agricultural economy, extended petty commodity production, and self – employment in the 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 (independent small–holding farmers); a weakly organised working class; an enduring old middle class, called by Sotiropoulos and Petmesidou the petite bourgeoisie; a well organized and mobilized category of public sector employees; a politically strong stratum of urban liberal professionals (lawyers, doctors engineers); and a state–dependent capitalist class made of industrialists, bankers, land owners, ship owners, mass media businessmen and public works contractors (Petmesidou and Tsoulouvis 1994).

The Greek state has traditionally promoted economic development through patronage of certain industrial sectors and business interests (statism). Statism involves protectionism, autarky, 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 W. European countries have also experienced 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, not to say 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.

What is also striking is that although Greece has experienced economic growth, it has not experienced even 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, where the state clearly promoted the “winners”(right – conservatives) against the “losers” (the left). The aftermath of the Civil war was the creation of a dual society that prevented the

³ This what Petmesidou calls familialism. Familialism refers to a “system in which public policy assumes that families and households are the relevant locus of social aid and that they do not fail when performing that role”. Lopes, A. (2003). Social protection in South Europe, familialism and care for the elderly: a discussion on concepts and methods using some evidence from the European Community Household Panel. Workshop for Young Researchers, Marstrand (Sweden), European Institute of Social Security.

development of a social contract between the citizens and a neutral state. On the contrary, there was a deliberate attempt to exclude the “losers” from politics or even social welfare benefits. Social strata that are close to the state are the business strata, the liberal professions (where physicians are included) and segments of the petite bourgeoisie. The relationship that was formulated by this interaction cemented the long-term dependence of these privileged groups on the state, and it has increased their desire to control the state apparatus. This favourable treatment led the state to create specific jobs to accommodate their supporters and also to enact legislation and allocate funding that promoted the insurance funds of the liberal professions and other groups with special proximity to state power such as civil servants. As a result, research carried out on ministerial and parliamentary elites in S. Europe, shows that there is a significant overrepresentation of the liberal professions, especially lawyers and doctors, in the Greek state and politics. 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 2004)]

Current Features of the Greek Health Care System

The Greek Health Care System is a “mixed” system of “public contract” and “public integrated” models⁴, and is financed by a mixture of general taxation and social insurance. There are three major categories of providers: (1) The NHS (public hospitals, health centres, rural surgeries and emergency pre hospital care), (2) insurance funds health services with their representative units and polyclinics (mostly established within the biggest Greek insurance fund called IKA⁵, and (3) the private sector (private hospitals, diagnostic centres, independent practices, surgeries and laboratories). The NHS offers universal coverage of 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 it is occupationally based. There are approximately 172 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 population⁶(Karagiannis, Lopatzidis et al. 2003). The three largest funds are IKA (Social Security Institution), OGA (Organization of Agricultural Insurance) and OAEE (Fund for Self – Employed). People employed in banks, public utilities (i.e. telecommunications) and some self – employed (10% of the population) are covered by separate funds. Moreover, the government runs separate schemes for civil servants, their dependents and military employees (12% of the total number of insurees (Sissouras and Souliotis 2003 January).

⁴ **Public contract model** is about public payers contracting with private health – care providers. Payers can be either a state agency or social security funds. On the other hand, **Public integrated model** combines on – budget financing of health care provision with hospital providers, that are part of the government sector. Docteur, E. and H. Oxley (2003). Health - Care Systems: Lessons from the Reform Experience, OECD <http://www.oecd.org/dataoecd/5/53/22364122.pdf>.

⁵ Social Security Institution (IKA)

⁶ It is estimated there is 5% of the population, mainly illegal working migrants, are not covered through health insurance funds, but they can still access, in theory, health services through the NHS.

Management of the insurance funds is the responsibility of representatives of employees, employers and the state. One would expect that the state would be the dominant party in the management of the funds, since they receive financial support from the state. However, this is not so. One explanation for this peculiarity lies in the fact that two of the largest trade unions in Greece, GSEE⁷ and ADEDY⁸, are controlled by unionists that are influential within PASOK, the political party that has been in government for 19 of the past 22 years⁹.

Overall the system is fragmented in terms of financing and providing health services. There are lots of social insurance funds that offer different levels of quality and quantity of benefits to their insurees. For example, privileged funds, such as the civil servants' fund and the banking or public utilities funds offer the most comprehensive benefits to their insured populations (comprising around 17% of the total population)(Davaki and Mossialos 2005).

Greece spends approximately 9.4% of its GDP on health care (2000), a percentage that lies above the median of the EU – 15, yet its per capita GDP is one of the lowest and its citizens the least satisfied with the health services they enjoy(Mossialos 1997; OECD 2002). Health care in Greece is funded mainly through the central government budget (general taxation, 30.4% in 2000, of which 58.4% were indirect taxes), social insurance funds (25.9% in 2000, employers and employees contributions), private health insurance (2.3% in 2000), and out-of-pocket payments for the remaining 41.46%. A significant part of the out-of-pocket payment is informal. 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 finally 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 (general public utilities), professionals and the self – employed contribute less to the funding of NHS and social insurance funds than average, yet many of them enjoy better benefits and services than an employee insured in IKA would ever 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. This is another peculiar characteristic of Greek health care funding. 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 personally their gratitude to the doctor 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 people, and the self-employed as far as tax and social insurance contributions

⁷ Greek National Confederation of Labour

⁸ Civil Servants' Association

⁹ On March 2004, and for the first time in 11 years the Conservatives (ND → New Democracy) gained power.

are concerned, and high official and informal private payments). Thus there is no overall pooling of health resources. Furthermore, as the administration of the insurance funds is not linked, their purchasing activities are uncoordinated. Resource allocation is based on historical precedent, and regional differences in needs and access flourish.

Physicians working for the NHS (hospital doctors and doctors working in health centres) 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 illegal¹⁰ 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: (1) doctors providing services on an exclusively private basis, the cost of which is fully covered by the patients through out-of-pocket payments, (2) doctors working in polyclinics of insurance organisations, and (3) doctors contracted to one or more funds, working from their private surgery and paid by fee-for-service.

The medical care reimbursement methods used by the Greek health care system provide 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 the severe over-supply of doctors. Once these physicians begin their practice they realize that the payment they receive does not meet their expectations. On the contrary, payments they receive are consistent with the limited resources available to the Greek public health care system.

There is a significant oversupply of physicians, dentists and pharmacists and there is no control over numbers or the quality of care provided. Compared to the EU-15, Greece relies on expensive human resources to deliver health care. In 1992 Greece had the 2nd highest ratio of doctors (4.4) and the highest ratio of specialists per 1,000 inhabitants. The number of practising physicians has approximately doubled over the past 20 years, with a notable increase in female representation, yet nursing staff numbers have not increased at the same rate. Compared with the rest of Europe, Greece has almost half the average ratio of nurses per 1,000 inhabitants, 3.1 (ESYE 1970 - 2001; OECD 2002).

The involvement of the private sector in health care delivery¹¹ 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 1983¹², 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 diagnostic centres and are paid to refer patients to them. Around 85% of radiology laboratories and 75% of nuclear medicine laboratories are in the private sector. In addition to this, Greece has a high proportion of private MRI and CT scanners, 80% and 68%, respectively. Furthermore, it has one of the highest ratios of MRI and CT scanners per 1 million inhabitants at 16.4 in 2001, as against the UK with 6.1, France 9.7 and US 13.3 scanners/million inhabitants. Doctors refer patients to private diagnostic centres, thereby stimulating demand for private diagnostics, and then return them to NHS hospitals to receive treatment from the same doctors.

¹⁰ Since 1983 till 2001, except from a small period of time in 1992 – 1993 when private practice of hospital doctors was legalized

¹¹ Mainly middle or small types of enterprises, also found to the rest of the Greek economy

¹² They were reversed in early 1990s

A brief history of Greek health care reform, 1983-2001

This account is based on preliminary data collected as part of an ongoing doctoral research thesis comprising articles from newspapers, Parliamentary minutes relating to the main health system reforms, public records and the archives of major medical associations, trade unions. In addition, data are derived from pilot semi-structured interviews with key informants involved in the reforms.

Foundation of NHS – The Populist Era of PASOK (1983-1989)

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. 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 the winner of the elections of October 1981 (PASOK). PASOK's populist policy focused on the need for reforms at institutional and social participation level in the interests of the urban middle classes and peasants. Although public expenditure rose significantly during PASOK's period in government¹³, 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 was to attempt to repair the damage caused by the socially divisive periods of conservative government through proposing a bill for the establishment of a National Health System (NHS).

Law 1397/1983 signalled the foundation of a universal system of health care, in principle to be free at the point of use, based on the principles of equity and efficiency. Yet the reforms of 1983 were only partially implemented and key provisions were never implemented. The state was unable to prevent hostile interests undermining important parts of the reforms. Issues such as decentralisation of authority, 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. This happened mainly because there was no coalition of interests in support of the NHS. The role of the medical profession in the implementation of the reforms was ambiguous as the medical profession was fragmented into various segments in the form of the medical guilds. Power and ideological differences, and conflict over the ability of NHS doctors to have public and private practice divided hospital doctors into two categories. Socialists on the one hand, mainly junior doctors, were in favour of the idea that doctors should only practise in the NHS, as a safe and stable working environment would secure them high wages and guarantee them future promotions. Conservatives on the other hand, mainly senior hospital doctors, had multiple practices (hospitals, private clinics and private surgeries) and were against the law that banned private practice for NHS employees. They argued that the law was Marxist, and that it violated their human rights since they would be forced to choose between public and private practice.

Academic doctors working for the NHS were also against the law, as they were obliged to quit their private practices. The specific clause at issue was a continuation of a previous statute (1268/1982¹⁴) that had introduced the concept of "full – time and

¹³ In 1960 total expenditure was 19.6% of GDP, in 1980 rose to 34.2% and in 1989 it went up to 51.5%.

¹⁴ A law settling university matters, such as funding, personnel, and administration

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 happened, as the powerful academic elites, who kept close relations with Prime Minister Papandreou, influenced him in favour of their professional rights. As a result, academic and army forces doctors were the only two categories of doctors excluded from “full – time and exclusive” practice.

Bill 1397/1983 was debated in the Greek parliament for about 4 weeks, and although in the beginning the government wanted to establish a unified insurance fund, in the end organized opposition from the MP’s representing the so – called “noble – funds¹⁵”, whose “insured population would lose their benefits and access to better health services”, obliged the government to amend the statute and go for a voluntary unification of the insurance funds in the future (by 1989), that again never happened.

Finally, the private clinics and pharmaceutical companies 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. 45% of the hospitals beds were in the private sector. During the 6–year period, 1975–1981, only 1505 public hospital beds had been refurbished and 5578 private beds built. It was thus reasonable for a government that wanted to establish a NHS to ban the building of new clinics and that way to shrink the private sector that in the future could harm a new public system. Private clinic owners opposed the law, as they were not allowed to expand or invest on their companies, a provision that, they argued, would jeopardise the survival of small operators.

Finally the reform also 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 happening.

The 1990 – 1993 Conservative government

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 introduced, reduced inflation and social expenditure. Following two years of political instability, general elections in 1990 brought the conservatives back to power¹⁶. New Democracy (ND) ruled until 1993 and pursued neo-liberal policies. 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. “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 (Act 2071/1992) that altered fundamentally the provisions of the 1983 reform. It 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 (almost tripling them)¹⁷. It also permitted insurance funds to contract with private clinics and diagnostic centres, introduced co – payments for drugs, and fees for visits to out–patient departments and

¹⁵ Representing only the 6% of the population in 1983

¹⁶ Election results though, did not grant New Democracy (ND – The Conservatives) the necessary state consolidation for pursuing major policy reforms. ND took only 151 of the 300 parliamentary seats.

¹⁷ This provoked huge deficits to health insurance funds.

inpatient admissions. Furthermore, the conservatives increased social insurance contributions and introduced tax deductions for private insurance premiums.

The new law was passed after a long and lively debate in the Greek parliament. The debate was focused on specific articles of the statute concerning mainly doctors' working conditions. Doctors no longer had to work "full-time and exclusively" within the NHS. According to the 1992 law they could practise either full – time or part – time within the NHS. Thus 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, and at the same time recruit patients, using the public hospital infrastructure, for their afternoon private surgeries. University doctors that were also registered with the NHS, were forced within a deadline of sixty days to choose whether they wanted to be academic teachers in the university or academics working full – time for the NHS and in reality quit teaching. The sixty-day deadline for their decision was later changed and in the end became a one year deadline, as university NHS doctors exerted pressure on the MoH.

Most medical associations, except the Pan – Hellenic Medical Association, were against some groups of doctors having privileges denied to others¹⁸, and especially against the article that established non– permanent residency for hospital doctors hired after 1992 when the legislation had been enacted. A few MPs argued that most medical associations were in reality against 2071/1992 law because doctors preferred to receive informal payments in NHS, than to work part – time in the NHS and at the same time be taxed for their afternoon private surgeries (according to the new regulation). Evidence produced by a parliamentary committee, which discussed a first draft of the statute, confirmed that almost 80% of NHS doctors received informal or "under the table" payments. Finally, ND did not take any steps towards the establishment of a single insurance fund, as they were aware what had happened to the 1983 reform, when severe opposition had postponed the unification indefinitely.

The 2001 Reform - PASOK's comeback

PASOK was re – elected in 2000 and for the first time in 17 years a non–medical Minister of Health was appointed. Minister Papadopoulos had already gained his reputation as a successful minister of finance and 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 reform plan for the longer term¹⁹ including not only the establishment of regional health systems, but also the much discussed unification of the insurance funds and the establishment of a family medicine system. Discussions about the reforms had started in summer 2000, and many interest groups had already expressed their opposition. Nevertheless, the Minister decided to proceed with the production of statute 2889/2001. However, he deliberately compromised at this stage 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 in the bill, as there were vested interests opposing the unification, and there were not enough resources for financing primary health care.

¹⁸ Full – time or part – time hospital doctors, with the latter being able to have a private practice

¹⁹ "Health for the citizen"

Instead, he focused simply on decentralisation of the public hospital system, through the establishment of 17 Regional Health Systems (RHS).

University doctors were another interest group that strongly opposed the statute during parliamentary discussion, and after its voting, because it forced them to choose between public and private practice. Parliamentary minutes of the discussion of the plan show that the debate between MPs that 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, since he was not a medic²⁰. They continued their debate by going to the Constitutional Court claiming that their human rights were violated on the basis of the European Convention of Human Rights. After they were not supported by the Court, they 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 do their private practices and teaching.

Opposition to the law came also from hospital doctors. Medical associations were 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 doctors²¹. Finally, the civil servants' trade union 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' code²². As a result regional directors could not enforce the law, and hospital doctors refused to move even within their region.

Directors appointed to the Regional Systems and some of the hospital managers initially appointed were not affiliated to the ruling party. This was highly unusual in politics in Greece. Most of the previous hospital committees had been staffed by former politicians, apparently closely linked to the governing political parties. As a result, many MPs affiliated with the socialist trade unions, or even other ministers of the socialist government, expressed their dissatisfaction with the way the Minister of Health had handled the appointments and accused him of not being in position to control developments in the health sector. At the same time, civil servants in the Ministry of Health expressed their dissatisfaction at relinquishing power to the Regional Health Systems (Mossialos and Davaki 2002). The Prime Minister, Simitis (a well known academic before becoming the Prime Minister), did not support his own Minister of Health over the idea of unifying the insurance funds and the introduction of a family medicine system. He was reluctant to see his minister clash with the university doctors.

Minister Papadopoulos was quickly replaced by Professor Stefanis, a famous 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 directors and hospital managers, a movement that signalled the granting of more powers to the civil servants' pressure group and the reduction of state influence and control over the new system.

Explaining the history of Greek health care reform, 1983 – 2001

In view of the historical sketch presented above, 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

²⁰ They vividly said “Your plan is doomed to fail”

²¹ One MP who was also a doctor implied that “doctors should be judged only by doctors”.

²² A code, established by the cooperation of state and civil servants, that refers to civil servants rights and obligations.

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 in Greece that non-medical managers and others could not and should not have any jurisdiction over how they worked). 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 the national 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). Theories of the professions are necessary but not sufficient to explain the medical profession's role in health care reform in Greece.

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 current and previous reforms in Greece (1983 – 2001) suggests that corporate rationalizers²³ have not developed or are not represented, at least to the same level as in U.S.A. or Europe, due to a 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 in its interests. Some Greek scholars have attributed this to the absence of a universalistic culture and collective forms of representation.

Instead, preliminary analysis suggests that historical institutionalism provides 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 1980's with specific inherited characteristics, that reflect its socio – political structure and organisation and that have direct effects on the Greek Welfare State. It is highly politicised (dual party system), centralized and fragmented, 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 exist, and where the notion of individualism dominates policy making at the expense of universalism. It is within this broader context of policy making that decisions about the Greek health care system are made.

This institutional context has determined to a large extent the degree of success 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. All the reforms that contained clauses that harmed 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 reforms to use the institutional context to protect their positions and in some cases to enhance their privileges. They focused their efforts on being exempted from the reforms or by turning the law into a dead letter at the implementation stage. Typical examples of this were the failure to establish a unified insurance fund, the inability to prevent academic doctors continuing their private practices and the inability to end

²³ State bureaucratic elite, medical schools, public health agencies, insurance companies or insurance funds

informal payments to both junior and senior hospital doctors. In all cases the established interests in the health sector protected their interests by excluding themselves from the reform by presidential decree (noble insurance funds and university doctors) or by rendering the statute a dead letter in their everyday practice (junior and senior hospital doctors). In this way, the status quo was largely preserved, and by no means in the interest of citizens²⁴.

Conclusions

This paper has discussed Greek health care reforms, and has attempted to 1) reveal the peculiarity and “uniqueness” of the Greek health care arena, and 2) illuminate the theory that best explains its dynamics. Three theoretical frameworks were used to explain and understand the Greek case. Preliminary analysis suggests that Historical Institutionalism appears to offer the greatest potential to help explain the direction of health care reforms since 1983. However useful insights were derived from the theory of professions, particularly to explain the way in which appeals to professional autonomy and the inability of “lay” people to judge doctors’ behaviour were able to be used successfully in parliamentary debates to maintain medical privileges. Further investigation needs to be carried out on how the medical profession gained its power and how it maintains authority both at the clinical and the political/managerial levels. This is where the role of institutions may prove crucial - in particular the specific peculiarities of the Greek Welfare State, an understanding of the development of Greek society and nature of the Greek state. As the brief history of the three periods of recent system reforms shows how vested interests, such as the trade unions of already privileged groups²⁵, the medical profession (junior hospital doctors, senior hospital doctors and university doctors), 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 impeded the establishment of a universal health insurance system. Recent reform efforts have been critically limited by the decisions of the past.

Neoinstitutional theory suggests that reforms can only break out of such “path dependency”(Wilsford 1994) when a “window of opportunity” or a “critical juncture” occurs. An incomplete set of favourable 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

²⁴ This what Mouzelis calls formalism. Formalism is the degree to which discussions and disputes receive a formalistic – conformistic character at the expense of social values. Formalism is a way of distracting attention of people from substantial to the 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.

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²⁵ Almost 17% of the population

institutional change in the health care arena (Immergut 1992; Lavdas 1995; 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 from reform. Unfortunately, no consensus was ever achieved in 1983 and there has been none since in favour of significant health sector reform.

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