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LSE THE LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

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Contents

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Theofanis Exadaktylos[1], Nikolaos Zahariadis[2] and Maria Mavrikou[3]

ABSTRACT

Despite consecutive MoUs (2010, 2012, 2015), Greek health reforms have been slow-moving with some successes and failures. Why did some reforms succeed while others failed to be implemented? Using the Multiple Streams Framework (MSF), this working paper presents evidence collected from interviews with health policy-related elites and stakeholders in Greece and traces the process of implementation to identify sticky points and configurations of pro- and anti-change coalitions. We hypothesise implementation outcomes are due to three factors: the strategies and power of the main non-state coalition partner (the medical profession), the size of resources needed for successful implementation, and the ability (or not) of government to mobilise public opinion. We examine three cases: the liberalisation of the pharmacy profession (successful implementation), family doctor reforms (partial implementation), and the referral system (mainly unsuccessful implementation). The working paper concludes with implications about policy implementation and practical lessons for policymakers considering possible implementation obstacles.

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1. Introduction

After a long battle with financial discipline and a series of consecutive Memoranda of Understanding (MoU) in 2010, 2012 and 2015 with international lenders to avoid bankruptcy, the Greek government formally announced the exit from bailout agreements in August 2018. The exit signalled that following the turbulence of the Greek financial crisis in 2009, Greece was able to return to a degree of normalcy in public policy making. One of the main reasons behind the Greek financial crisis has been identified as the lack of structural reforms in the public sector to allow Greece to maintain future fiscal stability (Featherstone, 2011; Vasilopoulou et al., 2014; Ioannides and Pissarides, 2015; Perez and Matsaganis, 2018; Spanou, 2020). The purpose of the international monitoring regime that Greece was put under during the consecutive MoUs was to address the structural inefficiencies of the country, initiate and implement a series of reforms in the public sector and restructure policymaking processes, instruments, and interactions between stakeholders. As such, all three bailout agreements came with stark conditions that had to be met for the loans to become available to the Greek government and the parameters of Greece's debt management to take effect, in what was seen a very tight schedule of severe austerity measures.

Beyond the tackling of direct spending by the Government, the bailout agreements set out a schedule of reforms in practically all areas of public policymaking, ranging from the introduction of new investment and growth laws and initiatives, to reforming processes of hiring and dismissing personnel in the public sector, the introduction of new digital systems for spending monitoring, the liberalization of closed-shop professions, the restructuring of ministries, government agencies and public-facing bureaucracies, alongside a programme of further privatization and leasing of public assets to private actors. One of these areas identified as problematic from a structural and spending point of view was health policy. At the start of the financial crisis, spending gaps, severe deficits and systemic underperformance were highlighted as areas of immediate attention (Karokis-Mavrikos, Mavrikou and Yfantopoulos, 2023). The aim of any reforms should be to tackle efficiency, effectiveness and social impact (Ladi, 2014; Featherstone, 2015; Exadaktylos, 2020a, 2020b). All three MoUs signed by the Greek government, the European Commission, the European Central Bank and the International Monetary Fund (the latter three known as the Troika), included clauses on

reforming health policy (Simou and Koutsogeorgou, 2014; Keramidou and Triantafyllopoulos, 2018; Ladi et al., 2021), but progress has been slow-moving with some successes and some failures. The purpose of this report is to examine the reasons behind the variable implementation of reforms in health policy to identify the opportunities, obstacles and constraints that lead to full, partial and unsuccessful implementation. Hence, despite the direct mandate by the MoUs, why did some health reforms succeed while others failed to be implemented?

We argue that policy reforms are more likely to succeed (a) when the main non-state stakeholder is co-opted or agrees with the direction of change; (b) when the government is able through political communication to clearly articulate the benefits to the public and create a favourable trend in public opinion; and (c) when few resources need to be expended for implementing the reforms. To that end, we use the Multiple Streams Framework (MSF) of the policy process and apply it to the case of health policy reform in Greece with the objective to (1) map out the implementation of health policy reforms as outlined by the MoUs; (2) understand the points of friction, the conditions for forming a pro-change coalition of actors, and the involvement or embeddedness of stakeholders in processes of decision-making and implementation; and (3) to process-trace the policy outcomes to determine the conditions for success, partial success and failure, as well as the impact of the reforms in the state of play. We use evidence collected through semi-structured interviews with the full spectrum of health-related elites and stakeholders in each of our cases, ranging from high-level government officials to street-level implementors of the policy, specifically focusing on identifying sticky points and mechanisms of configuration of the pro- and anti-change coalition. It is important at this stage to highlight that pro- or anti- does not incorporate any assessment of the goodness of fit, appropriate direction or the goals policy reforms set. Here we refer to coalitions of actors advocating for changing the status quo versus those who advocate the maintenance of the status quo.

In MSF terms, the mechanisms linking the process of stream coupling to implementation success (or failure) involve decoupling problems from solutions, undermining support (or not) in the politics stream and altering estimates of equity and efficiency in the policy stream. Hence, we hypothesise implementation outcomes are due to three factors: the strategies and power of the main non-state coalition partner (the medical profession), the size of resources

needed for successful implementation, and the ability (or not) of government to mobilise public opinion. We examine three cases:

(a) the liberalisation of the pharmacy profession as a case of successful implementation,

(b) family doctor reforms as a case of partial implementation, and

(c) the referral system for specialised care as a case of unsuccessful implementation.

We conclude with a discussion of the implications about theories of implementation and practical lessons for policymakers in light of possible implementation obstacles that extend beyond the health policy remit.

2. Multiple Streams in Greek Health Policy Reforms

Our main research question is: despite being mandated by the MoUs, why did some health reforms succeed while others had a harder time or failed altogether to be implemented in Greece? From a public policymaking perspective when looking at implementation of reform, the Multiple Streams Framework is an approach that looks at problems, policies and politics as parallel streams coupled together to produce policy outcomes. The main argument is that policies are made when policy entrepreneurs, broadly define both as state and non-state actors couple or join together three distinct streams: the problem (identification/definition) stream, the policies (options/solutions) stream and the politics (distribution of power) stream (Zahariadis, 2014).

The chances a particular policy will be adopted increase significantly when all three streams are coupled during open policy windows. We extend the argument to implementation (see also Ridde, 2009). Windows are opportunities that open in the problem or politics stream; they define and limit the context within which policy is made. Policy entrepreneurs are individual or corporate actors who operate in or out of government and are willing to invest resources—time, energy, expertise, or money—to advocate for (or prevent) major policy change (Kingdon, 1995: 122; Mintrom & Norman, 2009: 650). Entrepreneurs continuously advocate and broker, display social acuity, define problems, identify or create favourable institutional venues for change, build teams, and lead by example supporting or opposing

policy alternatives at any policy process stage (Mintrom & Norman, 2009: 651; Mavrikou, Zahariadis and Karokis-Mavrikos, 2023). A key element within MSF is ambiguity, which involves contestation over issues, meaning, causes, and consequences. By encouraging rival interpretations, ambiguity affords opportunities for policy entrepreneurs to build and sustain coalitions that advocate or oppose policy change. We are interested in how entrepreneurial strategies can be used successfully to implement policy, connecting context and coalitions around linked but ambiguous frames of problems and solutions.

Implementation frequently depends on coalition-building to sustain policy momentum and overcome opposition (Zahariadis and Exadaktylos, 2016). Ambiguity is essential because disparate coalitions need to be built and supporters must declare victory, each perhaps for their own reasons. It provides room for interpretation to those who must implement laws, leading to contingent strategies of implementation. When ambiguity is low with bitter conflict over goals, compliance is contested, and outcomes are determined by political power. When ambiguity is high and conflict equally high, the strength of local coalitions shapes the outcome. Matland (1995) labels the former political implementation and the latter symbolic implementation. Strategy success is therefore likely to vary because reforms, being redistributive policies, generate conflict and often ambiguity.

Issue linkages and framing are discursive coupling strategies used to attract or co-opt supporters to new policy proposals, mobilise opponents, and justify policy interventions. Linkages between cooperation on one issue and cooperation on another can ensure that all parties gain by participating. Or they can play a strategic role by expanding the agenda to mobilise opponents and increase policy conflict (Schattschneider, 1960). Problem definition and framing play a critical role in focusing and sustaining the attention of coalitions by altering perceived consequences and policy images (e.g., Rochefort & Cobb, 1994). By framing consequences, policy entrepreneurs establish causal links between problems and desirable policy options. Successful frames also enable entrepreneurs to supersede institutional constraints and move across streams with relative ease (Knaggård, 2015). Framing is thus a coupling strategy that joins together problems, solutions, and politics to build narratives among coalition members. Such narratives in turn enable entrepreneurs to affect coalitional composition, cohesion, size, and sustainability (McBeth, Jones, & Shanahan, 2014).

Reforms frequently involve framing contests (Boin et al., 2009) and contradictory demands. The last factor is especially troubling in periods of crisis because policymakers are pushed by internal and external forces to adopt policies that return some semblance of normalcy and pulled by others to reform in order to address the conditions that created the crisis in the first place (Zahariadis, 2013, Zahariadis et al. 2021). Crises involve significant turbulence and uncertainty, hence creating demands for fundamental changes (Katsanidou and Lefkofridi 2020; Zahariadis et al., 2022). When these demands become ambiguous laws, coalitions form to seek particular interpretations of (including opposition to) the new rules (Mahoney & Thelen, 2010: 11). Conflict increases and resistance to programmatic change stiffens because autonomous agents and/or clients usually do not participate in the decision-making process. The chances of implementation success rise when frames are used consistently to broaden supporting political coalitions and reach out to public opinion.

Prospect theory predicts that individuals will likely take more risks if they are trying to avoid losses (Tversky and Kahneman, 1981). Implementation is likely to overcome opposition and be more successful when issue linkages or frames are used as potential losses to important stakeholders (e.g., the medical profession). Therefore, when the policy area is linked to problems in other policy areas (e.g., fiscal discipline or spending cuts to avoid bankruptcy) and framed under a paradigm of conditionality (such as refusal to bailout the whole country), important stakeholder may weigh out their support differently.

Finally, *resources and side payments* are used to create and sustain winning coalitions. They involve current and future promises to pay that increase value for coalition members. Policies typically include such provisions to strengthen support and minimise opposition. Riker (1962: 108-14) lists several types of relevance here. Monetary/value-based payments often constitute the main incentives to join and sustain winning coalitions. For example, implementing parts of the law might result in additional funding or open possibilities to improve quality of service. Negative incentives in the form of sanctions sustain coalitions by specifying the consequences of non-participation: e.g., not enforcing legal provisions might result in funding cuts. If governing members of the coalition can be reasonably expected to play the same role in future policies, they can then credibly offer promises about subsequent decisions. Finally, payments accommodating the ideology of coalition members are highly valued for moral satisfaction of serving their cause or defeating the “enemy.” The more

ambitious the changes, the more resources are needed for implementation and the greater the use of selective side payments to sustain the minimum implementing coalition. Beyond a minimum amount of side payments, implementation in times of economic crisis is less likely to succeed when more resources are needed to put laws into practice (Exadaktylos and Zahariadis, 2014; Zahariadis and Exadaktylos, 2016; Exadaktylos, 2020c).

The MoUs identified many areas of concern in Greece when it came to health policy. In the context of this article, we focus our attention based on the policy outcome in terms of the implementation of reform. Therefore, we zoom into an area where the required reform was implemented; one where reform began, some change was observed, but other elements of the reform were either changed, selectively implemented, or scrapped altogether; and one, where despite any efforts for implementation, reforms faced significant structural and support obstacles and were abandoned in full.

(a) Reform implemented: the liberalization of pharmacists as a profession

One of the main issues identified as problematic in the Greek economy has been the presence or imposition of unnecessary barriers to trade (Ioannides and Pissarides, 2015; Pagoulatos, 2019; Konstantinidis and Karagiannis 2020). Such barriers hinder the competitiveness of the Greek economy and therefore can impede sustainable growth in the future. Many interventions were conditioned because of the MoUs in the financial crisis period, such as for taxi drivers (Exadaktylos and Zahariadis, 2014). Lifting the barriers was a measure seen as improving service provider competition and ensuring regulatory quality. The first MoU highlighted the positive effect of liberalizing restricted professions on growth. The Greek business environment imposed securing several licenses and certifications before someone could operate a business, which went beyond the qualifications of the person providing the service, restricting the number of operating businesses in an area, the merging of businesses, but also entry and exit regulations, subsidies and the presence of consortia or conglomerates.

The second memorandum went beyond the identification of specific professions in the economy and included the promotion of further reform and easing of regulations governing the operation of such professions. One of those identified within the MoU was community pharmacies, the liberalization of whom targeted improvement of service efficiency. This was

coupled with the liberalization of more types of non-prescription medicine and other pharmaceutical products in supermarkets for instance. Law 4336, voted in August 2015 incorporated the legal basis for lifting restrictions in response to the third MoU. Following the general legal framework, an additional set of three Ministerial Decisions (82829/2015; 6915/2016; 36277/2016), a Law (4558/2018) and a Presidential Decree (64/2018) were defining the prerequisites for opening new pharmacies, and regulation ownership, hours and terms of operation. This did not come easy, as the original Joint Ministerial decision (36277/20.5.2016) was revoked at the Council of the State following legal action by the Pharmaceutical Associations of Athens and Thessaloniki.

(b) Reforms partly implemented: Universal primary care system (family doctors and general practitioners (GPs))

Another component against the deficiencies of the Greek public sector identified in consecutive MoUs was the management of public funds as well as the number of points of corruption in the public sector system that opened the door to side payments, briberies and the exploitation of the public purse for private endeavours. Closing these gaps would enable better control and management of taxpayer money, centralization of the system of information, better record keeping, improvement of accountability and transparency of process and the improvements of the networks providing public services on the ground. In the context of health policy, the first MoU identified holes in the provision of primary care. The problematic areas were the governance of national insurance agencies, the contracting of physicians to supply services as part of the national health system, and the corruption of the primary care system in managing the uninsured.

The MoU prescribed the unification of all national insurance funds under a single payer structure, aiming at improving governance and management of the resources allocated to primary care. The new agency, the National Organisation for Healthcare Provision (EOPYY in Greek), was established in 2012 (Law 4052/2012) and started operating in 2013 as a unified structure, combining both purchase and supply of healthcare services. The focus of the new agency included preventive measures and promotion of health, supply of primary care including check-ups and other medical tests, physiotherapy, occupational health, speech and

mental treatments, pharmaceutical provision, dental care, hospitalizations and nursing services, expenses for transfer of patients, obstetrics and labour benefits, hospitalization abroad, rehabilitation, supplements and prosthetics, and other special treatments. The beneficiaries of these services included all those insured under the national insurance agency.

The new law made provisions for the new agency to incorporate the primary care clinics from the Social Insurance Organization (IKA in Greek) and to contract many private physicians to provide public primary care services on a part-time contract, allowing time for private practice. Reforming the primary care system was an essential element in improving the governance system of healthcare provision according to the joint proposals between the Troika and Greek Ministry of Health.[4] The SYRIZA government in 2015 also included additional provisions to provide care to those who were uninsured with Law 4368/2016. The biggest change within the provisions of the new agency was the institutionalization of primary care teams into autonomous system units in the form of neighbourhood primary care services with special reference to the provision of care within the urban communities. 240 Local Health Units (TOMY) were planned in all urban areas to be operational by the end of 2018 (Law 4486/2017) when the law was sent to public consultation.[5] Each TOMY would incorporate four General Practitioners (GP), one paediatrician, two nurses and two public health professionals, one social worker, and two administrators. Despite the intention to have those TOMY set up by the end of 2018, only approximately half of them have been established.[6] The main reason for the severe delays in the implementation of the policy were reactions from doctors who were reluctant to join the system claiming low salaries and a requirement for public-only service while providing services for EOPYY (i.e., could not combine private patients in the allocated visiting hours).

[4] For details on the debate between the Troika and the Ministry of Health see https://www.moh.gov.gr/articles/ministry/grafeio-typoy/press-releases/1195-synenteyksh-ypoyrgoy-ygeias-kai-koinwnikhs-allhleggyhs-k-andrea-loberdoy-sto-r-s-real-fm-kai-ton-dhmosiografo-giannh-papadopoylo

[5] For the consultation stage see https://government.gov.gr/σε-δημόσια-διαβούλευση-το-νομοσχέδιο/

[6] The target date has been extended to 2023 under the new rules for clawing back funds available by the European Union for missing the targets: https://www.in.gr/2022/05/23/health/health-news/240-tomy-promitheies-kai-clawback-ypo-epitirisi-stin-ygeia/

(c) Reform mostly not implemented: Referral system from primary to other care tiers

One of the issues identified within the Greek public sector was corruption regarding service provision. This phenomenon resulted in additional payments required by citizens to benefit from services to which they were entitled or reach a specific specialist who could support them. Part of the reforms for healthcare provision hence aimed at improving the referral system so that citizens would not seek out shortcuts to be able to benefit from specialist healthcare or specialist medical personnel. In a similar vein, an issue of over-prescription was identified due to the lack of a digital system of monitoring referrals and prescriptions (Kolokotsa, 2021). The practice of bypassing the formal referral and prescription systems led to corruption between doctors and patients, and pharmacists and customers, as well as the burdening of the system with the provision of free or subsidised medicines to patients not requiring either the amount or the type of medicine to improve their health.

All primary care system reform proposals envisage that the primary care physician (family doctor/GP) would act as a patient gatekeeper within the system (Mavrikou, 2023). Having access to digital patient records and a unified database, which were absent in Greece, primary care physicians would be able to refer patients to specialist care (Law 4486/2017). Such implementation endeavour in terms of the modernization of the referral system and the closing of the points of corruption and inefficiency required the mapping of available services within the primary care areas across the country, in addition to the mapping of secondary care services and contracted specialist primary physicians. The exercise identified a considerable lack in family doctors and GPs. At the same time, in terms of recruiting such personnel, a large number of private specialists were unwilling to abandon private practice to incorporate public services. Hence, it was mainly these two factors did not allow the referral system to materialise.[7] A Ministerial Decision (29106/13-4-2018) describing the process of referrals from the family doctor or GP to specialist care or other healthcare tiers was issued in April 2018, but it made reference to the fact that the system would not be operational until all secondary and tertiary institutions were linked to the e-prescription system, incorporating an e-referral system. The document did not specify timelines, however, and the system was

[7] At the time of the requirement by the MoUs the system had not materialised. As a result of Covid-19 related legislation however, the government recently managed to complete the e-referral and e-prescription systems using a top-down approach allowed by the emergency laws in 2020 (Law 4704/2020). The original law (3892/2010) was passed but never implemented until ten years later.

temporarily suspended. Even though the relevant law was adopted in 2022,[8] implementation remains mostly on paper. National elections in May 2023 have pushed the timeline further into the future, making this reform mostly unsuccessful in terms of the policy process. While adoption is an important start, implementation has not yet been forthcoming. Besides, our research question explores the fate of reforms mandated by MoUs. The fact that it was suspended upon successful official completion of bailout conditions justifies our characterization of this reform as mostly unsuccessful.

Overall, the state of the art regarding the provision of health care in Greece shows that in the selected reforms for the purposes of the article, all elements identified in the MSF approach are present: lack of policy momentum, inability to build coalitions for change and sustain them in the longer term, issue linkage and framing of the issue, resources and side payments, alongside a prolonged financial crisis which was replaced by the pandemic crisis. These point to the presence of different implementation outcomes, which depending on various degrees of resistance, political bargaining and public support resulted in successful, partial, or unsuccessful reform implementation.

3. Methodology and Research Design

Implementation *success or failure* (our dependent variable) is difficult to define and measure. There are several definitions around the outcomes of implementation, for example, efficiency, effectiveness, compliance or accountability (see Ingram & Schneider, 1990; Matland, 1995). However, considering the short-term horizon of our case in focus on health policy reforms since 2010, we require an output approach. To that end, we view implementation in a dichotomous way: either the proposed changes have been implemented within the specified period (as originally envisaged) or not. This operationalisation gives us two values, which we further break down by including the reasonable outcome of partial change.

[8] The system of referrals was resuscitated in April 2022 when the modifications to Law 4486/2017 were put under public consultation (http://www.opengov.gr/yyka/?p=3230), which became law in June 2022 (4931/2022). The implementation of the law is still questionable but in general it is way out of the timeline proposed for the original reform and contains important deviations from the original framework.

Successful implementation exists when changes are either faithfully executed or when the vast majority of the proposed changes in an area is implemented within the timeframe of the law—from the earlier discussion this applies to the case of the liberalisation of pharmacists as a profession. Partial change refers then to within-case variation. In other words, some mandated changes happened within the time frame, but the majority did not or were completely abandoned or modified in a way that does not reflect the original vision in full. This was the case with the primary care system of family doctors and GPs, where there were severe delays and pushbacks to modify part of the legal framework. Failure, i.e., inertia or no change, exists when implementation did not happen at all, or changes were so fragmented that it was postponed or eventually abandoned. Such was the case with the referral system. Despite adoption of the enacting law in 2022, four years after Greece officially exited the bailout, implementation still remains on paper.

The main methods of evidence collection are interviews in Greece and additional qualitative reports and document analysis of policies by the Ministry of Health, other agencies and various stakeholders. We conducted 35 elite interviews in addition to 4 pilot ones prior to the start of the project (2019) with policymakers, government officials and stakeholders. The project was severely disrupted as a result of the Covid-19 pandemic considering the focus and turn of attention to the tackling of the pandemic and restrictions to mobility and availability of said elites. The interviews identified different obstacles, policy positions and scope conditions for reform. Interviews allow us to discover obstacles and support (coupling strategies), policy entrepreneurs in the process, problem frames and sources of opposition (for the problem and policy streams), and mechanisms of coalition building (as part of the political stream). The qualitative data from our document analysis reflect on support by public opinion, specific references to different positions, the number of resources expended (material or human), and the number of changes implemented within the pre-specified time frame.

For purposes of our research design, each bailout agreement (MoU) opens a policy window of opportunity to implement or revisit reforms that have not yet been implemented. Hence, our time period begins in May 2010, when the first MoU was signed and ends in August 2018, when the third MoU expired, and the Greek government announced the exit from the conditionality of the bailout agreement by the international lenders. Through frame analysis

of the interview material alongside the supplementary material from legal, policy, newspapers and other publicly available documents, we recreate the process of implementation, the opportunities and drawbacks as well as the outcomes. Information from those sources is tabulated to multiply data sources and identify discrepancies from the interview data (Yin, 2014). Evidence is then clustered into themes around each case study to aid process tracing.

In terms of the interviews (as per the list of interviewees in the Appendix), we conducted four pilot interviews in the context of piloting our research project before it started with four academics in the field of health policy in Greece in June and September 2019. We then conducted a further 21 interviews from November 2019 to January 2020 with four politicians, six advisors to the Ministry of Health, seven members of health policy think tanks, and four more health policy academics, mainly focusing on the issues of the family doctors and the referral system. Finally, following the ease of various restrictions and our ability to locate additional interviewees not fully engaged with the tackling of the pandemic a final set of 14 interviews were conducted between January and February 2022 with four leading members of pharmaceutical associations, four advisors to the Ministry of Health, two politicians and four more academics. Some fulfilled more than one role, for instance academics serving as advisors. In this case, they were recorded as advisors on the premise that at the time of the reform implementation periods, they were acting as such, or the advisory role was their primary vehicle of influence at the time.

4. Health policy reforms in Greece during the bailout agreements

Our archival research and the document analysis of the various policy documents and legal acts led us to the outcomes analysed in the section above. Complemented with our interviews on the three specific case studies for health policy reform implementation in Greece, our findings suggest that our discussion of the application of the MSF approach to these reforms has been largely appropriate. Despite reforms in our three cases being placed on the agenda or mandated by the Troika, these were long-standing reforms that go back in time, in terms of the attempts by previous governments to redesign health policy and implement their

programmatic platforms. In fact, some had been legislated already but not implemented, such as in the case of primary care.

In terms of general themes, we observe and highlight a number of constraining factors to the reforms, including the change of government in the middle of the process, the polarised coalitions for change, the absence of clear road maps, strong special interests, the lack of monetary and human resources to implement the changes, the absence of incentives for the coalitions to align with the reforms, the over-fragmentation of the health system, and the absence of supporting infrastructure – some of the reforms were not connected to other policy areas or necessary interventions in a holistic way. Nonetheless, we observed a number of facilitating factors in the cases where the reforms either went forward or were partly implemented, including the low political cost, the conditionality attached to the reform by the Troika and the narrative this created politically, the absence of a strong public opinion against it or the presence of favourable public opinion, the split of the targeted stakeholders in terms of common position vis-à-vis the reforms, the inclusion of external funding in supporting the reform and the political commitment to reform. The main stakeholders that comprised the coalitions were pharmaceutical associations, doctors supporting the national health system, hospital doctors and younger professionals seeking opportunities. Finally, in terms of the types of reactions to the reforms, we encountered meetings with Troika representatives and local political actors, plenty of opinion pieces in the media including live interventions on news programmes, proclamations of strikes, and submitting appeals to the Council of the State. Therefore, within our cases we have all the ingredients supported by MSF to discuss how during certain windows the mix of different ingredients verifies or falsifies our hypotheses.

Within each case study of a reform, we divide the analysis in two parts, the planning of the reform and the implementation processes. We further discuss favourable and unfavourable factors to the reform to answer the question of not only why our hypotheses may (possibly) not be confirmed but also what other explanations may account for the outcome.

(a) Reform implemented: The liberalisation of pharmacists as a profession

Our hypotheses maintain that reforms will be adopted and implemented when non-state stakeholders agree or are somehow co-opted, when the government gets public opinion on its side and when few resources need to be expended. On balance, our interviewees suggest that our hypothesis regarding *public opinion* is partly confirmed. From a government point of view, they all noted that the political cost for taking the reform forward was relatively low and this is why the liberalization of pharmacists as a profession was successfully adopted (Interview AA, Interview AB, Interview AU, Interview AV). In fact, they highlighted that public indifference towards the opening of the profession (unlike other professions) was an asset in the case of implementation, because it made liberalisation less politically contentious. The media coverage, but also the public interventions from members of the pharmaceutical associations in newspapers and television did not create the political traction expected among the public (Interview AW). Therefore, pharmacists were unable to create a public front to oppose the reform and mount pressures on the political leadership.

On the importance of *non-state stakeholders*, the hypothesis is partially confirmed. Our interviewees highlighted disagreement between the pharmaceutical associations, who were opposing the bill (Interview AU, Interview AV). This was a sever impediment towards the ability of the involved trade sector to oppose adopting liberalisation. Political efforts to placate those groups ran into trouble because there were always groups that were not satisfied with the proposed solutions. This internal discord spilled over to the political arena and turned liberalisation into a political issue. The literature suggests that disagreement among the main stakeholders is a way to 'divide and rule' – a sign of political weakness. Our findings reveal the opposite: division (or non-agreement) was an asset in the adoption stage, confirming our hypothesis, but it became a liability in the implementation stage, facilitating it, rather than acting as a veto point. Opposing views during implementation means that there is no coordination within the non-state stakeholder group and the political leadership can continue without any barrier with the reform.

Finally, regarding the importance of *resources*, our findings do not show a strong support for this argument but equally they do not disconfirm it. The interviewees did not mention resources explicitly as a factor, although they noted the strong political rhetoric in support of

liberalisation as part of Greece's first bailout package (Interview AA, Interview AW). Such support had two important dimensions. The first one was the stifling of opposition. The government presented the case as imperative to save the country from bankruptcy, therefore any opposition would derail this broader effort to save the country from financial ruin. The second one had to with the financial aspects. The bailout agreement included explicit mention of the measures with external funding attached to them to alleviate their impact. Liberalisation would bring several positive effects mostly on the public purse, i.e., removing public subsidies and other government expenses such as the 35 per cent guaranteed profit to pharmacists on certain drugs, but its symbolic value was even more important. Linking the reform to the bailout package made it politically essential but financially neutral from the government's point of view, since it did not involve additional domestic public funding but rather expenses already funded by outside sources.

Our interviews confirmed that the reform was regulatory in nature, without any particular demands on infrastructure and was perceived as cost-saving for the state, as opposed to the primary care reform which required finances and human resources and was persistently underfunded (Interview AH), with inadequate budgets decided arbitrarily and frequently not corresponding to the population's needs (Interview BL). It was argued that the pharmacy reform brought changes to the operating hours which was enticing to pharmacists (Interview AY) and could contribute to the forging of business partnerships (Interview AE).

(b) Reform partially implemented: Universal primary care

The first bailout agreement identified cases of overspending and corruption within the social security system and the national health system, and the mismanagement of national insurance funds. The identification of problems was within the governance structures of the social security mechanisms. Hence, the MoU prescribed the unification of all national insurance funds under a single payer/supplier structure targeting effective governance. The new agency, the National Organisation for Healthcare Provision (EOPYY in Greek), established in 2012, started operating in 2013 as this new unified agency, set-up both as a purchaser and a provider of primary care services. The primary clinics belonging in the Social Insurance Organisation (IKA) were absorbed within this new structure, and a number of private

physicians were contracted to provide primary care services on a part-time contract, with the ability to exercise in parallel their private practices.

EOPYY's purpose was to minimise and ideally eliminate the fragmentation of spending and the inequalities between separate public insurance funds and integrate primary care with the National Health System. The positioning of EOPYY within the Ministry of Health, as opposed to its predecessors under the Ministry of Labour, worked towards achieving this integration principle. However, it also inherited the medical personnel of the clinics, meaning that its role as a negotiator was limited for the provision of primary care services (Interview AJ). At the same time, in 2014, the establishment of National Primary Health Network (PEDY in Greek) through L.4328/2014 supervised by the regional health authorities, included the establishment of local healthcare centres, the former IKA clinics and contracted doctors and medical laboratories. This turned EOPYY into merely a buyer of services rather than the intended provider of services. Such change was mandated by the Troika (Interview AD), arguing that EOPYY could not act both as a manager and provider.

EOPYY was further limited, despite its role as an exclusive buyer, as its budget is fairly constrained, and the negotiation committee is supervised by the Ministry of Health instead. Therefore, in this to-and-froing between EOPYY and PEDY faced interest group resistance (Interview BC) seeing a struggle to staff the primary care units and confronted nation-wide strikes, which turned the public against the reform (Interview BD). Striking doctors were demanding better financial incentives, more choice for patients and more access points, which struck a chord with the public who is traditionally relying on hospitals for all medical needs. Hence at this stage, the system remained fragmented, with the same divisions largely remaining, simply shifting supervisory authority to the regional health authorities and constraining EOPYY as a provider of care (Interview BA).

Reforming primary care was an essential element in improving system governance according to the joint proposals between the Troika and the Greek Ministry of Health. In the second memorandum, SYRIZA when in office included the issue of providing care to the uninsured which was a thorny issue, as the system had suffered misuse from patients without social security contributions (a point of corruption). The biggest element of the reform itself was the introduction of a set of autonomous primary care units serving as neighbourhood primary care provides, institutionalised into a system of primary care provision. The original reform

envisaged the creation of 240 local primary care units (TOMY) to be operational by 2018. Following our previous discussion and the various delays, only half of them had been established within the intended period of the implementation of the reform. The primary reason behind the delays was the inability to recruit doctors. Our interviewees suggested that doctors opposed the reforms primarily on grounds of low compensation for providing medical services. They claim this was extremely low compared to the remuneration received from their private practice. At the same time, the hours allowed for private practice were limited and that reduced their ability to see other patients, as these were demarcated as public only service. Therefore, doctors were reluctant to join in support of the reform.

Revisiting the hypotheses of our framework, the argument around *resources* received considerable support. Our interviewees noted that funding by the European Union budget and the support received by international and European institutions had a positive role to play in reforming primary care (Interview BE, Interview BF). The EU funding made the reform plausible, but under a fixed term of four years, hence the contracts offered to doctors to join the TOMY were fixed only for two years. This disincentivised doctors who resisted joining, especially those who would have to give up their private practices, alongside the more junior ones (Interview BG).

Interview evidence also confirms the first hypothesis about *non-state stakeholders*. Doctors and their associations are quite powerful in Greece, and they can easily bring the system to a halt and had a large input towards the proposed reform. However, their group was somewhat divided along political lines in terms of supporting (or not) the reform (Interview AK, Interview BH). This confirms our hypothesis. When the stakeholders do not have a common line, liberalisation does not on the whole move forward. But the inability to bring stakeholders on board in this case, according to our interviews (Interview AM, Interview AN), also had to do with the structure of the profession itself, which is fragmented along the lines of different specialisms, hence the expectations for financial remuneration for providing services was different.

Despite the availability of external funding and support for the reform, it never got the traction it deserved fully among doctors as there are relatively fewer general practitioners as opposed to specialists in Greece. In 2019, the number of GPs was 4604 out of a total 66058 (Ministry of Health 2020) or roughly 7%. Looking at the numbers of doctors per 10,000

inhabitants, this was 4 GPs, 3.5 paediatricians, 2.9 gynaecologists, 2.1 psychiatrists, 22.3 hospital specialist doctors, 12.3 surgeons. Because the reform directly affected GPs, this meant that they held disproportionate power among doctors as a group. Although the purpose of TOMY and its predecessor, PEDY, was to introduce a degree of gatekeeping to the system, there was never a concentrated effort to increase the number of GPs and enhance their status within the medical hierarchy. According to one interviewee, "GPs did not pose resistance, driven by an understanding that the reform could never be fully implemented" (Interview BM), and the government was reluctant to introduce private sector operatives in the new system (Interview AL). GPs are assumed to be a less powerful interest group considering that most medical personnel in Greece are specialists, hence for the reform to take off it would require the co-optation of specialists in primary care. Nonetheless, the political and medical community did not consider this intricacy and had been traditionally disregarding the role of GPs in its importance to a properly functioning primary care system (Interview AS). This confirms that the inability to recognise the value of GPs for universal primary care and because the reform was replicating existing inefficiencies, full implementation was inherently unlikely. Such prospect was not aided by the Troika who, despite seeing the major deficiencies in primary care, did not provide a framework for the direction of the reform (Interview AX).

Beyond the discussion on how structural reforms lacked direction from those imposing the conditionality, the government was also unable to persuade GPs to join the new system because of the lack in financial incentives. According to interviewees from the medical associations (Interview AQ, Interview AR), because the reform would not link organisationally the primary care units in an organic fashion to the National Health System, it lacked the seamless connections it needed to the rest of the health care system in Greece, leaving those who would join the system overworked and possibly underpaid. Confirming our hypothesis about the importance of public opinion, our interviewees suggested that there was favourable opinion that managed to bring some of the reform forward (Interview AO, Interview AP). However, the inability of the government to staff the primary care units, so much demanded by the general public, left the reform half-way with severe delays and long backlogs of patients (Interview AF). The latest carrot and stick approach with clawbacks from

the external funders has recently given new momentum to the reform as previously discussed, but at the original timeframe the implementation was fragmented and partial.

(c) Reform adopted but not implemented: Referral system from primary to other care tiers

The reform was designed on the premise of GPs being able to refer patients to specialist doctors in the secondary and tertiary tiers of health care (i.e., practices and hospitals). Two categories of patients were designed, a simple referral for a visit to be held within 30 calendar days to a specialist and a chronic patient referral with a 12-month validity to cover the total number of visits required. The referral system would be set-up as a digital only system from GPs to the specialists in Health Centres, other public structures of secondary and tertiary care tiers and to the doctors contracted under EOPYY. This would close a serious corruption loop of paper-based referrals that was in place and frequently exploited with side payments for fast-tracking. The operational linkage between the digital systems and referral processes between primary and other care tiers would take place following the ratification of the legal framework, while the system would prioritise emergencies without referrals.

Every member of the public would have to register with a personal or family doctor (as per the previous reform on primary care). Those doctors would be responsible for providing personal doctor services as the first point of call, update individual patient digital medical records, monitor vaccinations, provide public health services, and refer patients to specialists. Each personal/family doctor would have a quota of 2000 registered individuals. They would staff health centres, local health units, rural health practices alongside the privately contracted ones by EOPYY as described. They would be the ones referring patients to specialist services, filtering them through the digital system towards secondary and tertiary hospital care, private practice-based specialists, and private diagnostic laboratories for tests. From this process, it was made clear that access to the system would be allowed only to registered doctors within the EOPYY system.

Our interviewees underscored the importance of completing the reform of universal primary care before proceeding to the referral system, the argument being that the reform on this matter would be incomplete without a successful reform of the provision of primary care and

largely unlinked. The GPs association sent a reaction letter to the Minister of Health at the time, highlighting the right to access the electronic prescription system and by extension to the referral system by doctors not registered under the personal/family doctor lists (Interview AC). The Athens Medical Association in fact, supported by other local associations around the country issued a statement supporting the unequivocal right of any doctor to prescribe medicines and tests to patients (Interview BG, Interview BH). The medical associations created considerable noise with more than 15 questions in the relevant parliamentary committees also highlighting the lack in recruiting doctors (Interview AZ, Interview BB). Yet, one interviewee suggested that the actual reform for the referral system "was never seriously considered" (Interview BI).

In terms of resources, those were never there both in terms of infrastructure (as outlined in the policy design) and of human resources, as it was apparent from the primary care reform and the government's inability to incentivise practitioners financially. This impeded the ability of this new system to collect, process and disseminate the necessary information to assist in the development of a unitary approach to primary care (Interview BK). In terms of organised interests in this case, our interviewees suggest that the same reasons as with primary care reforms applied in this case too in terms of the reaction, with doctors being reluctant to join the system and abandon their private practices (Interview AG, Interview AI). The reform of TOMY did not replace PEDY but added an institutional layer of the same purpose. Instead, the original intention was that these structures would be there for prevention and not for therapy (Interview BJ). Coupled with the stark reaction from the National Doctors Association who had established perspectives and practices, the resistance was rather strong (Interview BG, Interview BH). Finally, in terms of the public opinion, it tended to be from indifferent to negative. According to our interviews, there was a general disdain by the Greek public to be forced to rely on a family doctor who would then refer them to a specialist (Interview AT). Moreover, the Greek public has a general preference of going to the specialist doctors privately on grounds of self-assessing their needs (Interview AX, Interview AY) and because of long-term trust-building practices, which are societal constraints. The Greek public's mindset towards referrals is generally negative as it is hard to break the misconception that hospitals should be the points of first contact with the health system (Interview AF) and that a consistent approach is not present (Interview AH).

Nonetheless, the main argument against the reform came from doctors who were reluctant to release time from their private practice and join a system that would remunerate them less (ranging according to the 21st Healthworld Conference 2022 to approximately €27 euros per patient per year). Public opinion was also not supportive and very sceptical of the reform, fearing that it would severely restrict freedom of choice when it comes to referrals. Patients would be unable to explore different options from private doctors contracted under the system, but rather take advantage of the first available appointment. So even if this system would be generally cheaper for patients in the long run, the inability to choose negatively affected the possibility of reform. The absence of resources to support linkages between the different health care tiers and the inability to complete reforms further up the tier system prevented the reform from taking off altogether and was soon abandoned. At the time of writing, the referral system was initiated again in 2022, with 49.64% of eligible citizens having registered with a personal/family doctor, with half of those in a primary care unit and roughly one third in freelancers employed by EOPYY. This was made possible with the additional penalty to citizens who did not register with a personal/family doctor of a 10% premium on their contributions to purchases of medicine and taking medical diagnostic tests in labs.

5. Conclusion

The three MoUs sought to address chronic issues with Greek health care among other policy sectors. Despite reforms being mandated by creditors and agreed to in principle by the Greek government, some succeeded, and others did not. We asked why, examining three cases:

(a) the liberalisation of the pharmacy profession as a case of successful implementation,

(b) family doctor reforms as a case of partial implementation, and

(c) the referral system for specialised care as a case of mainly unsuccessful implementation.

Our analysis uncovered evidence to support the MSF-derived claim that implementation outcomes are due to three factors: the strategies and power of the main non-state coalition partner (the medical profession), the size of resources needed for successful implementation, and the ability (or not) of government to mobilise public opinion. Our study has implications

for Greek health reforms and more broadly about MSF and implementation, which may travel comparatively to other national contexts.

We draw two main implications about Greece. First, despite the crisis narrative and the MoU mandates, domestic political support is critical for implementing reforms. The structure (unity or not) and mostly political power of pro- and anti-change coalitions made a big difference. In terms of the actual support among the targeted stakeholders, a series of interesting dynamics developed. The pharmacists were not united but at the same time public opinion was along their side. The primary care general physicians had an overly disproportionate power stake over other specialists and managed to leverage delays on the implementation of the reform and the rollout of the primary care units. In the referral system, the administrative capacity of the system was not prepared to undertake the task of digitally linking the different care tiers and in addition to an unfavourable public opinion who place the issue of choice above the one of cost, creating an overall hostile environment against the reform, which was effectively suspended but recently resuscitated (2022). Future health reforms, or reforms in general, especially those mandated by external actors, should pay attention to content, i.e., the problems they seek to address, but also the domestic political game that will be played in the policy adoption and implementation stages. Crisis inspired narratives are not compelling enough.

Second, public opinion plays an important role in putting pressure to reform in the 'right' direction. Mobilising the final consumers of health services is critical in overcoming inertia and political pushback from those groups who fear they will lose their benefits from policy change. Corrupt systems sustain themselves by creating stakeholders in the form of special interests. As Olson (1965) argued in his classic work, small, organized interest groups are far more likely to gain politically than large unorganized masses. The implication is that Greek governments should have far more actively engaged in public information campaigns about the necessity and patient benefits of health reforms. (Partial) failure in some cases, like primary care and especially referrals, showed the folly of taking special interests head on without mobilizing public support.

Looking at the current state of play, despite the reform of the pharmacists' profession, Greece still operates a local pharmacy approach, as the pharmacy is largely linked to personalised primary care services for the immediate neighbourhood, although the hours of operation and

the night shifts availabilities have improved. Nonetheless, the advent of the pandemic was instrumental in making the pharmacy a first point of combat against the Covid-19 virus with pharmacists engaging with the digital prescription system (Zahariadis and Karokis-Mavrikos, 2022). When it comes to primary care units, the reform has recently picked up because of a clawback provision regarding external funding. As a result, the Greek government has managed to secure an extension for implementing the reform, partly due to the advent of the pandemic. Finally, seeing the success of the digital prescription system and the change of mentality by the general public in seeking referrals through the use of digital portals, the registration scheme to personal doctors has been partly successful following the pandemic (Karokis-Mavrikos, 2023). This did not come without an incentive, which was the mandatory premium on top of patients' contributions to medicines and medical examinations. This brought concern to the public, which under pressures from the cost-of-living increases saw this as an opportunity to prioritise affordable health over choice.

The health care reforms in Greece have not finished and there's still a number of areas where reform has not even begun to be designed or its general principles not even conceived. Some of the remaining issues of contention concern the vagueness around the sustainability of the system in terms of workload and backlogs, the imposition of penalties on citizens who may increase their reluctance to access the system, especially those who are chronically ill, the low inclusion of a good number of doctors who are specialists, but also the ability of those of a specific specialisation to refer patients to other physicians outside their expertise, and the unintended financial burdens from the availability of doctor appointments on the citizens who seek quick turnaround and locally based medical support.

Our study also raises two important points about implementation and MSF that could be applied in other countries. First, it demonstrated linkages between implementation and policy adoption. In both cases, political coalitions needed to be built to support the reform process. While previous MSF studies have identified the disparities between coalitions needed to pass legislation as opposed to those that are involved in implementation (e.g., Zahariadis and Exadaktylos, 2016), our study nuances this argument by showcasing the importance of including major non-state actors in the process. Health reforms are less likely to be successful (or be politically far more costly) if major actors, like doctor unions or public hospitals, are not involved in shaping at least the direction of change. The argument is reinforced by the strong

resistance these coalitions have managed to pose historically in the implementation phase of major health reforms (Mavrikou, 2023; Mavrikou, Zahariadis and Karokis-Mavrikos, 2023). The key to understanding the process of reform is mapping out the preferences of major organized stakeholders.

Second, external actors are important, but their impact should not be overemphasized. Findings from developing countries, including MSF studies of implementation (e.g., Ridde, 2009) maintain the 'myth' of the omnipotent external actor, such as the World Bank, who holds the power of the purse and shapes, if not dictates, the direction of reform. Our study tempers this argument. External actors make a big difference if they have vital resources to offer. However, domestic politics continues to hold the key to success or failure of implementation. Moreover, success comes in small, sometimes very slow, steps, as the referral system shows. The implication is that bailout agreements cannot be viewed simply as apolitical, i.e., technocratic, blueprints of good intentions. They must also be seen as political bargains that marry the ideal and the feasible. While domestic actors have little to no leverage in MoU negotiations with creditors, they have more say in implementing the terms of MoUs. MoU-inspired reforms may, therefore, aim at more than just fiscal stability involving the recipient government. Our study shows that the rate of success depends also on non-state actor involvement. This is not to say that under these conditions, reforms will be successfully implemented. It merely suggests that external actors at least will not be blamed for any failures.

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Appendix

List of Interviews (with coded abbreviations for anonymity)

1. Interview AA. Pharmacists Association
2. Interview AB. Member of the Pharmaceutical Association
3. Interview AC. Advisor to the Ministry of Health
4. Interview AD. Former advisor to the Ministry of Health
5. Interview AE. Former senior personnel at the Ministry of Health
6. Interview AF. Health care professor - pilot
7. Interview AG. Health economics professor - pilot
8. Interview AH. Health policy professor - pilot
9. Interview AI. Health economics professor – pilot
10. Interview AJ. Member of Parliament
11. Interview AK. Member of Parliament
12. Interview AL. Member of Parliament
13. Interview AM. Advisor to the Ministry of Health
14. Interview AN. Advisor to the Ministry of Health
15. Interview AO. Local government politician
16. Interview AP. Local government politician
17. Interview AQ. Senior member of the Athens Medical Association
18. Interview AR. Senior member of the Athens Medical Association
19. Interview AS. Health policy professor
20. Interview AT. Health economics professor
21. Interview AU. Pharmacists' representative
22. Interview AV. Pharmacists' representative
23. Interview AW. Advisor to the Ministry of Health
24. Interview AX. Advisor to the Ministry of Health
25. Interview AY. Senior advisor to the Ministry of Health
26. Interview AZ. Advisor to the Ministry of Health
27. Interview BA. Advisor to the Ministry of Health
28. Interview BB. Advisor to the Ministry of Health
29. Interview BC. Expert on health policy
30. Interview BD. Expert on health policy
31. Interview BE. Expert on health policy
32. Interview BF. Expert on health policy
33. Interview BG. Senior member of the Athens Medical Association
34. Interview BH. Senior member of the Athens Medical Association
35. Interview BI. Expert on health policy
36. Interview BJ. Health policy professor
37. Interview BK. Public health policy professor
38. Interview BL. Health economics professor
39. Interview BM. Health care professor

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