

National Health Policy In Greece:
Regulations Or Reforms ? The Sisyphus Myth

By

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Abstract

This paper attempts an evaluation of health care reforms and regulations in Greece. The main findings indicate that the existing Conservative Government has kept but not developed some previous Social-democrats' major reforms concerning decentralisation and hospital management arrangements. The government also announced new regulations concerning the pharmaceutical sector and the procurement procedures of the national health units. On the other hand, precedent regulations for primary health care were to be postponed and the fundamental financing issue of the system has been neglected. In addition, this paper intends to take parallel account that terms such as globalisation and enlargement are still within the European perspective of the country. Overall, the Greek NHS seems to be developed and enlarged, besides the lack of strong political will to consider reforms and even regulations, into a continuous managerial process, assessment and public dialogue. In this sense, there is a continuing gap between - on the one hand - principles and goals and - on the other hand - rational planning, political issues and implementation process, all resulting in a never-ending reform scenario.

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1. Introduction

The rising cost of health care services, structural and organizational problems of health systems challenging the principles of effectiveness, efficiency, equity and quality, and changing epidemiological patterns are the main forces driving health care *reforms in Europe* during the last decades (Saltman and Figueras, 1997; Figueras et al., 1998). Effectiveness, macro-efficiency and cost-containment measures were predominant over reform trends in the 1980s, while micro-efficiency, quality and patient choice were considered mainly during the 1990s (Ham, 1997). The shift from integrated public health systems to contractual models, the introduction of cost-containment measures through the purchaser-provider split, the measuring of clinical performance, and the strengthening of consumer orientation of health services are some common themes. These various reform processes aimed at the allocation of resources more effectively, the control of health expenditures, the strengthening of accountability of the providers for the use of purchasers' resources, the achievement of efficient clinical performance at the micro level and the protection of patient rights (Ranade, 1998; Flynn and Williams, eds, 1997; Mossialos and Le Grand, 1999; Davies and Mannion, 2000).

The *Greek health care sector* faced similar challenges, although it has followed a different policy pathway. The government established a National Health System in 1983 with the aim to achieve full and integrated coverage and access to health services. Instead, during the 1990s, central administration implemented various policies and introduced certain laws placing emphasis on efficiency and control of spending. Table 1 summarizes major reform plans and proposals after 1983. In the next sections of this paper, we intend to prove that these governmental interventions were fragmented and only few of them have been largely implemented.

The 2000 reform agenda was a view of changes in some of the country's rules of the NHS game, attempting to alter the institutional setting of the NHS provision side and giving a central role to health policies that many people might reasonably expect to be implemented, since they had in mind the capacity of the then government and the minister's political willingness to fulfill relevant processes. Taking account reflections on a theory and practice of reforms (Stiglitz, 2000), one of the main problems of this period (and of the others also) was that implementation and political sustainability were sideshows, but not the main event in the reform agenda.

Nowadays, health care sector in Greece is characterized as a mixed system of health care provision financed through salary based NHS providers, prepaid administered payments based on the social and private insurance funds and fee-for-service private practitioners. A large number of problems remain and malfunctions persist including high private expenditure and side payments (1/2 of the total), low user satisfaction, mal-distribution of human resources and facilities, and inequities in access to services. However, WHO 2000 evaluation classified the Greek health system in the 14th place among all UN countries, and thus approved the so-called Greek "paradox".

The present paper attempts a critical and empirical review of the basic health care policies in Greece mainly during the last two decades. Its purpose is to investigate the reasons of the existing gap between the political agenda and legislation, as well as the relevant implementation process; a gap that strengthens resistance to change and results in a never ending reform scenario (Geitona et al., 2004).

2. Health policy issues in Greece before NHS (1983)

Until the decade of '80, the political system was strongly polarized and mainly dominated by right parties. Industrialization was inadequate to create a middle class and also to support effectively a welfare state. Employment to public services was increased and usually dealt with clientelistic relations. This public culture made few social groups to earn disproportionate privileges. Trade unions obtained strong power after the 1967-1974 dictatorship and the democratization of the state.

Following the relation of the Greek economy and the state, the Greek health system evolved in a fragmented manner, with a political climate unfavorable for universalistic ideals and strong vested interests successfully blocking effective reform attempts (Mossialos and Allin, 2005). More specifically, the influence of stakeholders, the presence of clientelistic relationships between the political party in power and certain groups on the one side, and the fiscal constraints on the other side pose significant barriers to any health system reform (Davaki and Mossialos, 2005).

The Greek health system historically was based on Bismarckian features, possibly reflecting structure of Greek economy (small businesses – small insurance funds). However, some small white-collared unions managed to gain comprehensive insurance coverage (Mossialos et al., 2005). The major Social Insurance Fund, IKA (for blue and white collar workers, near ½ of the population), was established in 1934 and played a central role in the development and organization of health care services since 1980s (even today). Other multiple social insurance funds for the self-employed concentrated in TEVE & TAE funds many years later (during 1950-60s). The 3rd major Social Insurance Fund for Farmers, OGA (1/4 of the population), was founded in 1961. Public servants were totally covered by the state, due to low salaries (OPAD was recently established as the 4th major social fund).

The *first attempt* to establish a - Beveridge type - National Health System was in 1953. Law 2592 created a new organizational and peripheral structure for public and charitable hospitals. This provision was viewed as “too socialist” in the light of the then conservative ideology (Niakas, 1993) and had no implementation. A new hospital reimbursement system was initiated (Geitona and Yfantopoulos, 1995). It was based on per diem rates paid by the social insurance funds.

The country faced high rates of growth during 1960s and 1970s. However, public health care spending remained below 2,5% of GDP until 1960s and below 3% until 1970s (4% in 1971 and 4,5% in 1981), while public health services were characterized from the old infrastructure, dispersed and limited primary care,

scarce organization and funding. Until the end of 1960s health policy was vague, since the state and the various funds were not well coordinated. Provision of services appeared deficiencies in lack of equipment and personnel, and geographical disparities as well (Ministry of Health and Welfare, 2003). The private sector expanded rapidly, taking into account physicians in solo practice and small hospitals (“clinics” of low level requirements by the royal degrees of 1963-4). The state developed few public hospitals in large cities and continued to subsidize few old charity and public hospitals mainly through the various funds.

Dictatorship period 1967-74 has been characterized as the “black box” of the Greek political history. Nonetheless, in 1968, the Minister of Health presented a reform plan to the junta government (Patras, 1970). Its aim was to develop, organize and decentralize public health services, to unify the funds’ regulations and to introduce a primary care system (including GPs) in rural areas. The proposals had no serious implementation into health policy actions. However, by the end of 1960s, graduating doctors have been obliged to spend a period (1-2 years) in order to cover rural remote areas, since there were no GPs or other doctors to cover these areas.

After the reinstatement of democracy in 1974, the prerequisites for the development of a comprehensive national health care system appeared in place. A conservative government runs the country until 1981. Firstly, in 1976, KEPE (National Center for Planning) presented a research defining the problems and proposing measures to the government to create *a national health policy* (KEPE, 1976). The Minister of Health (Prof. Doxiades) prepared a draft of legislation (1980) provided

- the establishment of a National Health System,
- the creation of a Planning Agency concerning the provision side,
- the increase in public sector financing through the unification of services of the 3 above mentioned major insurance sickness funds (IKA, OGA, TEVE/TAE - OAEE now - covers 83 % of the population),
- the placement of emphasis on training of general practitioners all over the country and the development of a network of health centres, especially in rural areas.

Regionalisation, improvement of quality, universal coverage and strengthening of the public financing of health services were the main objectives.

A strong opposition mainly faced by doctors’ unions resulted in the withdrawal of the bill presented in Parliament (even parliament-members of the conservatives disagreed) (Liaropoulos, 1992). This period closed with the efforts of various parties to establish a national health policy or system, even-though various health policy lobbies resisted. On the other hand, presented measures failed to face institutional realities (Papoulias and Tsoukas, 1994).

3. Two decades of NHS (1983-2001): another Sisyphus myth or an achievement?

In 1983 an extensive *reform* plan of Greece’s health services established the National Health System (NHS), designated ESY (metaphorically means “you” in

Greek) by the then Socialist Government. This reform was based on the experience of some European countries (especially the UK and the Scandinavian countries). It presented some similarities with the plan referred previously and it mainly passed this time due to political will and doctors' support. It attempted mainly to increase the share of state funding in health care (Maniadakis and Yfantopoulos, 1996) against insurance and private expenditures. By the end of the decade, an almost full financial transition from a predominantly insurance-based model to a tax-based one had been occurred (Tragakes and Polyzos, 1998). Thus, in the beginning of 90s, NHS could be characterized as a complicated mixture of a public integrated model and a public contract model, with the former predomination over the latter (OECD, 1994). Besides this main target, law 1397 of 1983 referred to the following principles that were converted to the following policy measures:

- equity in financing and delivery by the universal coverage of the population of all regions (*the unification of social insurance provision or financing was quickly abandoned*),
- decentralization in planning process by the creation of the KESY (central planning agency) and 13 PESY (*regional health councils were not established*),
- primary health care development by the establishment of various health centres in rural areas (today over 200), as well as in urban areas (*the latest abandoned, due to IKA infrastructure of over 200 clinics and polyclinics*),
- preparation and education of a GP scheme, especially in urban areas (*it is now estimated that only 500 works for ESY, 500 for the social insurance funds and 500 for the private sector, instead of total needs of 5.000 GPs*),
- management improvements occurred mainly in NHS hospitals that developed new organograms (*"coordinators" - general managers did not engage in the process, which was in the hands of politically appointed persons*),
- new labour relations (creation of the NHS "exclusive" doctor, while all other health professionals would employed as public servants) came along with increased salaries of the physicians, who earned a lot of enthusiasm,
- a new public-private mix, since some old NHS hospitals had been reconstructed and equipped or new hospitals built up, while restrictions for new entries of private hospitals' entrepreneurs had been strictly imposed,
- new financing mechanisms were implemented concerning a low tariff policy for public health services (*although the old-fashion managerial structure of financing bodies – state and insurance funds – remained the same*).

Therefore the Greek NHS was adapted to the basic principles of development and equality, which characterized the health systems of the western developed countries (Abel-Smith, 1992; Schieber and Poulter, 1991), with a delay of few years. However, it should be noticed that even this effort lacked cost-containment measures and evaluation of efficiency, at least the first 5 years of implementation (Karokis et al., 1992), since the development of public health units was the main objective. Implementation failures can also be attributed to the lack of expertise in

the management of change and the relevant doctors' resistance to these changes that found alliances to the political field (Yfantopoulos, 1998). There was also a lack of evaluation of the reform policy and a significant shift in favor of public provision (Kyriopoulos and Tsalikis, 1993). However, ambitious targets of this period - even though some of them intermediate - were almost succeeded, such as:

- public expenditures has risen almost to 5% of GDP,
- construction of 184 new rural centers and about 5.000 new beds in 20 new hospitals (3 regional and 17 district),
- 6.000 new NHS doctors (1.800 in the rural health centers) and 50 % more qualified nurses,
- indicators like infant and childhood mortality or even expected years of life at birth were remarkably reduced.

The **1992 regulations** (law 2071), imposed by the Conservative Government (1990-3), had the following principles and policy implications:

- the state would guarantee the citizen's right to have freedom of choice (*this finally had a low impact, due to the absence of a referral system*) (Kyriopoulos et al., 1994),
- the legislation introduced *patients' rights* for hospitalization based on European standards,
- the law abolished the previous restriction concerning entries of new private hospitals (*requirements were imposed and made the construction of new hospitals almost impossible for the coming years*),
- a change was introduced in doctors' labor relations and doctors could choose between exclusive and part-time employment (*nonetheless only 5% of doctors chose the latter form of employment*) (Tragakis and Polyzos, 1998),
- managerial and similar to the previous changes were introduced (*not implemented mainly due to the inadequate political time of the government*),
- the financial policy was based on newly introduced per diem hospital tariffs (in order to cover the rapid development of the appeared hospital deficits), some cost-containment measures (co-payments in drugs-outpatients visits-inpatient admissions) and tax reductions of private insurance premiums.

As a result, the expansion of the private provision and certainly of the private insurance was obvious the forthcoming years (Liaropoulos, 1995) (*almost 4% of GDP devoted to private health expenditures at the end of 1990s, 30-40% of this attributed to doctors' induced demand or/and unofficial payments*). Policy agenda mainly included fiscal priorities by transferring responsibilities, directly or indirectly, to the private sector (either in private health services, or through public contracts to outsourcing services). Efficiency, instead of equity, became a first priority, although the public financial transfers to the private health sector increased without institutional limits.

The Socialist Health Policy Agenda (beginning of **1994**) changed most of the above, since many articles of the legislation were abolished (mainly for doctors' labor relations and tax reductions). Two Committees were established to

investigate major **reform plans**: a Greek experts' one evaluated the entire system (Ministry of Health, 1994) and an International experts' one exposed an analytical framework of recommendations (Abel-Smith et al., 1994). Following this, three subcommittees worked further to specify the proposals and made partially the law plans, as following:

- the unification of sickness funds and the decentralization of the provision (Sissouras et al., 1995),
- the new organization and management of health manpower (Dervenis and Polyzos, 1995),
- the primary and public health network, including a new GP system (Moraitis et al., 1995).

The whole process was unique for Greece, especially for the international relevance, the plans' consistency, the technical-scientific evaluation field and the public dialogue.

However, the so-called "Kremastinos Law Plan" delayed to be submitted to the Parliament (December 1995) *resulted to the postponement*, since the prime minister and the minister of health changed within the socialist administration (January 1996). A "political surprise" was the abandonment of the plan few months latter. One of the reasons was the change of attitude and the opposition of the two main doctors' bodies (the NHS hospitals' doctors controlled by the socialists and other left parties, and the National Union of doctors controlled mainly by the conservatives), while all other unions of multiple health professionals seemed to be in favor of the reforms. Another strong reason was the elections still announced (June for Sept. 1996).

The same party re-elected and the government declared "**modernization**" in all areas of public life. The new Minister of Health (Mr. Geitonas) solved the problem of hospital deficits, through subsidies from the general taxation, nonetheless without imposed new and stable financial mechanisms. Also, he consulted by other Greek experts and presented his Plan. That was a less radical proposal at least compared to the previous referred. The 2519 Law passed quickly (1997) from the Parliament. It was supposed that the political will was again strong and the technical preparation of the plan was pretty adequate. Its main new provisions were:

- 13 regional public health authorities (*not established*) and the corresponding "laboratories" (few public health doctors were employed in the district level, and a *National Center of Infectious Diseases was established*),
- chief executives would be employed in every NHS hospital through international tender and evaluation, following specific standards (the tender concerning 30 hospitals was carried out by an evaluation committee following standards, but *the employment phase was never formulated*),
- clinical budgets (or even cost per case on a DRG type) were to be implemented, following relevant proposals (Polyzos 1998a and 1998b), (the per diem reimbursement altered from a "general" to a "clinical" one, while *the accounting systems did not change*),

- “primary health care networks”, mainly for urban areas, were to be established during the coming 3-year period (few establishments were taken place in the private sector, *no one in the public*),
- a positive and a negative drug list were in place (*at the end of this period*), given to the EOF (National Drug Organization) more responsibilities concerning the pharmaceutical policy.

The period discussed here is very important for the NHS and the national health policy of Greece. Until 1985, the strong political will along with people’s and scientists’ expectations were constituted to materialize a huge project of constructions (hospitals, health centers) and other organizational or financial changes. This was not exactly the case of the second socialist period (1985-9), where emphasis was given mainly to doctors’ labor relations and payments. There was little effort in securing the effectiveness, the efficiency, the responsiveness and finally the quality of the system. The beginning of the ‘90s had put a strong emphasis to the so-called new-liberal health policy approaches, but there was a weak willingness at least to evaluate health policies or the system itself.

The new socialist period (1994-2000) came along with reform and planning policies in health. They were cases of a top-down process by scientists (with international acceptance) and individuals from several political or union groups in the Ministry of Health, rather than professional or institutional bodies (central or regional administrators or official planners). Unions and members of political parties were coming to and leaving from the planning or policy process, without continuation, consistency, serious dialogue and formulation of contingency plans. Further more, the lack of serious large databases within the health system did not help the health policy agenda, at least to promote further new policy issues.

However, a remarkable increase of infrastructures, technology and human resources was obvious in the decade of 1994-2004 (*table 1*). This was assisted by European convergence policies through programs and funds from the European Commission Cohesion Fund (mainly for hospital investments) (Theodorou, 2002). Health Manpower increases had a strong influence on domestic policy affairs. Generally, the state put strong emphasis to NHS hospitals, leaving space for primary care installations (especially in urban areas) to the private sector.

Regulations of the decade of ‘90s were impeded on an incremental way (Duncan et al., 1995) rather than on a structural or institutional systematic manner (Lee and Mills, 1982), at least compared to the 1983 reform (summary for all in *table 2*). Plans to decentralize the system failed to result in a concrete change. Unification of the funds or transferring the international experience of provider – purchaser split was both not implemented in some way. Various interests might prevent the formulation of a consensus for radical changes (Walt and Gilson, 1994), since it is known that different voices may induce “enemies” of the reform (WHO, 1997) and provide indirectly “slow and light” regulations. Imbalances among stakeholders, similar to other health systems (Horev and Babad, 2005), caused several aspects of the reforms to stray from the original plans. Expenditures have increased (6,5% in 1980, 7,5% in 1990, 8,5% in 2000 and over 9% now) plus the problem of hidden economy (15%) (Souliotis and Kyriopoulos, 2003). It should be noticed that almost ½ of total expenditures are out-of-pocket

money. The question reflects: has NHS been yet an achievement? If not, it needs reorganization. If yes, clear strategic goals should be rethink (Tountas, 1996).

4. The “Socialist” Reforms of 2001-4

The failure to proceed to reforms over the period of ‘90s, prevented the solution of several delay organizational problems of the health system, regarding regionalization (Abel-Smith et al., 1994; Tragakes and Polyzos, 1998; Niakas, 1993), health services administration (Dervenis and Polyzos, 1995), financing system (Kyriopoulos and Sissouras, eds, 1997), and reorganization of primary health care services (Moraitis et al., 1995). The European reform tendencies, regarding purchaser - provider split, formation of internal market conditions, development of a negotiation process into the health system, and implementation of effective cost-containment policies, had little opportunity to influence the system. Further, the formation of effective policies for human recourses development, quality assurance of health services, improvement of consumer satisfaction as soon as other qualitative elements, were not proven feasible into the health system (Kyriopoulos et al., eds, 2000; Tragakes and Polyzos, 1998; Ministry of Health and Welfare, 2000a).

The Socialists were re-elected again in 2000 and the Ministry of Health was assigned to a powerful politician (Mr. A. Papadopoulos), who became famous for his radical reforms, implemented in the fields of economics and internal affairs, during the past decade. The basic characteristic of the new era is the strong political will to promote global reforms, not restricted to sectional regulations or interventions. The new strategy was based on the major political objectives of (i) strengthening the welfare state and expansion of social benefits, (ii) elimination of social and regional inequalities in health benefits and (iii) establishment of effective managerial processes (Ministry of Health and Welfare, 2000, Papadopoulos, 2001):

The initial reform plan, called "*The 200 Points of Reform*" (Ministry of Health and Welfare, 2000), was constructed around eight main targets:

- Regionalization of the National Health System.
- Reorganization of hospital management.
- Unification under the same authority of primary health care services and gradual equalization of primary health care benefits.
- Distinction between supply and demand of health services and unification of the management of the main social insurance funds recourses.
- Development of a human resources policy and introduction of an evaluation process of NHS doctors.
- Development of a National Health Policy based on health targets.
- Restructuring and reorganization of Public Health Services.
- Development of a broad quality assurance policy.

The regionalization of the system was implemented by the establishment of 17 regional organizations, named “Regional Health Systems” (PESYs). All NHS units were under their authority (Ministry of Health and Welfare, 2001). In greater regions and islands, more than one PESY was established. “Regional Health Systems” were actually founded and started running in 2001.

The administration of hospitals passed from political executives to managers, who were recruited via objective procedures and employed by the end of 2001. The hospital board of directors, which were consisted of political persons, became official bodies, consisting of executives (e.g. CEOs and heads of the medical, nursing and administrative branches of each hospital). The establishment of new units within hospitals, such as information technology department, quality assurance unit, personnel training department, etc, was encouraged, together with a restructuring of some major economic procedures on financial management (Ministry of Health and Welfare, 2004; Zilides, 2005).

The unification of primary health care services under the same authority was planned to be implemented through the transformation of the social insurance health care units to “NHS Health Centres” and through their subordination under the Regional Health Systems (PESYs). The expansion of the Health Centres network and of a Family Doctor (or “Personal” Doctor) model, based on a contractual relationship with primary care doctors, all around the country, were also designed (Ministry of Health and Welfare, 2000; Moraitis et al., 2000; Zilides, 2005). The role of the social insurance organizations would be limited exclusively to financial functions, without provision of any health services.

The plan for purchaser/provider split in the social insurance field was to be combined with the establishment of a single health insurance financial organization (ODIPY) for the unique management of all health resources of the four largest social insurance funds, covering nearly 90% of the Greek population, and optionally of other smaller funds. The unification of financing side was linked with two equity policies: (a) Gradual equalization of benefits and elimination of insurance and social inequalities and (b) resource allocation according to demographic criteria, aiming to the elimination of geographic inequalities. At the same time, the regionalisation of budgeting was expected to lead to the configuration of an internal market among regions and hospitals (Zilides, 2005), and the fund(s) that would examine new financial allocation mechanisms to the region and the hospital (Arredondo et al., 2005).

The supply/demand distinction, as well as the change in the social insurance financing system, was included in the same *draft of law* with the reform in Primary Health Care. However, this part of reform was inevitably linked to both

- (i) wide redistribution of power and responsibilities, not only among governmental authorities or social insurance administrations, but also among trade-unions, and
- (ii) important changes in the labour relationships of doctors employed by social insurance organisations.

The implementation of the reform in the social insurance sector presupposed

- (i) powerful governmental cohesion and commitment in the implementation of such a policy and
- (ii) ensuring social and political alliances, both among social partners and health employees.

These conditions were not achieved. Strong reactions of different interest groups and key stakeholders (e.g. social insurance organization doctors, university doctors, civil servants’ associations etc), as well as political opposition, prevented the construction of the appropriate social and political alliances (Mossialos and Allin, 2005). Some socialist MPs and ministers along with interest groups e.g. doctors’ or

civil servants' associations were supporting politically them (Mossialos and Allin, 2005). Thus, the governmental cohesion was eliminated and the support of many ministers on the reform plan was reduced. As a result, despite the initial Ministerial Council's approval, this part of the reform did not progress, although it was ready to be introduced to the Parliament, twice.

The reduction of the adequate governmental support to his plan led Minister of Health to resignation (June of 2002) and to his replacement by Prof. K. Stefanis. The new Minister attempted to blunt the oppositions and to promote changes that would not cause other redistribution of power or responsibilities. In such an environment, in the beginning of **2004**, the Minister introduced to the Parliament a Bill establishing optional measures for the social insurance organizations (Ministry of Health and Welfare, 2004), which were not materialised because of the defeat of Socialist Party in the 2004 election.

The new human resources policy was based on the following elements:

- (a) Establishment of an internal and external evaluation system for all NHS doctors,
- (b) suppression of doctors' permanent employment and proclamation of all relative positions for a five year period (the permanence granted under the condition of three positive evaluations and ten year experience),
- (c) expansion of exclusive employment to academic doctors and
- (d) implementation of lifelong learning system by the regional health authorities.

The policy did not include important changes in incentives or measures linking income to productivity (Ministry of Health and Welfare, 2000 and 2001; Zilides, 2005). The new regulations were applied in 2002, but their effectiveness was diminished due to a general climate of low administrative accountability in the public sector, especially among doctors.

Concerning the development of a National Health Policy, a process for setting up and monitoring national health targets, and action plans in priority areas, such as psychiatric reform, coordination between health and social welfare services, scientific support, development of quality assurance policy, etc, were designed. Regarding these issues, two Bills were introduced to the Parliament, one establishing a "Health and Social Welfare Services Inspectors Body" and the other incorporating the Social Welfare Services into PESYs (Ministry of Health and Welfare, 2003) (now PESYPs, including also the welfare services). Two more draft laws, establishing the scientific organisations supporting the National Health Policy and the national health care quality assurance organization, were prepared, however they were not introduced to the Parliament after Minister's resignation. Therefore, the whole plan for a National Health Policy was not fully materialised.

The reorganization of Public Health Services provided measures to strengthen central Public Health Services, to achieve intersectoral collaboration at a national level, to establish regional Public Health Services, to rearrange local Public Health Services and to enhance employment in Public Health (Zilides, 2002). The relative Bill was introduced in 2003 (Ministry of Health and Welfare, 2003), but its application was prevented by the pre-election climate. After the election, the announcement of the introduction of a new bill on Public Health Policy by the Minister of the new conservative government (Mr. Kaklamanis) led to the complete inactivation of the law (even many of the articles of the new law re-introduced same constitutions).

In summary (*table 3*), the organisational reconstruction of the National Health System, through the establishment of the 17 regional PESYs, progressed considerably, while the core of the reform, concerning the segregation of financing and health services provision, the establishment of a single financial institution and the unified provision of primary health care services under the authority of NHS, made no progress. The optional collaboration of social insurance organisations, which was introduced by the last socialist law in 2004, had no results in practice. The need for coordination mechanisms between social insurance funds and NHS, as well as the need for a primary health care policy remains an imperative. Under these circumstances, the effectiveness of decentralisation achievements should be evaluated as considerably lower than in other developed countries (Wyss - Lorenz, 2000).

A critical ascertainment is that the implementation of reform measures that presupposed involvement of other Ministries (e.g. Ministry of Labour and Social Insurances) was not achieved, due to the loss of the governmental cohesion and the appropriate political support. The implementation of several other policies was delayed due either to the limitations of the system's performance (Geitona et al., 2004) or to the decrease of political support and interruption after the results of the 2004 election. Political objectives were proven more important determinants of the developments compared to the needs of rational planning, as in other cases (Powell, 2000).

On the other hand, measures and policies were implemented for the first time in the country (regionalization, professional hospital management, introduction of new rules and methods in budgeting and hospital logistics, new policy in human resources, a plan for doctors' evaluation, a quality assurance policy, improvements in meeting patients' needs, new legislation for Public Health Services, etc). In contrary to the experience of other recent reform attempts in Greece, these measures were not simply "rationally planned", but they were also really implemented. Some of these policies and measures constitute indisputable gains to the NHS, while some other acquired a dynamic towards their realisation, even though they were not implemented. From this point of view, an important contribution of the 2000-3 reform process was the development of a "change culture" in the health system, creating favourable conditions to continue efforts for the reform.

5. The "Conservative" policy of 2004-7

The victory of the conservatives in the 2004 election stopped the 2000's reform process. The new government, according to its prior oppositional policy, blaming most of the reforming measures, was led to contradictory choices. The first bill on health policy that conservatives introduced to parliament in 2005 (Ministry of Health and Welfare, 2005) preserved the regional structure of NHS (simply renaming the regional authorities) and proceeding in regulations that aim to the political control of NHS. The professional hospital management established in 2001 was abolished and replaced by a pattern of "political administrations". Thus, the service of most hospital managers appointed in 2001 was terminated before the end of its normal duration. The "new" managers appointed by the Minister of Health (Dr. N. Kaklamanis) without objective criteria or an evaluation process. The control responsibilities of regional authorities over the economic functions of hospitals were considerably limited and the administrative

tools for a regional health policy development (e.g. aggregate regional budgets) were almost abandoned. Both the Law on Public Health Services and the Law on the optional cooperation among social insurance organizations in the field of primary health care services were inactivated. The doctors' evaluation process stopped. None of the drafts of law prepared during the 2000-3 period was introduced to Parliament. The new Minister gave priority to issues with minor impact on health services provision, such as medical ethics or establishing nurses' professional organizations.

In the middle of 2006, a new Minister of Health was appointed (Mr. D. Avramopoulos) who announced some new regulations, concerning the reduction of the number of Regional Health Authorities (now called DYPE, Administration of Health Region) from 17 to 7 and the intention to use a public - private partnership model (PPP), for some new investments (paediatric and oncology hospital) in health sector, like other countries (e.g. Portugal and Ireland) (Thompson and Mckee, 2004). Another law for pharmaceutical regulations (rebate etc.) has already approved and a new procurement NHS agency (concentrated all supplies in the Ministry) was approved to be established.

The main characteristic of the 2004-7 period is the transition from a type of "rational planning" to a "muddling through" model, without a concrete health policy. Even a privatisation policy - as an element of a conservative policy - does not seem to be under planning. Respectively, the whole political management is transforming from a rational reform policy to a number of micro-regulations, setting aside the main necessities of NHS. Monitoring and accountability might be difficult, since the absence of real contracting or pricing schemes, or even formal relationships between purchasers and providers (Ashton et al., 2004), became obvious. The future of an investment plan is obsolete, even though the Ministry of Economics has started to examine public - private partnerships (PPP), for new investments, like the announced coordination between Red Cross and Hygeia hospital.

6. European Union's Enlargement and Health Effects on the reforms in Greece

Globalization *inter alia* affects the operation of health systems and the exercise of health policy, as a process where territorial, time and cognitive restrictions of human interaction are raised and lead progressively to the emergence of new forms of social organization (Waters, 1995). It imposes a number of challenges concerning the organization, financing and provision of health services, and influences parameters such as the quality, the availability and access to them (Frenk and Gomez-Dantes, 2002; Warner, 1998).

In the level of the European Union, these challenges render imperative the configuration of an integrated health policy, particularly in the light of recent enlargement with ten new countries, the majority of which constitute former Socialist countries of Central and Eastern Europe. The differences observed in the level of health and the problems that the health systems of these countries face, reveal the gravity of likely tendencies in regard to: (a) the free movement of health professionals that affects labor market and quality of provided services, (b) the patients' cross-border flows and their consequences for health systems and

social insurance και (c) the free movement of persons and public health risks due to infectious diseases (European Commission, 1999 and 2003; Bowis and Oomen-Ruijten, 2000).

In this context, the health sector in Greece faces a double challenge: on the one hand, it has to cope with internal structural problems which were examined in the previous sections of this paper and on the other hand it has to confront with the changing environment of a continuously expanding European Union. More specifically, the admission in the European Union of Bulgaria and Romania in 2007 is expected to have repercussions in the cross-border flows of health professionals from these countries to Greece. The reflection receives more intense form if someone contemplates the gravity of Greeks who study medicine in these two countries and seek to be registered in the domestic universities, as well as the Greek *doctors* that have graduated from universities of these countries.

More specifically, studies have pointed out that for long time intervals the number of graduates of medicine from Greek universities exceeds the number of new entrants, due to the fact that Greek students who study abroad mainly in Bulgaria and Romania achieve to get registration in a Greek university. The extent of the phenomenon, for example, results in doubling the students of the Medical Faculty of University of Athens (Kalamatianou, 1993; Medical Association of Athens, 2002). **Table 4** shows the registered physicians in their fund (TSAY: Social Insurance Pension Fund for Health Manpower in Greece) according to the origin of their degree for the period 1980-1999. A significant percentage of them, which was 33,3% in 1999, have been graduated from medical schools of other countries. According to the data presented in **table 5**, Bulgaria and Romania are the two countries that have awarded the majority of medical degrees to register in TSAY physicians.

Registration in faculties of medicine of Bulgaria, Romania and other countries of Central and Eastern Europe and the acquisition of degree from them or the objective to transfer registers in corresponding Greek faculties, create the preconditions of appearance of medical inflation in the country and raises questions with regard to the quality of medical education. Perhaps the danger of more extensive immigration of medical manpower to other states of EU will appear, depriving the country from specialized personnel. Non-the-less, a qualitative scorn of educational process is possible to take place. Thirdly, as a consequence of the two precedents, the national planning of medical manpower in the public sector is possible to face difficulties in the achievement of its objectives. This overproduction leads to medical unemployment and demotion of the medical profession. An agreed – structured European Health policy on this field might moderate the vibrations of this EU enlargement (Avgerinos et al., 2004).

With regard to the *nursing* personnel, Greece faces important lacks. As a consequence, individuals, mainly women coming from the new Central and Eastern Europe members of EU, are installed in Greece and provide via private associations and labor offices nursing services in the public hospitals, and home care services primarily in old and feeble for self-service individuals. The level of education and the quality of provided services from this work force is an issue that

requires further investigation (Gitona et al., 1998). However, given the serious shortages in nursing personnel that is observed in the Greek hospitals, the presence of foreign nurses has positive effect in the function of the health system since it contributes in the replacement of the vacancies. In addition, we must consider the indirect social benefit resulting from the fact that the relatives of the hospitalized or those in need of home care do not suffer loss of time and income emanating from their absence from work and other activities in case they were supposed to look after their relatives themselves.

Apart from the free movement of the medical and nursing personnel, another critical issue is the incidence of communicative *diseases* on the health level of the Greek population due to the free movement of persons as well as the demand of health services from citizens of the new EU member states. Unfortunately there are no sufficient available and reliable data to document the reported cases of infectious diseases in Greece caused by migratory movements of populations from other states. Various studies attempt to investigate the epidemiologic profile of different groups of economic migrants; however, they offer a fragmentary picture. The findings of these studies indicate, for example, a relatively increased incidence of hepatitis in the population of migrants from the Balkan countries (Giannopoulos et al., 2000; Chatzitaki et al., 2002; Peteineli et al., 2002), an increase of new cases of tuberculosis in the economic migrants from countries of Eastern Europe (Kornarou and Roumeliotou 2001) and high risk of AIDS transmission and infection from migrant women sex workers from Eastern Europe and the Balkans (Kornarou et al., 2001).

An important parameter of the effects of EU enlargement in the spread of communicative diseases is related with the conditions and the special needs in which the frontier regions of the EU, that border with the new member states, will be called to correspond with. In order to enforce the interregional cooperation the Commission established the INTERREG initiative (Commission of the European Communities, (2001). In the context of *INTERREG* II (1997-2001) and due to the sociopolitical developments in the Balkans (Dolgeras and Economou, 2001), the promotion of measures and actions with the aim to improve the health status of people who reside in the cross-border line of Greece and Bulgaria was pursued, with the establishment of Cross-Border Public Health Centers. Unfortunately, these centers were not yet fully developed and their effectiveness is limited.

Similarly lack of sufficient data exists in the case of patients' cross-border flows and *utilization* of Greek health care services from citizens of EU member states. For example, visits of foreigners to outpatient services are not recorded. The data are also insufficient concerning inpatient care due to restrictions in the statistics of the Greek National Statistical Organization (no aggregate data concerning the nationality of the patients discharged and the causes for which the foreign patients hospitalized).

In addition, a study concerning the consequences for the Greek health care sector of the judgments of the European Court of Justice in relation to the *free movement* of patients has never been conducted. These insufficiencies characterize the Greek health care system and render an imperative to the engagement of Greece for the promotion of proposals which led to high-level

reflection process of the Commission of European Union, with regard to the mobility of patients and health care. A need for intensification of European collaboration is for the better use of resources, the strengthening of information of patients, professionals and health policy makers, the promotion of quality and access of services and the harmonization of national health policies with the European commitments (European Commission, 2003).

7. Concluding Remarks

The *history* of the described *policies* and its reflection on general *theories* of reform could be even more mixed than this discussion indicates. The principles in relation to the goals have usually showed (on the other side) a gap concerning:

- a. the strategies for attaining the goals, and the clearness of both, towards the pacing and sequencing of any reform or regulation, and
- b. the political processes by which reforms or even regulations are attained.

In *table 6*, we intend to give such another but similar to the above evaluation.

Social reforms constitute a political affair and they are determined by the degree in which they express a vision and the degree in which specialized mechanisms for implementing the vision have been developed. The vision concerning these objects in Greece is not explicit, while - under the pressure of economic situation - the confrontation of current problems is pursued by fragmented, contradictory and without cohesion measures. Thus, the implementation is based on individual initiatives or is imposed by international organizations (Papoulias and Tsoukas, 1998).

Concerning relevant health literature, in the case of Greece, the metaphor of the “pendulum” is the most appropriate to describe the planning and implementation of health policy. The retrogressive continuous movement from the one side to the other implies that the impulse towards a favorable direction of achieving a higher degree of effectiveness and efficiency is followed by an impulse towards the diametrically opposite direction and the application of contradictory policy measures. Ministers have changed almost every 1,5 year (17 between 1978 and 2007). Decision makers and stakeholders appear to disagree over what “values” essentially use or mean, like in health policy reforms of other countries (Giacomini et al., 2004). *NHS needs a new and long term vision statement.*

Health policy and reform is a political and top-down process characterized by a structural, purposive and sustained change in policy objectives. This is followed by institutional change and determined by country specific characteristics of the health system (Figueras et al., 1997). The content of policy, the context in which policy is implemented, the participating actors and the process by which policy is formulated constitute the core parameters that determine the degree of successfulness of change (Walt, 1998; Rathwell, 1998). *The weakness of promoting important reforming plans in Greece is related with intrinsic difficulties of reforming programs in concrete social conditions and historical conjunctures. Imbalances among stakeholders* caused several aspects of health

reform to stray from the original plan (Horev and Babad, 2005), and that was mainly the case of Greece.

During the **1980s**, the strong political will along with people's and scientists' expectations formulated the consensus for implementing a major reform in health services in Greece. However, the absence of technical evaluation of health policy and the inability to secure effectiveness, efficiency, responsiveness and quality of the system resulted in substantial distortions. The neo-liberal era of almost first half of the **1990s** put an emphasis on the development of the private health sector, and health policy was based on political ideology and rhetoric rather than the conduct of evaluation studies. A serious attempt for a technical-scientific evaluation of NHS and evidence-based reform was held in **1995**, although it was abandoned due to the political conjunction, conflicting views inside the government and interest groups' opposition. The rest of the 1990s was characterized by incremental regulations rather than institutional systematic changes.

In the beginning of **2000s**, a "big bang" approach was introduced in reforming the Greek health care sector, which was doomed to partially fail. *Large-scale interventions presuppose governmental cohesion, social consensus and a well-functioning public sector* bureaucracy organized according to Weberian rational principles, which were almost absent from the Greek scene.

The conservative government elected in **2004** started again regulations in a muddling through approach, which has not yet been intergraded, especially in the financing and the gate-keeping of the system (again left). Strategies based on the performance of health services (Garcia and Pardo, 2004), have not yet appeared. All though the proof of any reform or regulation is within the implementation, the so-called "change-energy" (Blas, 2004) is obscured from the NHS nowadays.

Successful public reforms will be again activated, if a highly political-symbolic process appears. That *change process* must first disrupt the "self-referentiality typical of state-political firms" (Tsoukas and Papoulias, 2005). Such disruption appeared in Public Power Corporations (DEKO) in Greece (1998-2002), but not yet in health services. Even during the last health reform, the difference between "technical" and "institutional" environment was not grasped. Trade unions are still so influential as to co-manage key aspects of the public firms. Managing changes at "Evangelismos" or "University" hospitals is like "making elephants dance". Each of them employs almost 3000 people, accepts 100.000 patients and spends 150 million Euros every year. *Strategic change* in state-political firms is more than "paradigmatic" – it is constitutive, "third order", change following a. policies & strategies, b. governing values, c. symbolic beliefs & management practices (Tsoukas and Papoulias, 2005). These organizations need new top management teams (not only a solo manager) assisted by some elements being in place simultaneously (political support, specialised systems, economic discipline, coherent processes, employees' and users' participation or even information, etc.).

Concluding analysis focused on the *Greek NHS reforms* during the last decades identify the political will, the commitment to a common vision, the configuration of consensus via compromises, the impact of the international

experience, the availability of resources, the technical and institutional barriers and the level of managerial culture (Niakas, 2002; Kyriopoulos and Tsalikis, 1999; Kyriopoulos and Levett, 1999). Along with the international perspective or/and European convergence of the country, these are the main interpretative determinants of the extent to which health policy reforms have been implemented. The degree of their success in the future should be critical and thus need to be again evaluated, in order to avoid next Sisyphus myth.

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Table 1: Development of public hospital recourses, 1994-2004.

I. INFRASTRUCTURES AND TECHNOLOGY	
<i>No of new regional hospitals</i>	4
<i>No of new local hospitals</i>	13
<i>No of large extensions in existing hospitals</i>	17
<i>Total surface of new hospital buildings</i>	830.000 m2
<i>No of new hospitals in progress</i>	25
<i>Total surface of new hospital in progress</i>	375.000 m2
<i>No of new large extensions in progress</i>	20
<i>Total surface of new extensions in progress</i>	220.000 m2
<i>Total increase percentage in hospital surface</i>	75%
<i>Increase percentage in intensive care beds</i>	85%
<i>Increase percentage in modern medical technology</i>	250%
II. HUMAN RECOURSES	
<i>Increase percentage in medical staff of NHS</i>	33,1%
<i>Increase percentage in nursing staff of NHS</i>	25,0%
<i>Increase percentage in total staff of NHS</i>	19,5%
<i>Doctors per bed (increase from 0,45 to 0,53)</i>	+17,8%
<i>Nurses per bed (increase from 0,95 to 1,06)</i>	+10,6%

Table 2. Major health reforms and reform plans in Greece, 1983-2005.

1983	Law 1397/83	<ul style="list-style-type: none"> • Establishment of the National Health System (NHS) • Development of rural health centers • Emphasis on decentralization and equity
1992	Law 2071/92	<ul style="list-style-type: none"> • Emphasis on cost containment policies and introduction of management • Privatization policies
1994	Law 2194/94	<ul style="list-style-type: none"> • Rehabilitation of the public character of the system
1994	Abel-Smith Experts Committee Plan	<ul style="list-style-type: none"> • Establishment of a unified health fund • Family doctors • Decentralization and regionalization • Strengthening of public health • Hospital general manager • Human manpower education
1995	Kremastinos' Plan	<ul style="list-style-type: none"> • Adoption of Expert Committee's proposals
1996	Peponis' & Papadelis' Plan	<ul style="list-style-type: none"> • Regional global budgets • Hospital global budget and cost accounting • Encouraging insurance funds to introduce family doctors • Establishment of a National Centre for Quality Assurance
1997	Law 2519/97	<ul style="list-style-type: none"> • Administrative reorganization • Development of a network of primary health care and family doctors • Public health, quality assurance, mental health and emergency care • Cost-containment measures • Global budgets and DRGs
2000-3	Papadopoulos' Plan (Laws 2889/01, 2920/01, 2955/01, 3106/03, 3172/03 etc.)	<ul style="list-style-type: none"> • About 200 proposed measures for a radical reorganization of the health system • Establishment of Regional Health Authorities • New Hospital Management • Health and welfare services inspectors
2004-5	(Law 3329/05, etc.)	<ul style="list-style-type: none"> • Hospitals' administration autonomy from RHA • Abolishment of drug lists • Announcement of next steps (public health, quality organization, primary health care, etc.)

Table 3: Main elements of the 2000 Reform Plan.

Regionalization of NHS (Law 2889/2001)	<ul style="list-style-type: none"> • Establishment of 17 Regional Health Systems (PESYs) • Transformation of hospitals to decentralised units of PESYs
Hospital management (Law 2889/2001) (Law 2955/2001)	<ul style="list-style-type: none"> • Employment of Hospital Managers • Managerial re-arrangement of hospitals • New hospital supplies procedures
New role for social insurance funds (Draft of law)	<ul style="list-style-type: none"> • Purchaser/provider split • Coordination of social insurance funds • Unification of the social insurance financing management under a new organization (ODIPY) • Regional allocation of resources
Primary Health Care (Draft of law)	<ul style="list-style-type: none"> • Unification of PHC services under the responsibility of PESYs • Expansion of the Health Centre model to all population - establishment of urban health centres • Establishment of a "Personal Doctor" model for all population • Gradual equalization of PHC benefits
Primary Health Care (Revised policy, 2003-4) (Law 3235/2004)	<ul style="list-style-type: none"> • Optional establishment of Primary Health Care Networks from Social Insurance Organisations • Optional application of a Family Doctor model from Social Insurance Organisations • Prospect of establishment of new services for home care, post-hospital care, rehabilitation etc.
Human resources policy (Law 2889/2001)	<ul style="list-style-type: none"> • Exclusive employment of university doctors in NHS • NHS doctors' evaluation • New policy for human resources development
National Health Policy (Draft of law) (Law 3106/2003)	<ul style="list-style-type: none"> • Establishment of a process for developing National Health Policy • Establishment of scientific organisations supporting National Health Policy • Incorporation of welfare services into the Regional Health Systems
Public Health Policy (Law 3172/2003)	<ul style="list-style-type: none"> • National committees for intersectoral cooperation in Public Health • Establishment of Regional Public Health Services • Reorganisation of local Public Health Services • Human resources policy for Public Health.
Quality Assurance policy (Law 2920/2001) (Draft of law)	<ul style="list-style-type: none"> • Foundation of the Health and Social Welfare Inspectors Body • Establishment of a National Organisation for Accreditation and Quality Standards Development in Health and Welfare Services

Table 4: Registered physicians in TSAY according to the origin of their degree

Year	Total number of physicians (1)	Origin of degree		Percentage % (2) / (1)
		Greece	Abroad (2)	
1980-4	7668	6244	1424	18,6
1985-9	8129	5742	2387	29,4
1990-4	8560	6759	1801	21,0
1995-9	10096	7187	2909	28,8

Source: Medical Association of Athens 2002

Table 5: Recognized by DIKATSA* degrees of medicine originated from countries other than European Union and USA, 1995-2000.

Country	No	(%)
Albania	79	2,7
Bulgaria	643	21,7
Romania	1269	42,8
Hungary	347	11,7
Yugoslavia	163	5,5
Turkey	12	0,4
Czech Republic	74	2,5
Poland	11	0,4
Countries of the former USSR	365	12,3
TOTAL	2963	100,0

Source: Medical Association of Athens 2002

* *DIKATSA: The Greek inter-university center for the recognition of foreign degrees.*

Table 6: Reform “Principles” (Stiglitz, 2000) - Transformation “Errors” (Kotter, 2007) of the Greek NHS

“Principles”	< Year	Year >	(avoidable) “Errors”
1. ambitious goals versus reasonable intermediate objectives	1983-2007	(except) 1983-2007	(not) establishing enough sense of urgency (cooperation, motivation, leadership)
2. popular support or political dynamics or consensus	1983	(except) 1983	(not) creating a powerful enough guiding coalition
3. attention to the political economy of reform – Pareto improvements	1983, 2000	(except) 1983 & 2000	lacking a Vision
4. confidence in reform – continuity - credibility - sustainability	1983-5, 2000-2	1983-5, 2000-2	(not) anchoring changes in the culture of the institutions
5. ideology versus evidence – hidden agendas	1990s	1990s	under-communicating the Vision (by a factor of ten)
6. inconsistency between advice and action – vested interests	1994, 1997	1994, 1997	(not) removing the obstacles
7. privatization as a solution	1990	1990	(not) declaring victory too soon
8. policymakers’ attention in sequencing & pacing of reforms	2000-2002	(except) 2000-2002	(not) systematically planning and creating short-term wins