"2nd LSE PhD Symposium on Modern Greece"

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1. Introduction

This paper explores the situation which exists in the private health sector in Greece. The challenge we are facing is the following: Which can be the new role of the Private Health Sector in the Greek National Health System (NHS)?

The question set is going to be dealt with in three steps. First, we examine the Public and the Private health care sectors, second we examine basic aspects, background information, recent reforms of the Greek NHS, as well as the reasons behind the inevitable movement towards collaboration of Public and Private Health sectors. Finally, we examine the respected European experience on Public Private Partnerships (PPPs), since such cooperation between the Public and Private Sector has been developed a long time ago and it is now a tradition of the NHS in many EU countries like the UK.

The analyses can not come to a conclusion due to the fact that the research is still on process. Nevertheless, some key points are provided for consideration at the present stage.

2. Public and Private Health Care Sectors

2.1 Basic characteristics

Most health care systems involve a mixture of public and private provision. In a National Health Service (NHS) though, the role of private health care is quite different than in private (or mixed) health care systems along several dimensions[1].

In particular, within the Public sector, Health care is mainly provided publicly and financed by general taxation rather than private insurance payments. Nevertheless, there exists with the NHS, a private sector alongside the public one in most countries. An important difference, though, is that patients in the public sector receive public health care for free, when others seeking private health care often have to cover the costs of the medical treatment by themselves.

Another interesting feature of NHS systems is that a substantial share of doctors tends to work in both sectors. For example, in the UK most private medical services are provided by physicians whose main

[1] Besley and Gouveia, 1994

commitment is to the NHS. Similar observations can be made in Norway, Sweden, France, etc. In other words, there seem to be close links between the public and the private sector not only on the demand side but also on the supply side[2]. This is the reason that nowadays, the health sector reform plans, in most countries, include developing structural Public-Private Partnerships (PPPs), using the word "Partnership" to refer to the long term, task oriented, and formal relationships.

2.2 The Public Sector

The Public sector refers to national provincial/state and district governments, municipal administrators, local government institutions and all other government and inter-governmental agencies with a mandate of delivering "Public Goods". In particular, in most settings when we use the term "Public Health Service" we understand a service which belongs to the state. It is well known that the Public Health Sector stands on the top of the health care debates for years. Examples of organizations funded and administered by the public sector include national health ministries, national police or military hospitals, provincial or state health departments, district hospitals, and public health centers.

Advantages

- Universal coverage
- High quality of scientific and other personnel
- Great potential Market

Disadvantages

- Corruption
- Waiting lists
- High cost
- Maladministration (misgovernment)
- Particularism
- An excess of beds
- Financial shortage
- Low quality of services provided

2.3 The Private Sector

The word Private devotes two sets of structures; the for-profit private encompassing commercial enterprises of any size and the non-profit private referring to Non Governmental Organizations (NGOs),

[2] Kurt R. Brekke, Lars Sorgard, "Public versus Private Health Care in a National Health Service, 2003

philanthropies, and other non-for-profits. Examples of private sector organizations include community-based organizations, NGOs, private businesses, private voluntary organizations (PVOs), and commercial sector firms. Specifically in the health sector, the term "Private" is used when health care is delivered by individuals and /or institutions not administered by the state[3]. The private health care sector in Greece covers 50% of the total activity.

Advantages

- Own funds
- Modern infrastructure
- Biomedical Technology
- Managerial adequacy

Disadvantages

- High Costs
- Uncertainty concerning the quality of health services provided
- Small-scale market
- Inability to provide specific services

3. Greek Health Care System (ESY)

3.1 Main Features

The development of the health sector is closely related to the social and political evolution of the country. Greece, just like other countries, has adapted its health system based on the geographical and population needs, as well as, on the financial and political situation in order to ensure effectiveness and patient satisfaction. Attempts for the establishment of a universal health care system in Greece began with the founding of the Modern Greek state and took a concrete form with the establishment of a National Health System in 1983. Its aims were to provide universal access to healthcare and, in particular, free, equitable and comprehensive health care coverage to all citizens.

The Greek NHS can be characterized as a "Mixed" system for both funding and delivery, with elements both of the Bismarck model (increased importance of social insurance in funding health care) and the Beveridge model (health care primarily funded by the state budget). The State runs the public hospitals and Provides primary and hospital health care as well as emergency pre-hospital care on a

[3] D.Giusti, B Criel and X De Bethune, "Viewpoint: public versus private health care delivery: beyond the slogans, Health Policy and Planning, vol 12, 192-198, 1997

universal basis. On the other hand, the private sector plays a strong role in hospital, diagnostic and out-patient services.

3.2 The Organizational Structure of the Health Care System

The Ministry of Health and Social Solidarity has the responsibility for ensuring the general objectives and fundamental principles of the Greek NHS, such as free and equal access to quality health services for every citizen. For this reason the Ministry decides on the overall health policy issues, planning and implementing the national strategy for health. The Ministry sets priorities at a national level, defines the extent of funding for proposed activities and allocates relevant resources, proposes legislative framework changes and undertakes the implementation of laws, and generally of any change and reformative measures. It is also responsible for health care professionals and coordinates the hiring of new health care personnel, subject to approval by the Ministerial Cabinet.

Until 2001, the Ministry was responsible for the planning and regulation of the NHS at central, regional and local level. With the establishment of the Regional Health and Welfare Authorities, known as (Pe.S.Y.P.), some of those responsibilities have been transferred to these new administrative bodies. Nevertheless, the core function of the Ministry is still the regulation, planning and management of the National Health Service and the regulation and control of the private sector, while social health insurance is under the auspices of the Ministry of Labor and Social Affairs.

Apart from the Ministry of Health and Social Solidarity, a number of other Ministries[4] have responsibilities, which are linked in one way or another with the public health care system and leads to a lack of coordination, excesses in spending, mismanagement, and the development in recent years of an extensive parallel private health care system. Indeed, the involvement of the private sector in health care delivery is extensive and has been growing rapidly over the last 10 years[5].

3.3 Health Coverage

Insurance coverage is compulsory for all employed persons and their dependants and is based on occupation. The unemployed continue to be covered where they were before. Furthermore, several people are

[4] More specifically, the Ministries of: Labor and Social Affairs, National Defense, Education & Religious Affairs, Development, Economics and Public Administration & Decentralization.
[5] Kontozamanis V, "Greece: Pricing and Reimbursement Policies", 2000

insured with more than one insurance fund.[6] The three largest funds are IKA (Fund of Social Insurance)[7], OGA (Organization of Agricultural Insurance) and OAEE (Fund of self-employed). Insurance funds are funded through employer-employee contributions. Thirty-nine Social Health insurance organisations provide coverage to about 95% of the Greek population by contracting with public and private providers.[8] Approximately 5-8% of the Greek population has private insurance. Payments from private health insurance account for 2.3% and out-of-pocket payments for the remaining 41.4%.

3.4 Health Financing and Expenditure

The Greek NHS is mainly financed from the central government budget (general taxation), from social insurance, as well as from the Private insurance Schemes. In 2000 taxes accounted for 30.4% of total expenditure on health (compared to 33.7% in 1987)[9]. According to the Greek Ministry of Finance, tax revenues are mainly from indirect taxes on goods and services and taxes on income represent a much smaller proportion.

Viewed in aggregate economic terms, Greece, despite having one of the lowest levels of per capita GDP in the European Union (EU), spent 9.6 % of its GDP on health care in 2002, and lies above the mean in a ranking of EU countries. Health expenditure as a proportion of GDP rose steadily from 5.6% in 1970 to its current level. Greece spends more on healthcare than other southern European countries like Italy (8.2 %|), Portugal (7.7%), Spain (7.0%) as well as Austria (8.0%), Finland (6.9%) and Sweden (6.9%).[10]

The structure of the Health care delivery and financing system is shown at **figure 1.**

3.5 Health Care Reforms

During the 1980's and 1990's Greece began to face major problems.[11] These problems mostly refer to the rising cost of health care and the

[6] This may happen if an individual has two occupations covered by different funds, or if he is insured directly in one and indirectly (in case of another working member of the family) in another (Kanavos P, "Pharmaceutical pricing and reimbursement in Europe"-Scrip Reports, 1999).

[7] IKA covers 55% of the population, and is responsible for the funding and provision of primary health services through "policlinics". OGA covers about 23% and takes advantage of the NHS facilities.

[8] Lycurgos Liaropoulos, "Ethics and the management of health care in Greece.

[9] In reality the percentage of health expenditure through taxation is much higher since the government subsidises the contributions of civil servants and the deficits of insurance funds.

[10] "Health care developments in Greece: Looking back to see forward?" (Elias Mossialos and Dina Davaki, 2002).

[11] 1) Continuous cost raise, 2) Low financing resources, 3) Demand for better health care, 4) Shortages in resources, staff and facilities in the public health sector, 5) Fragmented administrative framework, 6) Low levels of Public expenditure, 7) There is a lack of coordination of purchasing policies and inefficiencies, (such as over- treatment and the repletion of diagnostic and therapeutic treatments and prescriptions), 8) Different access to services and choice of services undermining the equity principle of access to services based on need and not on ability to pay, 9) Lack of credibility, 10) Unethical practices (under-the-table payments to doctors).

low effectiveness of resources. Several attempts to reform the Greek health care system have taken place. Most of them intended to resolve organizational problems, funding issues, and the efficiency and effectiveness of services. Implementation of cost containment measures has been intense but with minimal impact. Policy priorities, lack of continuity in health care, administrative inefficiencies, prevailing perverse financial incentives and vested interests, as well as lack of co-ordination of financial resources, have all been blamed for this.

Two reform attempts are considered as large-scale interventions that changed the structure of the health care sector, despite the fact they were not completed.

Law 1397/1983 establishing the Greek NHS was a landmark in the development of health care, as it was the first time the basic principles of health care organization and policymaking were embodied into a reform. It is characterized as the most significant attempt for a radical reform in the health sector, as it led to the evolution of a complete public health care system. The years that followed the voting of the law were most productive, mainly concerning quantitative growth of the system. Until the beginning of the 1990's, many rural health centers, a certain number of regional and prefectural hospitals were built, equipment was renewed to a large extent, and health system personnel was upgraded. But in the areas of organization, decentralization, administration and effectiveness the results were very poor. The lack of sufficient financing, oppositions and disagreements interrupted and finally stopped the completion of a series of reform attempts in the 1990's (laws 2071/92, 2194/94, 2519/97).

The implementation of the second most significant Law 2889/2001, led to, amongst others, the regional organization of the NHS into 17 Regional Health Authorities (Pe.S.Y.P.), the modification of the terms of employment of NHS doctors and the introduction of professional hospital management. This reform changed basic elements of the structure, management and administration of the system.

Further to NHS decentralization and improving the administration and operational effectiveness of public hospitals, more specific reforms were implemented. The establishment of Health and Welfare Auditors (Law 2920/2001), Hospital Procurements (Law 2955/2001), the Welfare law (3106/2003) and the development of Public Health Services (Law 3172/2003).

The most recent reform of the Greek NHS is the 3329/2005 law, after a major the political change.[12] The new law changed the 17 Pe.S.Y.P.,

[12] The Government now is Nea Dimokratia.

and created 17 Administrations of Health Regions (D.Y.PE.) which hold extensive responsibility for the coordination of regional activities and the effective organization, operation and management of all health and welfare units within their catchment area. Each D.Y.PE. is a public entity, managed by an administrative board and chaired by a Director appointed by the Minister of Health & Social Solidarity, subject to parliamentary approval. All health care units operate as Legal Entities of Public Law and are controlled as well as supervised by the Director of each D.Y.PE. NHS hospitals are managed by a Governing board and by a Hospital Manager.

With Law 3329/2005 the Greek government allows NHS hospitals and other public healthcare units, to sign contracts with private companies for household services like security, catering, cleaning, as well as for the administration of hospital grounds. Other reforms are still underway, primarily for the merging of social insurance funds, the development of Primary Health Care (especially in urban areas, and the introduction of family doctors), and the introduction of Services' Accreditation and Quality Assurance.

Greece today is still undergoing a reform process in the health care sector. Although we examine the Greek NHS, most countries face similar problems. The different approaches taken to dealing with these problems, allow a country to understand and learn by the experience of others, and the various alternative solutions that exist, such as the entrepreneurial approach, more specifically the PPPs, which will be the subject of the remaining part of the paper. Therefore, it is important to investigate first the methods of public/private interaction.

4. Methods of public/private interaction

The purpose of this paper is to investigate the interaction between the public and private health sectors in a National Health Service. It is well known that the public sector holds a dominant role in the development of European societies. Nevertheless, during the last decades, a new role for the private sector emerged in many countries, sometimes as a competitor in the coverage of the population and sometimes as a cooperating agent in dealing with problems.[13] We consider that there are various methods by which services can be privatized, such as contracts, formal/franchise agreements, vouchers, grants, subsidies, and Public/Private partnerships (PPPs). According to Savas,[14] the selection of a particular model of privatization must consider the unique dynamics of the "control function mix." Ownership,

[13] Lycurgos Liaropoulos, "Public and Private Health Care Sector in the current welfare state", 2003.
[14] Savas, E.S., Privatization: The Key to Better Government, Ghatham, NJ: Chatham House Publishers, Inc., 1987, p. 87.

management and day-to-day operations of any particular sector or segment could be controlled by either the public or private sector. A policy matrix to reflect this complexity has been suggested by Savas in **Exhibit 1**. Our analysis will focus on PPPs, and for this we must first explain what we mean by the term "privatization".

4.1 Privatization

Privatization refers to the provision of publicly-funded services and activities by non-governmental entities. In particular, we talk about a formal contracting out of services by the government to the private for-profit or non-profit sector. The market competition and the role of public sector vis-à-vis other sectors are the two separate but related dimensions of privatization.

Competition holds the key that will unlock the bureaucratic gridlock that hamstrings so many public agencies. According to Osborne and Gaebler in Reinventing Government (1992) quote Gov. Mario Cuomo, who stated (p.30) that "It is not government's obligation to provide services, but to see that they're provided". This would mean ending the tradition that certain public agencies be providers of services. Public agencies would have to compete against each other and against non-profit providers for a particular service market[15].

A second dimension of the privatization concept relates to activities or functions performed by the governmental and non-governmental sectors, regardless of whether funds actually are exchanged and regardless of whether there is a formal contract or agreement.

As Le Grand puts it:[16]. *Privatization can take many forms. A simple interpretation, such as the replacement of the state by the market, will not suffice. The kind of state intervention to be replaced must be specified; so too must be the type of non-state institution that will replace it. For this reason, LeGrand concludes that it is not easy to argue about the merits and de-merits of privatization in the abstract; the arguments will vary according to the types of state and private activities involved*[17].

4.2 Public Private Partnerships (PPPs) in Health Care

Public Private Partnerships (PPPs) are forms of cooperation between public authorities and the world of business which aim to ensure that infrastructure projects can be carried out or that services of use to the

[15] Demetra Smith Nightingale, Nancy M. Pindus, "Privatization of Public Social Services", 1997.
[16] Legrand, Julian, Robinson, Ray, "Privatization and the Welfare state", London: George Allen & Unwin, 1984, p4.
[17] Ibid.

public can be provided. S. Johnson & D. Collins defined the public-private partnership as "*an inter-sectoral collaboration, either non-contractual or contractual, between two or more organizations*".

According to Roy Widdus[18], a strict definition of PPPs would probably require a significant degree of joint decision-making. More broadly speaking, a partnership usually involves collaboration between two or more organizations, each having specified rights and responsibilities related to their partnership. Partners tend to pool their resources, technical, organizational, geographic, human or financial. Also, potential partners must consider and discuss a number of things before entering into partnership, including their goal, the type of agreement, the length of time they expect the partnership to last, the resources they can commit to the partnership, and the client population they intend to reach.

These forms of partnership have been developed in several areas of the public sector, such as transport, public health, education, public safety, waste management and water distribution.

PPPs is often confused with privatization or used interchangeably with public sector "decentralization" and/or "liberalization". Moreover, PPPs initiatives can be fragile and must be carefully planned and implemented to achieve their intended results in the health sector[19]. For this reason it needs to be differentiated from privatization, which involves permanent transfer of control through transfer of ownership right or an arrangement in which the public sector shareholder has waived its right to subscribe.

The need for public-private partnerships in the health sector arose against the backdrop of the inadequacies of the public sector to provide public goods, in an efficient and effective manner, because of a lack of resources and management issues. These considerations led to the evolution of a range of interface arrangements that brought together organizations with the mandate to offer public good on one hand, and those that could facilitate this goal though the provision of resources, technical expertise or outreach, on the other.[20] There are examples of individual governments forming partnerships with the for-profit private sector and situations when a government partners with a non-profit organization (NGO).[21] Participation of the private sector into the public sector requires legislative authorization, within the

[18] Roy Widdus, "Private-Public partnerships for health require thoughtful evaluation", Bulletin of the World Health Organization 2003, 81 (4).
[19] James A. Rice, "Methods of PPP: Global Experiences and insights".
[20] Sania Nishtar, Public-Private 'Partnerships' in health- a global call to action, 2004.
[21] Cross C., "Partnerships between non-governmental development organizations" Annals of Tropical Medicine & Parasitology. 92 Suppl 1: S69-71, 1998.

framework of which, procedural and process-related guidelines need to be developed.

The aim of the Public-Private partnerships is to create district health care systems in which the various independent actors operate as entities towards common goals and the performance of the entire health system is maximized. Public Health consultant's experiences show that to achieve these aims, the partners should be allowed to participate in all aspects of health care development and the collaboration needs to be institutionalized among all partners and at all levels. Important steps that need to be taken are the development of a specific partnership policy, the development of additional capacity and skills of staff within the institutions, representation of the partners in the organizational structures, adoption of the working methods and arrangements, and the development of new tools.

Moreover, the complex nature of healthcare demands an approach that mobilizes expertise, resources and efficiency from both the private and public sectors. Whilst governments play a vital strategic role in healthcare delivery, the private sector can be used in a variety of creative ways to meet investment and operational needs (**exhibit 2**). Many different *models* for public-private partnerships in health are being developed to illustrate solutions in broad areas like *clinical care infrastructure, and financing*.

Indeed, Governments are using a variety of contractual methods to achieve the efficiency gains of using the private sector to provide services. For instance, *clinical services* have been formally contracted to the private sector extensively in Latin America under various forms of contract. The crucial difference between them is the payment mechanism,[22] which establishes the private sector incentives and is therefore critical in determining the overall success of the service in promoting equitable and universal healthcare access.

On the other hand, models for injecting private investment to modernize healthcare systems *infrastructure* are well-developed and should be urgently considered by developing country governments. Private sector consortia contract with governments to design, build, finance and operate hospital facilities. The operational element may or may not extend to private sector management of the clinical services.[23] A key advantage of this approach is that the private sector takes the risk of maintaining the property for the life of the contract, usually 25 years, ensuring the quality of the asset in the long term. The Inkosi Albert Luthuli Central Hospital in South Africa follows the UK

[22] The population based/ historical payment model or the service-based allocation model.

[23] The next few years will probably see developing countries taking this to the next stage and including clinical care in the package of services passed to the private sector, as has been the case in Australia

model of privately financing hospitals in which support services such as laundry, security and catering are provided by the private sector, with clinical and care services provided by the public sector.

Finally, social insurance has been identified as a potential '"middle-way" between financing through private insurance and tax-based systems. Formal insurance markets are lacking in most developing countries, and a response to this has been the creation of 'social health insurance' that finances medical care predominantly through compulsory payments by employer and employee, collected through payroll taxes. This is a growing model in developing countries, with the objective to reduce the financial cost of healthcare provision and shifting the burden of the day-to-day provision of health services from the public to the private sector. This has the added value of transferring much of the operational risk, such as recruitment of medical personnel, to the private sector. Social insurance represents a potentially sustainable means of financing growing healthcare costs while meeting the objective of universal healthcare access.

A general theme in healthcare reform is the formalization of contractual arrangements with the not-for-profit sector, which have traditionally worked on 'understandings' without a contractual obligation to provide services. One of many examples is in Costa Rica, where the Government has contracted with the National Health Foundation to construct and manage the Hospital de la Imaculada Concepcion in Heredia. This is a welcome trend as it enables governments to monitor the quality of service provision under agreed contractual criteria.

5. European and US Experience on PPPs

Many governments have undertaken substantial health system reforms over the past decade. An important one is the introduction of PPPs. Comparisons are essential if one is to achieve an understanding of one's own national health care system. Logically, it is impossible to make a statement about cause, effect or the necessity of a reform (in particular for the PPPs), within a national system without considering the experience in other countries.[24] Therefore, a brief presentation of the European experience on PPPs is essential.

Several Western European countries (UK, Sweden, etc.) have recently known heated debates on the issue of privatization (Saltman, 2002c forthcoming). These debates have often shed more political heat than substantive light.

[24] Rudolf Klein, Risks and Benefits of Comparative studies: Notes from another shore, 1991.

What is intriguing about the current period is the extent to which complex cross-boundary relationships are increasingly appearing in a number of European health care systems. Policymakers are pursuing these in an effort to generate social not private entrepreneurialism.[25] Three examples are particularly noteworthy: the role of Bure AB in Sweden (and with it that of St. Goran's Hospital in Stockholm); the role of newly established public firms in the hospital system of Spain; and the role of primary care groups in the United Kingdom.

Sweden:

The Swedish health system is regionally-based, (it is organized on three levels: national, regional and local), publicly financed mainly through county council tax revenues, and publicly provided by hospitals and health centers owned and managed by the public county councils. Sweden's healthcare system is considered to be among the best in the world. The country has a low infant mortality and a high average life expectancy.

It can be described as a system that has been put under economic pressure during the 1990's and has undergone several major structural reforms. The government has launched a programme to tackle long waiting lists, reduce stress on staff, and improve the care of patients by putting more emphasis on cooperation among existing bodies. Changes have been initiated both at national level through legislation, and locally at county council level. The locally initiated reforms are mainly associated with the introduction of new management systems and new organizational structures, such as contracting out to private providers.

Bure's role with regard to melting public/private boundaries in the Stockholm county health system is fascinating. The central actor (Bure) was founded with (state-raised) tax funds; sold most of its shares on the (private for-profit) stock exchange, but still has a (state) pension agency as its largest stockholder (Johansson, 2000). It bought the operations of St Goran's, a (public but non-state) county hospital, but the hospital building continues to be owned by a (public non-state) public firm. The sale contract is contingent upon continued (public non-state) county purchase of services.

The Swedish coalition government recently banned the privatization of hospitals, amid fears that the expansion of private health care could destroy the principle of a fair and free public health service. Health minister Lars Engqvist, said that new legislation would end the practice

[25] Busse et al., 2002

of private patients "buying their way past" hospital waiting lists. Provincial authorities, which are responsible in Sweden for the local healthcare system, will not be allowed in the future to hand over the running of a hospital to a profit making company, because medical treatment must be given to every patient according to their need, not their ability to pay. The ban comes after two provincial authorities began to privatize state hospitals that had expanded their private care.[26]

Under the terms of the new reform, private companies will not be allowed to run hospitals that treat state insured patients as well as private patients. In addition, private companies will not be allowed to buy regional or university hospitals; only foundations and non-profit providers are to be allowed to manage hospitals. Also, provincial authorities will be forbidden from handing over the day to day running of hospitals to profit making companies. Existing private hospitals will be allowed to continue in existence, and private profit making companies will be allowed to start new hospitals, as long as they do not treat state insured patients.

Spain:

The Spanish health care system has been set up as an integrated National Health Service, publicly financed out of general taxation and providing nearly universal health care free of charge at the point of service, delivered through 17 Autonomous Communities. Under the direct authority of the Ministry of Health is the National Institute of Health (INSALUD). While autonomous health services and INSALUD provide health care through their own hospital networks, they also contract out services, where necessary, to private hospitals (profit or non-profit) so that both private and public beds support the delivery of public inpatient care.

Since 1986, the public health sector has undergone considerable development. The 1990 Catalan Health Care Law opened the way for the introduction of new flexible forms of organization and management of health care centers, explicitly including, for the first time, the possibility of contracting out the management of publicly-owned health centers to the private sector or to public providers opting out of the public system.

Efforts in Spain to restructure hospitals into Public firms involve several similar cross-boundary experiences. At least five of the autonomous communities (regions) which control their own health care systems have developed innovative models to establish autonomous or

[26] Vienna Jane Burgermeister, "Sweden bans privatization of hospitals", British Medical Journal, 2004.

corporative hospitals. Several, including the Basque Region, have gone further to establish complex cross-boundary relationships that place hospitals in a new legal category in which they are a "public entity under private law" (Busse et al., 2002). In Andalucia, three newly built hospitals have been structured in this fashion.[27]

Furthermore in Alcorcon a suburb of Madrid, the Fundacion hospital was built in 1997 by INSALUD, but contracted out to private clinical management. It is regarded by Celia Villalobos, health minister in Spain's rightwing People's Party government, as the jewel in her crown.

The Alcorcon hospital's board of ministry and town council representatives contracted a private team to manage the service and the government freed it from many of the rules imposed on Insalud hospitals. The company running the Alcorcon hospital is not allowed to make a profit, but receives a management fee. This arrangement allows the hospital to reach its own wage, productivity and working hours agreements with doctors, nurses and other health workers.

The Alcorcon hospital outperformed centrally controlled hospitals in virtually every category. It boasts shorter waiting times for serious operations. It has also reduced the number of hospital beds taken up by accident and emergency department patients. The management company has invested heavily in computer equipment and software, which, has also helped to reduce the time patients spend in hospital.

Nevertheless, from the Spanish trade unions point of view, the management company cut waiting lists by increasing working hours and sending difficult cases, complicated pregnancies, and the badly injured from traffic accidents, to publicly run hospitals.

Some of the new ideas harboured by health care politicians in Spain are: private sector to build and run some of the diagnosis and treatment centres that are to be set up to provide a fast-track service for common operations such as cataract surgery and hip replacements. They are also interested in an experiment in Bologna, Italy, where patients are given a prescription for an operation and can shop around for the hospital offering the best treatment, and finally, they are looking at New York, where patients can view data on the performance of individual heart surgeons.[28]

[27] De Manuel, 2000.
[28] John Carvel and Giles Tremlett, "Milburn seeks hospital role model in Spain", 2001

United Kingdom:

The United Kingdom has a long history of well-organized and successful health care, although some reforms are now underway. The health care system of the UK known as the National Health Service (NHS) is fully administrated and funded by the state without the contribution of insurance funds. The UK's population has excellent access to health care, with a high percentage of people being covered. The NHS is a model frequently referred due to its low cost, efficiency and effectiveness.

Some of the main elements of the present day organizational structure of the NHS can be traced back to the major changes that were introduced through the NHS Act of 1973. An important development in the history of the NHS occurred in 1979 by the government of Margaret Thatcher and with its commitment to a programme of radical economic and social reform. This government saw public expenditure and state involvement as the source of Britain's economic difficulties and embarked upon a major programme of privatization. Although early policy on privatization in relation to the NHS was restricted to mainly contracting out ancillary services (ie. laundry, catering and cleaning), the government's belief in the superior efficiency of private sector efficiency led to major changes in management arrangements.

Reforms introduced during the period 1989-1999, were part of a wider policy aimed at introducing a greater element of market discipline in the public sector. Following the election of the Labour Government in 1997, a new policy direction was announced. A system based upon competition within the internal market is in the process of being replaced by one based on *partnership and collaboration*. At the present time these policy changes are in the process of being implemented.

Private Finance Initiative (PFI) is one model of Public Private Partnership (PPPs), which have been implemented in the British NHS. PFI is a key policy for improving the quality and cost-effectiveness of public services. It enlists the skills and expertise of the private sector in providing public services and facilities. PFI is about building long term and mutually beneficial partnerships between public and private sector partners. In the health sector, the NHS continues to be responsible for providing high quality clinical care to patients. But, where capital investment is required, there will increasingly be a role for a private sector partner in the provision of facilities. Major PFI schemes are typically to design, build, finance and operate.

Furthermore, over time other forms of PPPs have been developed in the UK. For instance, the new structure of Primary Care Group (now Primary Care Trusts), introduced in April 2000, reflects the prior

pattern of private for-profit GP fund holders but with a stronger public supervisory input. These new mandatory management arrangements (the prior GP fund holders were voluntary arrangements) require private GPs who contract with the NHS to work in large group practices designed and closely regulated by the state (through the NHS Executive). This creates a merger of private for-profit with state interests.

On the hospital side, the UK has also, sought to deal with long waiting lists for elective procedure by collaborating more closely with private sector institutions both in the UK and on the Continent. This is not new – in the mid 1980s, the NHS had contracted out some 50% of certain elective procedures.[29] Moreover, a recent tendency on the public-private mix comes from the European Court which gives EU citizens the right to seek care across national boundaries paid for by their national health budgets. In the United Kingdom, this regulation has encouraged the NHS to reduce waiting times through contracts with, among others, British United Provident Association (BUPA) and also several not-for-profit French and Belgian hospitals.

Similar attempts have been made in Britain when government, in order to limit the up-front costs of much-needed new hospitals or to upgrade hospitals, decided to contract with private companies to build them and run non-clinical services for a set period, say 30 years for an annual fee. However, according to the British Health Service Union, the above attempt has been an unmitigated disaster.[30]

Nowadays, the government has reintroduced the internal market, but on a more ambitious scale than in the 1990s. Labour's boldest step has been to complement the internal market with an external one. It has turned to the private sector, contracting out more and more NHS work to independent firms. This landmark decision has buried the dogma that public financing of health care must mean that it is also publicly provided. Already, by the end of this year, private providers will carry out around 4% of publicly financed elective (non-emergency) treatments and Labour wants this to rise fast, towards 15% of elective work.[31] Despite its virtues and reform attempts, the system encounters problems, such as long wait lists for outpatient visits, hospital admissions and surgeries.

[29] Higgins, 1988.
[30] Health service union, "Private Sector versus the public sector", 2003.
[31] The Economist, "Health in Britain: Getting it right", April 23rd 2005.

Portugal:

The health care system in Portugal has been in a state of continuous change since the political revolution of 1974, which brought about a constitutional commitment to a universal coverage and free access for all citizens. It is financed by taxpayers, centrally directed and highly regulated. Most hospitals and primary care centres are owned by the public sector and the system is complemented by a liberal ambulatory medical system.

The Portuguese reforms are a response to dissatisfaction both of consumers and professionals with the services provided by the government. There is an increasing perception that higher quality services are provided in the private sector, particularly primary care and high technology services. It is also a response to centralised control of the services and to inadequate public funding. A new law passed in 1990 gave support to the development of private services, provided that they were licensed and inspected by the government. It sanctioned user's co-payments and encouraged the development of private services in public hospitals.

Moreover, during the 1993 reform, the Portuguese government allowed full-time salaried doctors to engage in private practice, provided it did not interfere with their duties for the National Health Service. Also, public services could be managed or provided by other organizations (public or private) under contract. In addition, regional health authorities could contract individual private doctors to provide services.[32]

The system of healthcare in Portugal currently is characterized by a public-private mix of both the funding and delivery function. Most public hospitals are public sector bodies and managed publicly. However, a pilot scheme has been in operation at one hospital where management has been handed over to a private company. Staff in this hospital is employed under contracts with the private management company and are not employed as civil servants, as are other NHS doctors. Furthermore, non-clinical services, e.g. maintenance, security, catering, laundry and incineration, are generally contracted out to the private sector.[33] Since 2001 there is an attempt to corporatize public hospitals. The government introduced the PPP Hospital program, which developed in two phases.

After the last general election in Portugal, the government's main strategic concept for public hospital management has changed. From a

[32] OECD, "The reform of health care systems: A review of seventeen OECD countries", 1994.
[33] Anna Dixon and Elias Mossialos, "Has the Portuguese NHS achieved its objectives of equity and efficiency?", International Social Security Association, 2000.

fully corporatized and "private" management approach maintaining public sector ownership to a semi-corporatization and less "private" approach (EPE Model). The main features of the EPE Model are: Corporate semi-equity and public management in conjunction with limited private management elements (more flexibility in public procurement, staff incentives and staff recruitment).

The new agenda for NHS reform include revision of PPPs legal framework, emergence of a new generation of PPP schemes (smaller scope and duration), enlargement of the role of the newly created health regulatory agency, more competences regarding competition among providers, evaluation of the existing corporate hospitals, and transformation of all administrative public hospitals into public corporations (EPE Model).

United States:

The US health system is unique in its heavy reliance on the private sector for both financing and delivery of health care. The public sector plays a not-insignificant role, providing coverage for the elderly, disabled and poor,[34] and spending as much on health as a share of GDP as most OECD countries (14 per cent of GDP as compared with an OECD average of 8 per cent).

Public-private partnership (PPP) models and methodologies in the United States began to emerge in the 1970s. By the early 1980s, privatization of public services began in earnest. By the mid-90s, a number of US public services were privately built, financed, managed, operated, or owned. Today the PPP market in the US covers the whole range from "pure public" to "pure private", having employed a diverse range of techniques and their hybrids in almost every sector of the economy. In the United States, most of the effort today is aimed at improving the design and implementation of PPP arrangements, strengthening PPP techniques, enhancing legislative support, and increasing the scope of PPP utilization in yet more groundbreaking areas.

Public-private partnerships are becoming more sophisticated, innovative, financially viable, and consumer-oriented, addressing both public and private needs in many ways. Building upon the experience of the last 25 years, the number of PPP transactions has increased dramatically as have the cost savings in most cases. The benchmarks for cost savings to national and local governments from PPP

[34] Medicare, a social insurance programme, covers virtually all senior citizens and some of the disabled. Medicaid and the State Children's Health Insurance Program serve as a social assistance safety net, covering the poorest and those whose medical expenses consume a large portion of their income, along with near-poor children (up to a family income level set by the state).

arrangements are ranging between 20-25%, as opposed to the 10-15% in previous years. Now, new PPP arrangements are designed to feature longer-term contracts, greater levels of service delivery, and the use of new technologies. Contracts are increasingly more sophisticated in allocating the risks between the public and private sectors, and PPP opportunities in general are becoming more financially attractive to government and consumers alike.

Greater opportunities for public-private partnerships in the US are driving the creation of better and more transactions. Across the sectors, the performance targets are met and exceeded in short periods of time, allowing governments to rip full benefits from PPPs. Technically experienced private sector partners are now more capable of offering better services at lower cost. Having tested the PPP success in traditional sectors, governments are realizing the need to further liberalize the regulatory control of public-private partnerships and bring PPPs to less customary sectors of the economy and society, through effective tri-sector partnerships[35].

Taken overall from the European and US experience on PPPs, new organizational arrangements on the provider/supply side of European health care system are emerging that combine public and private in complex, sometimes unique, ways. Far from being exercises in privatization, these new configurations are experiments in forming new types of public-private organizational arrangements that promote socially responsible entrepreneurial behavior.[36]

6. Key Points:

As we already mentioned, the analysis can not end to a conclusion due to the fact that the research is still on process. Nevertheless, some key points are provided for the moment.

First, it is well known how difficult it is to implement actual reform. We should always mobilize the involved agencies, and be aware that reform is an iterative process. Nevertheless, countries that seek methods to improve their NHS (Greece for instance), should never forget that international comparisons provide valuable guidelines. Model use as well as coordination is two necessary factors which can drive health care systems to success. But still, even if Knowledge is our

[35] Katia Karpova, "Public-Private Partnerships (PPP) in the United States: A Snapshot of Recent Developments and New Directions".
[36] Richard B. Saltman, Ph.D., 2002 "The western European Experience with Health Care Reform", the European Observatory.

advantage, improving output of the Health Care Systems is never a breeze case. Some compromises in the political targets are inevitable.

Privatization is not inherently good or bad. The performance or effectiveness depends on implementation. It is still too soon to know whether the most recent and highly publicized privatization efforts, will be effective or not. And of course, cooperation between the public and private sectors requires an organization, such as the state, to act as coordinator and guarantor of equitable access of care and fair distribution of costs.

However, new approaches must be implemented and public-private partnership innovations in the structure of health systems and infrastructure are developing across the globe. Combining public and private sector strengths is increasingly seen as an important tool in finding solutions to the challenge of universal healthcare provision.

Making public-private partnerships in health care a reality requires political commitment and a clear understanding of how they can be best implemented in a particular country. The first step is for health professionals to establish a dialogue with finance officials and agree on a strategy to engage private sector investment and commitment.

Health policy officials should take advantage of the variety of experience in carrying out PPP health projects by conducting site visits and talking to other officials and private sector providers who have been through the process and are in operation. Expert advice should be sought in order to have the best chance of selecting the right approach and then implementing it effectively through the development of the legal and regulatory framework, institutional arrangements, and the development of success-oriented pilot projects.

The most important lesson learned from countries where this model have been adopted, is that the government in question must have sufficient skills and a capacity to deal effectively with the private sector. Badly structured contracts can result in the opposite effects to those intended. Governments must be equipped with the knowledge to extract maximum benefits from these arrangements, in key areas such as project design, procurement, negotiation and monitoring.

Public-private partnerships should be actively considered by developing the tools to use in meeting the objective of expanding health services and making resources work more effectively. Nevertheless, these partnerships should be regarded as social experiments; they show promise but are not a panacea.[37]

[37] Roy Widdus, "Public-private partnerships for health: their main targets, their diversity, and their future directions", Bulletin of the World Health Organization 2001, 79(8).

Different solutions will, of course, be appropriate for different countries, depending on the current infrastructure and health system arrangements. Public-private partnerships offer governments the opportunity to benefit from private sector efficiency and access to investment, whilst retaining an overall strategic responsibility for healthcare systems. In the challenge of improving the health of all people, governments must look to all sectors for assistance and public-private partnerships can offer viable and sustainable solutions.[38]

[38] Emma Thomas, "Public-Private Partnerships in Healthcare".

Exhibits

Exhibit 1: Policy Control Mix Alternatives

Option Ownership	Management	Operation	Policy Description
Public	Public	Public	Typical Public System or State - Owned enterprise
Public	Private	Public	Management Contract
Public	Private	Private	Management & Operations Contract
Public	Public	Private	Operations Contract
Private	Public	Public	Equipment & Facility Leasing
Private	Private	Private	Typical Private System
Private	Public	Private	Government takeover
Private	Private	Public	Government-paid Workers assigned to a private firm

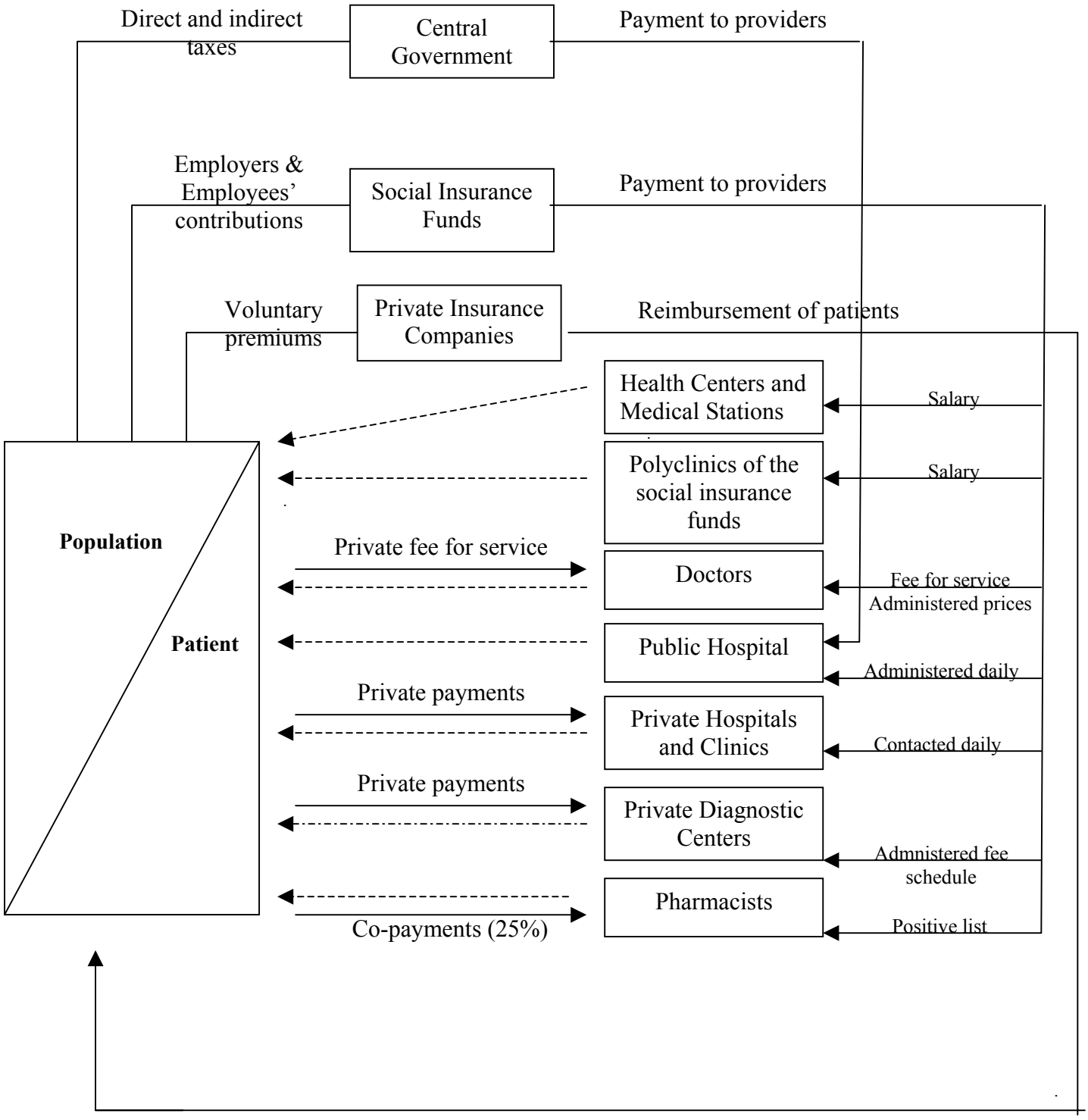
Exhibit 2: Overview of Options for using the private sector in the public health sector[39]

Option	Private Role	Public Role
Co-location of private wing	Operates wing and may provide accommodation or clinical services Manages public hospital/contract	Manages public hospital/contract
Outsourcing non-clinical support services	Provides nonclinical services and employs staff	Provides all clinical services and hospital management
Outsourcing clinical support services	Provides clinical support services e.g radiology	Manages hospital and clinical services
Outsourcing specialized clinical services	Provides specialized services	Manages hospital and provides most services
Private management of a public hospital	Manages hospital under contract and provides services. May employ all staff and be responsible for capital investment	Contracts with private firm for provision of services, pay for services and monitors compliance
Private financing, construction and leaseback of new hospital	Finances, constructs and owns new hospital and leases it back to government	Manages hospital and makes phased lease payments to private developer
Private financing, construction and operation of new hospital	Finances, constructs and operates new public hospital and provides nonclinical and clinical services	Reimburses operator annually for capital costs and recurrent costs for services provided
Sale of public hospital as going concern	Purchases facility and continues to operate it as public hospital under contract	Pays operator for clinical services and monitors compliance

[39] Katia Karpova, "Public-Private Partnerships (PPP) in the United States: A Snapshot of Recent Developments and New Directions".

Figures

Figure 1: The Greek Health Care System



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Karin Holm, "A meeting of managers and participants in product development public- private partnerships for health"

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

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Abstract

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

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

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

Introduction

Greece first attempted to establish a universal health care system, free at the point of use, in 1983, when the Socialist Government (PASOK[1]) introduced Act 1397/1983(MoH 1983). The goals of the reform were an equitable and efficient health system. Although three major reforms have taken place since 1983 (1992, 1997 and 2001), the overall objectives of the reformed Greek National Health System (NHS from now on) have not been realized in the face of sustained opposition to most of the major changes proposed (Mossialos 1997). The characteristics of the current health care system include: over–centralization, fragmentation of coverage (with 30 funds that distribute costs and benefits unevenly across groups in the population), regressive financing including extensive user charges and informal payments, inefficient allocation of resources based on history rather than needs, perverse incentives for providers and a heavy reliance on unnecessarily expensive inputs (Mossialos and Davaki 2002). As a result, the public is generally dissatisfied with the health care system and many of the major players in reforms appear puzzled at the relative failure of successive well-meaning reform efforts.

Understanding the failure of these reforms means answering fundamental questions such as: why do governments decide to undertake health reform and how are initial decisions and subsequent implementation shaped? The weakness of the Greek State and the complexity of its Welfare State, combined with the constraints afforded by political institutions, and the resultant influence of the major actors in the health care system (the medical profession, health insurance funds and trade unions) together offer the most fruitful potential explanation for recent and past failures of reform. This article will attempt to elaborate and refine this explanation.

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

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

The international scientific literature has shown the importance of the medical profession for the implementation of health care reform (Immergut 1991; Freidson 1994; Tuohy 1999). It is thus crucial for researchers of any health care reform to acknowledge, describe and interpret the relationship between the state and the medical profession as well as other interest groups. Three main bodies of theory in sociology and political science are relevant.

Theory of Professions

During the last forty years several theories of the professional power of physicians have been developed, mainly to explain the pivotal role of physicians in modern societies. Many scholars argue that the medical profession has a dominant role not just in delivering services, but also in the process of policy making, affecting the

[1] Pan – Hellenic Socialist Movement

health care system more widely. They argue that this dominance is derived from the expertise and the esoteric knowledge that only doctors control. As health policy directly affects their income, working conditions, ability to use their knowledge, power and prestige, it is quite obvious why they are involved in health politics. Freidson argues that doctors have been dominant and will remain so in the future, despite the external structural changes in the organization of the profession (Freidson 1970; Freidson 1985; Freidson 1994).

Other theorists argue that medicine was once dominant in health and health care, but is now being fundamentally challenged(McKinlay and Arches 1985; Colombotos and Fakiolas 1993; Coburn 1999; Coburn and Willis 2003). Coburn especially argues that recent changes in health systems reveal that, far from being unique, medicine is a normal occupation, subject to the same processes of industrialization, bureaucratization, corporotization and rationalization as other occupations. These processes are challenging doctors.

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

Historical Institutionalism (HI)

Historical institutionalists offer explanations as to how, in conflicts between rival groups for scarce resources, institutions[2] favor some interests and disadvantage others. Contrary to the behavioralists who dominated political science in the 1950s and 1960s, historical institutionalists believe that the organization of the political economy is the predominant factor structuring the outcomes of inter–group conflict. Behavioralists on the other hand argued, that social, psychological or cultural traits of individuals structured behavior and drove outcomes (Oliver and Mossialos 2005). Historical institutionalists examine how institutions distribute power unevenly across social groups. In particular they focus on identifying how institutions have a tendency to give some groups or interests disproportionate access to decision–making, and how these groups win and the others lose. This idea stands in contrast to the idea of freely contracting individuals whose actions will lead eventually to everyone being better off situation(Steinmo, Thelen et al. 1992) cited in (Hall and Taylor 1996).

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

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

However, Historical Institutionalists do not argue that major policy change can never happen. Radical change can occur, but this only if a major event – technological development, demographic change, change in the political climate, unusually dynamic policy actors, or exogenous crisis (e.g. the oil crisis during the 1970s) – affects the balance within the dominant interests. This situation is characterized in a variety of institutional studies as a "critical conjuncture"(Wilsford 1994; Lavdas 1995; Tuohy 1999; Guillen 2002). In other words, political development is punctuated by critical moments or junctures that shape the basic contours of social life for long periods afterwards. HI is important for contemporary political science for three reasons: first, HI offers answers to big questions that are of concern to broad publics. Secondly, it develops explanatory arguments about important outcomes or puzzles, taking into serious consideration time, meaning that it tries to specify and trace sequences of events. Finally, it tries to take account of the macro- context of policy, in particular, the combined effects of institutions and customary policy processes on policy outcomes. As a result, Historical Institutionalists tend to be interested in comparative studies of policy processes either through time or between countries (Pierson and Skocpol forthcoming). HI has been used to analyse health politics and health care reform in particular (Immergut 1992; Wilsford 1995; Tuohy 1999).

Structural Interest Theory

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

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

It is worth commenting on the category of repressed interests. These are structural interests of the community population.(white rural and urban poor, lower middle class etc.). Not only are the interests of the community population not represented in the health care system, but they are generally not organised as an interest group. As a result, their autonomous demands are not heard.

Current Features of the Greek Welfare State

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

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

movement, legitimized Greek families and individuals to act strategicaly in seeking employment from the state, or in securing income through formal or informal means from the state. In other words, the state in its effort to gain the support of its citizens by developing clientelistic patterns, pushed citizens to demand from the public sector extra revenue in the form of welfare provision[3], but at the same time created privileges for politically opportunist groups. (Petmesidou 1991; Petmesidou 1996; Petmesidou 2000). This is what Tsoukalas calls "clientelistic corporatism"(Tsoukalas 1987). That is to say that the state has corporatist, differentiated and uneven relations with selected powerful social groups. More specifically there is an unequal and uneven distribution of rights, opportunities and privileges to middle or upper class social groups and rarely to working class employees. That and the fact that trade unions do not have formal means of expressing their objectives publicly, results in a great degree of dependence of trade unions on governmental support for achieving their goals.

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

The Greek state has traditionally promoted economic development through patronage of certain industrial sectors and business interests (statism). Statism involves protectionism, autarky, transfers and subsidies, and control of specific industries. The civil service, which includes NHS employees, lacks a tradition of political neutrality, organisational coherence, status, class assets and expertise, unlike Western European civil services. Various W. European countries have also experienced strong and overprotective state policies in their efforts to control their economies by running specific industries or by offering subsidies to their citizens. What makes Greece different is that these strategies have a particularistic, not to say personal trait. Political parties have inflated the political component of the bureaucracy by colonizing bureaucratic structures and personnel through party factionalism and creating inter – ministerial committees of political appointees and councils of advisors to ministers. This has resulted in the formation of a central bureaucracy that is large, but has limited autonomy.

What is also striking is that although Greece has experienced economic growth, it has not experienced even economic development. Uneven economic growth has resulted in an unfair Welfare State, as the state tends to be more generous towards certain categories of the population, and indifferent towards others. This discrimination has its roots in the Civil War, of 1946 – 1949, where the state clearly promoted the "winners"(right – conservatives) against the "losers" (the left). The aftermath of the Civil war was the creation of a dual society that prevented the

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

development of a social contract between the citizens and a neutral state. On the contrary, there was a deliberate attempt to exclude the "losers" from politics or even social welfare benefits. Social strata that are close to the state are the business strata, the liberal professions (where physicians are included) and segments of the petite bourgeoisie. The relationship that was formulated by this interaction cemented the long–term dependence of these privileged groups on the state, and it has increased their desire to control the state apparatus. This favourable treatment led the state to create specific jobs to accommodate their supporters and also to enact legislation and allocate funding that promoted the insurance funds of the liberal professions and other groups with special proximity to state power such as civil servants. As a result, research carried out on ministerial and parliamentary elites in S. Europe, shows that there is a significant overrepresentation of the liberal professions, especially lawyers and doctors, in the Greek state and politics. Furthermore, it is possible that these key professional representatives, can influence the centres of decision making in a disproportionate fashion, protecting or even expanding their interests [(Tavares de Almeida, Costa - Pinto et al. 2003) cited in (Sotiropoulos and Bourikos 2001; Sotiropoulos 2004)

Current Features of the Greek Health Care System

The Greek Health Care System is a "mixed" system of "public contract" and "public integrated" models[4], and is financed by a mixture of general taxation and social insurance. There are three major categories of providers: (1) The NHS (public hospitals, health centres, rural surgeries and emergency pre hospital care), (2) insurance funds health services with their representative units and polyclinics (mostly established within the biggest Greek insurance fund called IKA[5], and (3) the private sector (private hospitals, diagnostic centres, independent practices, surgeries and laboratories). The NHS offers universal coverage of the population, but only in theory. In reality it covers only hospital care and primary care through 200 health centres and 1,000 health posts for the semi-urban and rural population. Social insurance is compulsory for the working population and it is occupationally based. There are approximately 172 social security funds that provide a variety of insurance schemes, such as health services and retirement pensions, or welfare and other benefits to the population. Around 30 health insurance funds offer coverage to 95% of the population[6](Karagiannis, Lopatatzidis et al. 2003). The three largest funds are IKA (Social Security Institution), OGA (Organization of Agricultural Insurance) and OAEE (Fund for Self – Employed). People employed in banks, public utilities (i.e. telecommunications) and some self – employed (10% of the population) are covered by separate funds. Moreover, the government runs separate schemes for civil servants, their dependents and military employees (12% of the total number of insurees (Sissouras and Souliotis 2003 January).

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

[5] Social Security Institution (IKA)

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

Management of the insurance funds is the responsibility of representatives of employees, employers and the state. One would expect that the state would be the dominant party in the management of the funds, since they receive financial support from the state. However, this is not so. One explanation for this peculiarity lies in the fact that two of the largest trade unions in Greece, GSEE[7] and ADEDY[8], are controlled by unionists that are influential within PASOK, the political party that has been in government for 19 of the past 22 years[9].

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

Greece spends approximately 9.4% of its GDP on health care (2000), a percentage that lies above the median of the EU – 15, yet its per capita GDP is one of the lowest and its citizens the least satisfied with the health services they enjoy(Mossialos 1997; OECD 2002). Health care in Greece is funded mainly through the central government budget (general taxation, 30.4% in 2000, of which 58.4% were indirect taxes), social insurance funds (25.9% in 2000, employers and employees contributions), private health insurance (2.3% in 2000), and out–of–pocket payments for the remaining 41.46%. A significant part of the out–of–pocket payment is informal. In addition to this, the self-employed under-report their incomes to avoid tax, and while employees and employers together contribute above 44% of gross wages to the social security system, small entrepreneurs and traders make lower monthly lump–sum payments between 17% and 37% of the gross earnings of an average production worker. Farmers make no contributions, and finally professionals have their own contribution supplemented by third–party taxes – essentially earmarked levies that are transferred to the relevant institution (Bronchi 2001). As a result, civil servants, bank and telecommunication employees (general public utilities), professionals and the self – employed contribute less to the funding of NHS and social insurance funds than average, yet many of them enjoy better benefits and services than an employee insured in IKA would ever receive from his/her health insurance. Thus the financial burden of the NHS is not evenly distributed among occupational groups.

Out– of–pocket payments are very high, mainly composed of direct (for dental or primary health care) and informal payments for NHS hospital care. This is another peculiar characteristic of Greek health care funding. Informal payments reflect the inability of the Greek state to establish comprehensive coverage of the population, the way health insurance coverage has developed, the desire of doctors for supplementary income, and some scholars argue, patients' willingness to express personally their gratitude to the doctor in order to encourage the doctor to provide better treatment. Incomplete funding of the NHS also results in a flourishing market in private diagnostic services and private primary care. In addition, around 5 – 8% of the population has private health insurance. Unlike private medical insurance in the rest of Western Europe, the bulk is insurance taken out by individuals and only 30% of policies are through employers (Economou 2001).

The financing mechanisms described above mean that health care services financing in Greece is regressive (relying on indirect taxes, with favourable treatment of high income people, and the self–employed as far as tax and social insurance contributions

[7] Greek National Confederation of Labour
[8] Civil Servants' Association
[9] On March 2004, and for the first time in 11 years the Conservatives (ND → New Democracy) gained power.

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

Physicians working for the NHS (hospital doctors and doctors working in health centres) are full–time salaried employees. Until 2001 they could not see patients privately in return for fees. However, many hospital doctors practised privately even when this was illegal[10] and some special categories of hospital doctors have always had this privilege, i.e. university doctors and armed forces doctors. Doctors that practise privately comprise three groups: (1) doctors providing services on an exclusively private basis, the cost of which is fully covered by the patients through out–of–pocket payments, (2) doctors working in polyclinics of insurance organisations, and (3) doctors contracted to one or more funds, working from their private surgery and paid by fee–for–service.

The medical care reimbursement methods used by the Greek health care system provide perverse incentives to doctors to offer more services irrespective of their value. This is more obvious in the case of doctors contracted on a part–time basis to various health insurance funds, such as IKA. Since service in these institutions is poorly paid, doctors recruit private patients through their everyday institutional salaried practice. In addition to this, Greece has to deal with the severe over– supply of doctors. Once these physicians begin their practice they realize that the payment they receive does not meet their expectations. On the contrary, payments they receive are consistent with the limited resources available to the Greek public health care system.

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

The involvement of the private sector in health care delivery[11] is extensive and has been growing rapidly since the early 1990s. One explanation for the rapid growth of diagnostic centres is the restrictions that PASOK imposed on the private hospital sector in 1983[12], the under–investment in the public sector and the establishment of special relations between NHS doctors and diagnostic centres, where doctors act as promoters of diagnostic centres and are paid to refer patients to them. Around 85% of radiology laboratories and 75% of nuclear medicine laboratories are in the private sector. In addition to this, Greece has a high proportion of private MRI and CT scanners, 80% and 68%, respectively. Furthermore, it has one of the highest ratios of MRI and CT scanners per 1 million inhabitants at 16.4 in 2001, as against the UK with 6.1, France 9.7 and US 13.3 scanners/million inhabitants. Doctors refer patients to private diagnostic centres, thereby stimulating demand for private diagnostics, and then return them to NHS hospitals to receive treatment from the same doctors.

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

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

[12] They were reversed in early 1990s

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

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

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

The socio-political and economic context of Europe in the 1980s was one of recession and slower economic growth in the aftermath of the oil shocks of the 1970s. Most European countries had already introduced a National Health Service or national health insurance during the expansion of their Welfare States after World War II, and were implementing cost containment policies. In contrast, Greece experienced a rapid increase in public expenditure, driven by the populist rhetoric of the winner of the elections of October 1981(PASOK). PASOK' s populist policy focused on the need for reforms at institutional and social participation level in the interests of the urban middle classes and peasants. Although public expenditure rose significantly during PASOK's period in government[13], the political scene was not generally supportive of a new Welfare State. However, one way for the government to express its commitment towards people's needs and make steps towards legitimising its own position was to attempt to repair the damage caused by the socially divisive periods of conservative government through proposing a bill for the establishment of a National Health System (NHS).

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

Academic doctors working for the NHS were also against the law, as they were obliged to quit their private practices. The specific clause at issue was a continuation of a previous statute (1268/1982[14]) that had introduced the concept of "full – time and

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

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

exclusive" practice to all university teachers, but which had stated that this would be activated only by presidential decree at some time in the future. This had not happened, as the powerful academic elites, who kept close relations with Prime Minister Papandreou, influenced him in favour of their professional rights. As a result, academic and army forces doctors were the only two categories of doctors excluded from "full – time and exclusive" practice.

Bill 1397/1983 was debated in the Greek parliament for about 4 weeks, and although in the beginning the government wanted to establish a unified insurance fund, in the end organized opposition from the MP's representing the so – called "noble – funds[15]", whose "insured population would lose their benefits and access to better health services", obliged the government to amend the statute and go for a voluntary unification of the insurance funds in the future (by 1989), that again never happened.

Finally, the private clinics and pharmaceutical companies also had a strong interest in the preservation of the status quo in health care and the failure of the NHS. The private hospital sector had experienced rapid growth during the late 1970s. 45% of the hospitals beds were in the private sector. During the 6–year period, 1975–1981, only 1505 public hospital beds had been refurbished and 5578 private beds built. It was thus reasonable for a government that wanted to establish a NHS to ban the building of new clinics and that way to shrink the private sector that in the future could harm a new public system. Private clinic owners opposed the law, as they were not allowed to expand or invest on their companies, a provision that, they argued, would jeopardise the survival of small operators.

Finally the reform also intended to outlaw "under the table" or informal payments, including both doctors receiving fully paid trips to conferences from pharmaceutical companies and doctors receiving informal payments from patients. However, the pharmaceutical companies and doctors prevented this happening.

The 1990 – 1993 Conservative government

By the end of the 1980s Greece was in an unstable economic and political condition. As a result, the EU had proposed an economic stabilization programme, in order to avoid further recession. Austerity programmes introduced, reduced inflation and social expenditure. Following two years of political instability, general elections in 1990 brought the conservatives back to power[16]. New Democracy (ND) ruled until 1993 and pursued neo-liberal policies. The requirement to meet the economic criteria of the Maastricht Treaty (1991) offered ND a convenient macro-economic, external justification to pursue policies of cost containment across the Welfare State and resist public expectations as well as the entrenched system interests, (i.e. "noble insurance funds" and the medical profession) that favoured increased health spending (Carpenter 2003). As a result, the conservatives were able to pass a law in 1992 (Act 2071/1992) that altered fundamentally the provisions of the 1983 reform. It focused on individual responsibility for health care, on a shift from public to private provision, and from public insurance to private finance of health care. In addition to that, it included a huge increase in the per diem hospital reimbursement rates (almost tripling them) [17]. It also permitted insurance funds to contract with private clinics and diagnostic centres, introduced co – payments for drugs, and fees for visits to out–patient departments and

[15] Representing only the 6% of the population in 1983

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

[17] This provoked huge deficits to health insurance funds.

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

The new law was passed after a long and lively debate in the Greek parliament. The debate was focused on specific articles of the statute concerning mainly doctors' working conditions. Doctors no longer had to work "full–time and exclusively" within the NHS. According to the 1992 law they could practise either full – time or part – time within the NHS. Thus the system created two types of doctors: (a) junior doctors that would work full–time and exclusively in the NHS as they did not have the necessary experience or financial resources to establish their own private practice, and (b) the medical elite (consultants) who were free to work part–time within the NHS, and at the same time recruit patients, using the public hospital infrastructure, for their afternoon private surgeries. University doctors that were also registered with the NHS, were forced within a deadline of sixty days to choose whether they wanted to be academic teachers in the university or academics working full – time for the NHS and in reality quit teaching. The sixty–day deadline for their decision was later changed and in the end became a one year deadline, as university NHS doctors exerted pressure on the MoH.

Most medical associations, except the Pan – Hellenic Medical Association, were against some groups of doctors having privileges denied to others[18], and especially against the article that established non– permanent residency for hospital doctors hired after 1992 when the legislation had been enacted. A few MPs argued that most medical associations were in reality against 2071/1992 law because doctors preferred to receive informal payments in NHS, than to work part – time in the NHS and at the same time be taxed for their afternoon private surgeries (according to the new regulation). Evidence produced by a parliamentary committee, which discussed a first draft of the statute, confirmed that almost 80% of NHS doctors received informal or "under the table" payments. Finally, ND did not take any steps towards the establishment of a single insurance fund, as they were aware what had happened to the 1983 reform, when severe opposition had postponed the unification indefinitely.

The 2001 Reform - PASOK's comeback

PASOK was re – elected in 2000 and for the first time in 17 years a non–medical Minister of Health was appointed. Minister Papadopoulos had already gained his reputation as a successful minister of finance and internal affairs and he seemed the ideal choice, to confront vested interests in the health care sector, and manage the likely political conflict that would result. He introduced a health care bill in the Greek parliament in January 2001, which was to be part of a wider reform plan for the longer term[19] including not only the establishment of regional health systems, but also the much discussed unification of the insurance funds and the establishment of a family medicine system. Discussions about the reforms had started in summer 2000, and many interest groups had already expressed their opposition. Nevertheless, the Minister decided to proceed with the production of statute 2889/2001. However, he deliberately compromised at this stage and did not include the proposals to introduce a single insurance fund which could develop into a national purchaser of services or establish primary health care in the bill, as there were vested interests opposing the unification, and there were not enough resources for financing primary health care.

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

[19] "Health for the citizen"

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

University doctors were another interest group that strongly opposed the statute during parliamentary discussion, and after its voting, because it forced them to choose between public and private practice. Parliamentary minutes of the discussion of the plan show that the debate between MPs that used to be university doctors and Minister Papadopoulos was lengthy and hard-fought. Most of these MPs challenged the authority of the Minister to judge their profession and their working conditions, since he was not a medic[20]. They continued their debate by going to the Constitutional Court claiming that their human rights were violated on the basis of the European Convention of Human Rights. After they were not supported by the Court, they stopped university teaching, and later on, even when they went back to their teaching they threatened that they would not pursue any clinical work inside the NHS, and that they would only do their private practices and teaching.

Opposition to the law came also from hospital doctors. Medical associations were against the introduction of professional hospital managers, arguing that managers were not doctors and that they did not have the esoteric knowledge and authority to judge doctors[21]. Finally, the civil servants' trade union opposed the possible redeployment of publicly employed doctors in line with the needs of the 17 RHSs, as this was not included in the civil servants' code[22]. As a result regional directors could not enforce the law, and hospital doctors refused to move even within their region.

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

Minister Papadopoulos was quickly replaced by Professor Stefanis, a famous retired mental health professor. New legislation was introduced under pressure from the civil servants' union to enable its president to become a member of the committee which oversaw the regional directors and hospital managers, a movement that signalled the granting of more powers to the civil servants' pressure group and the reduction of state influence and control over the new system.

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

In view of the historical sketch presented above, it appears that sociological theories of the professions and structural interest theories are unlikely to offer a complete explanation of the particularities of Greek health care reform. The theory of the

[20] They vividly said " Your plan is doomed to fail"

[21] One MP who was also a doctor implied that "doctors should be judged only by doctors".

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

professions can explain the professional dominance of doctors at the clinical and related levels. It is also useful in explaining the success of some of the profession's tactics in resisting reform (e.g. their status and control over esoteric knowledge enabled them to claim successfully in Greece that non-medical managers and others could not and should not have any jurisdiction over how they worked). However, in general, comparative studies of health care reform (Immergut 1992) show different trajectories in different countries despite the fact that in each the medical profession exhibits similar characteristics of occupational monopoly and clinical autonomy. Thus, in order to explain the different impact of the national medical associations on policy decisions and systems, we need to look beyond the professional dominance of doctors over their working conditions, clinical autonomy, and division of labour to focus on the role of institutions and how these influence the ability of major stakeholders to shape any proposed changes in health care policy (Immergut 1991). Theories of the professions are necessary but not sufficient to explain the medical profession's role in health care reform in Greece.

In addition to this, health care reform in Greece appears to deviate from what one might expect in terms of structural interest theory. Alford's theory is that contemporary health policy is shaped by corporate rationalizers challenging the dominant structural interests of doctors. The path of current and previous reforms in Greece (1983 – 2001) suggests that corporate rationalizers[23] have not developed or are not represented, at least to the same level as in U.S.A. or Europe, due to a weak state and non–existent bureaucratic elite. One thing that does match the Greek case is the "repressed" position of the consumers of health services. Although the majority of the population has expressed its dissatisfaction with the current health care arrangements, it has not developed a formal way of demanding change in its interests. Some Greek scholars have attributed this to the absence of a universalistic culture and collective forms of representation.

Instead, preliminary analysis suggests that historical institutionalism provides a better basis than the other theories for an overall explanation of the 1983–2001 reforms. Greece came out of an authoritarian period and entered the 1980's with specific inherited characteristics, that reflect its socio – political structure and organisation and that have direct effects on the Greek Welfare State. It is highly politicised (dual party system), centralized and fragmented, where reciprocal favours and mutual obligations between patron (the state or the two major political parties) and client (politically opportunist social groups such as the trade unions of the 'noble' insurance funds and key professional representative organisations, such as the medical profession exist, and where the notion of individualism dominates policy making at the expense of universalism. It is within this broader context of policy making that decisions about the Greek health care system are made.

This institutional context has determined to a large extent the degree of success of the three major reforms since 1983 by providing a secure basis for the stiff opposition of the major interest groups, such as the medical profession, trade unions and insurance funds. All the reforms that contained clauses that harmed vested interests of the medical profession or the insurance funds, were only partly implemented or failed to fulfil their main objectives. Representatives of these interest groups managed in all the reforms to use the institutional context to protect their positions and in some cases to enhance their privileges. They focused their efforts on being exempted from the reforms or by turning the law into a dead letter at the implementation stage. Typical examples of this were the failure to establish a unified insurance fund, the inability to prevent academic doctors continuing their private practices and the inability to end

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

informal payments to both junior and senior hospital doctors. In all cases the established interests in the health sector protected their interests by excluding themselves from the reform by presidential degree (noble insurance funds and university doctors) or by rendering the statute a dead letter in their everyday practice (junior and senior hospital doctors). In this way, the status quo was largely preserved, and by no means in the interest of citizens[24].

Conclusions

This paper has discussed Greek health care reforms, and has attempted to 1) reveal the peculiarity and "uniqueness" of the Greek health care arena, and 2) illuminate the theory that best explains its dynamics. Three theoretical frameworks were used to explain and understand the Greek case. Preliminary analysis suggests that Historical Institutionalism appears to offer the greatest potential to help explain the direction of health care reforms since 1983. However useful insights were derived from the theory of professions, particularly to explain the way in which appeals to professional autonomy and the inability of "lay" people to judge doctors' behaviour were able to be used successfully in parliamentary debates to maintain medical privileges. Further investigation needs to be carried out on how the medical profession gained its power and how it maintains authority both at the clinical and the political/managerial levels. This is where the role of institutions may prove crucial - in particular the specific peculiarities of the Greek Welfare State, an understanding of the development of Greek society and nature of the Greek state. As the brief history of the three periods of recent system reforms shows how vested interests, such as the trade unions of already privileged groups[25], the medical profession (junior hospital doctors, senior hospital doctors and university doctors), party-to-person clientelism, absence of political consensus on the type and the character of reforms, administrative and financial weaknesses of the state, institutional fragmentation, and a weak collective culture have all impeded the establishment of a universal health insurance system. Recent reform efforts have been critically limited by the decisions of the past.

Neoinstitutional theory suggests that reforms can only break out of such "path dependency"(Wilsford 1994) when a ''window of opportunity" or a "critical juncture" occurs. An incomplete set of favourable circumstances may explain PASOK's decision to introduce a NHS in 1983. Circumstances such as the consolidation of democracy, the worldwide economic instability (resulting mainly from the two oil shocks), the newly elected socialist party with an outright majority, entry into the European Community, and the broadly felt public need to correct the discrepancies of the previous system, seemed to offer the opportunity for major structural and

[24] This what Mouzelis calls formalism. Formalism is the degree to which discussions and disputes receive a formalistic – confromistic character at the expense of social values. Formalism is a way of distracting attention of people from substantial to the insubstantial problems. It results in a situation where only minor changes are acceptable, and where most institutional reforms remain dead letters, as politicians are afraid of the political cost.
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[25] Almost 17% of the population

institutional change in the health care arena (Immergut 1992; Lavdas 1995; Tuohy 1999; Guillen 2002). However in order to bring about major change, there needs to be a high level of consensus or at least the ability to compromise among the groups/interests whose support is necessary to implement reform and who potentially stand to lose from reform. Unfortunately, no consensus was ever achieved in 1983 and there has been none since in favour of significant health sector reform.

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Greek pension reform and the change 'from within'

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Abstract

The Greek welfare state has been described as a 'laggard' in terms of social protection within the European Union, and has historically developed into a fragmented and inherently unequal system of welfare provision. These characteristics are also reflected in pension provision in Greece, which is the policy domain this paper is concerned with, and have resulted in more and less protected sectors of society and the labour force. In this paper I argue that the effect of the European Union on pension reform in Greece has been minimal, although by some accounts the effect of the European Union has been felt more in other domains of Greek social policy. In this paper I firstly look at the characteristics that distinguish the Greek welfare state, and the pension system in particular. I then describe the common challenges that most European welfare states have been presented with at the peak of the debate on pension reform and the expansion of the discourse of 'multi-pillar provision'. I argue that the inherent paradoxes of the Greek pension system and socio-political context more generally have perpetuated the 'institutional sclerosis' of the system, which in turn has constrained the drive for reform. In order to illustrate this sclerosis, the third section briefly describes three attempts at pension reform from 1990 until today. By the third attempt [in 2002], the European guidelines on pension provision had already been outlined via the Open Method of Coordination, largely informed by the 'multi-pillar model' discourse that has dominated the debate since the early 1990s. These European guidelines, as well as the Greek National Strategy on how to achieve them, are discussed in the fourth section. In conclusion, I argue that the best hope for a radical reform of the Greek pension system lies *within* the Greek welfare state, society and polity.

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Introduction

'The problem of pensions in Greece is not a technical problem. For the system to become, as before, a basis for solutions and not a source of problems, we must restore the trust of Greek citizens in the system and its prospects. What is required is that the pension system should acquire a new authority and credibility'

Introduction of the Greek Report on Pension Strategy (2002) to the European Commission[1]

The 'problem of pensions' in Greece can be described in at least two ways. The first way is by pointing to the issue of medium- and long-term economic sustainability due to the high projected expenditure on pensions. This problem is essentially a problem of lack of funds, and is the result of a history of continued mismanagement of the insurance funds[2]. The remedy to this problem lies in the sharing of the cost between current and future generations of pensioners by adjusting conditionality and contributory regulations. The second problematic dimension of Greek pensions is the extent of its inherent inequalities: not only do pensions use up most of the social budget in Greece, in addition they are overwhelmingly biased in favour of older men with long and continuous working lives in specific 'protected' occupations such as civil servants. This problem is harder to remedy: it requires the unification of regulations for workers of all sectors, and this move will almost certainly mean the loss of privileges for some social groups. In addition, and as with all pension systems that operate predominantly on a Pay-As-You-Go basis[3], the Greek pension system faces a huge financial cost in order to move to a system with more funded elements. But what makes the Greek case unique is the past political inertia that has made the system path-dependent and unable to overcome this 'gridlock' (Featherstone, 2003). If we distinguish between 'parametric' and 'paradigmatic' reform[4] Greece has made a series of parametric reforms during the 1990s, with the pension proposal in 2002 –later aborted- coming the closest to a paradigmatic kind of reform. In this context, what is the role of the European Union? By some accounts, a small 'cognitive change' in the form of policy tools has filtered through in policy areas such as vocational training, employment and to a lesser extent, social assistance. Such reforms represent a positive development for the relevant sectors, but do they provide any lessons

[1] [Greek] Ministry of Economy and Finance, Ministry of Labour and Social Security, 2002

[2] Although this problem accounts for most of the accumulated deficit in insurance funds and often surfaces in policy debates within the Greek context, the relevant empirical evidence is scarce. What began during the 1960s and continued through the 1970s and 1980s was the management of the funds' assets by actors other than the funds themselves –mainly the government via the Bank of Greece-. Insurance funds were legally obliged to deposit their assets to the Bank, at extremely low interest rates, and when they ran into financial trouble, they were then obliged to borrow from the same Bank at extremely high rates. This was a scandal the degree of which is rarely mentioned in debates on Greek pension reform.

[3] In Pay-As-You-Go systems the current generation of workers pays for the pensions of the current generation of pensioners. Because of the nature of this 'contract' it follows that younger generations of workers 'lose out' as the population ages, because fewer workers are obliged to pay for the pensions of more pensioners –this relationship of 'dependence' is expressed by the so-called 'dependency ratio' which represents workers/pensioners.

[4] For the purposes of this paper, I use Holzmann, MacKellar and Rutkowski's (2003: 8) definition of 'parametric' and 'paradigmatic' pension reform. A parametric reform is an attempt to rationalise the pension system by seeking more revenues and reducing expenditures while expanding voluntary private pension provisions. It represents a more piecemeal approach to pension reform. A paradigmatic reform is a deep change in the fundamentals of pension provision typically caused by the introduction of a mandatory funded pension pillar, along with a seriously reformed PAYG pillar and the expansion of opportunities for voluntary retirement saving.

for the issue of pension reform? The question this paper is concerned with is whether the European guidelines on pension reform represent an opportunity for radical pension reform in Greece, given the peculiar rigidity of the Greek welfare state.

The Greek welfare state

The welfare regime literature has located the Greek welfare state in the 'Southern European/Latin/Mediterranean' rim (Leibfried, 1993: 139; Ferrera, 1996), although some writers place Greece in the 'corporatist-conservative' welfare regime (Esping-Andersen, 1990), only with a much smaller spending capacity (Katrougalos, 1996; Davaki, 2003)[5]. The governance of the Greek welfare state reflects a legacy of heavy politicisation and centralisation, coupled with a weak administrative infrastructure and a set of poorly developed social services (Venieris, 2003: 133; Featherstone, Kazamias and Papadimitriou, 2001: 462). The fragmentation of the labour market into protected and unprotected sectors is reflected in the fragmentation of social protection, and in turn creates vast inequalities between different occupational groups (Venieris, 1997: 268; Petmesidou, 2001; O' Donnell and Tinios, 2003: 264-8; Sotiropoulos, 2004: 269). Civil servants, workers in finance and insurance industries, and workers in nationalised industries belong to the 'insiders' of the welfare system, and enjoy a privileged position within the social insurance system. The long-term unemployed, those who have never worked, and those in need of a minimum income assistance fall through the social safety net. As a result of the fragmentation of the system, the relatively high level of social spending in Greece has paradoxically not translated into effective social transfers (Guillen and Matsaganis, 2000: 122), and the inequalities based on occupational status and political affiliation are further exacerbated.

Because of this system fragmentation, according to Petmesidou (1996a: 110) the Greek welfare state has allowed the reproduction of '...a welfare philosophy based on individual, particularistic needs rather than on universal well-being...', which is also reflected in the largely contributory mode of financing, rather than tax financing. There, in turn, lies part of the blame for the under-development of social services more generally and a focus on particularistic cash benefits (Guillen and Matsaganis, 2000: 122). This philosophy has since been allowed to exist largely due to the traditional family values that feature in Greek society. In the absence of strong universal values of traditions of social participation and an organised system of welfare provision, this 'rudimentary' welfare state (Leibfried, 1993: 139), or "state" (Venieris, 2003: 134) has relied on family and kin for informal protection. The Greek family has

[5] Theodore Papadopoulos argues, and I agree, that the Greek welfare state is significantly 'under-theorised' with the result of a misfit of Greece within the otherwise influential typology developed by Esping-Andersen in 1990. Indeed, the 'Latin/Mediterranean' regime was subsequently attached to this typology by other writers. The characterisation of the Greek welfare state, which cannot be part of this short paper, requires a much more detailed analysis of Greek political economy through modern history.

traditionally been a 'social shock absorber', especially in areas like childcare, unemployment assistance, care for the elderly, housing and social assistance (Matsaganis et al, 2003: 642). The immediate cost of this high degree of 'familialism' (Petmesidou, 1996b: 329) is the continuous strength of the 'male breadwinner model' in this country, and one of the lowest female labour force participation rates in the European Union, well below the target set in Lisbon. In 2001, 48.8% of all Greek women were in paid work, compared to the European average of 60.1% (OECD Employment Outlook, 2002). The gap with the European average was consistent across all age groups: about 34% of 15-24 year-old women were working in Greece in 2001, compared with 43% across Europe, 61% of 25-54 year-old Greek women compared to almost 72% across Europe, and about 24% of 55-64 year-old Greek women, compared to almost 32% across Europe (OECD Employment Outlook, 2002).

The origins of this unique 'welfare culture' are to be found in the historical development of the Greek welfare state. The birth of the Greek welfare state took place at an unconventional point in time for European welfare state development, in 1974, when the rule of a seven-year dictatorship was terminated. At the time when most other European welfare states were undergoing a period of expansion, both in terms of the amount and the scope of welfare provision, Greece was still under-developed in welfare terms. From the period of under-development, therefore, Greece went straight into a period of crisis in the 1980s (Rombolis and Hletsos, 1999: 402). Despite the fast increase in social expenditure during the 1980s and especially the second half of this decade[6], the balance of the social budget did not come about (Stathopoulos, 1996: 144-7; Petmesidou, 2000: 303), and the Greek welfare system did not develop in an organisationally cohesive manner with a long-term orientation. At the same time, it was access to political power –in return for electoral support-, rather than need that dictated the distribution of social provision (Petmesidou, 1991: 32-5), and this laid the foundations for the future governance of the Greek welfare state.

With respect to pension provision in particular, the fragmentation of the Greek system is one side of the story, complemented by a behavioural problem in the form of abuse of the system. On one hand, fragmentation is clearly reflected in the pension system, and it creates inequalities between different social groups (Featherstone, 2003: 3). Along with these divisions between more/less privileged groups come disincentives/incentives to maintain/change the status quo and prevent/promote radical reform. The numerous attempts for radical reform in the past –some of which will be mentioned later in this paper- prove this point. On the other hand, the pension system as it is,

[6] The average share of the GDP for public expenditure on social protection was 12.7% under the dictatorship regime in the early 1970s, rising to 13.5% [under the Conservative government] in the late 1970s and early 1980s, to 19.8% [under the Left-of-Centre government] in the late 1980s, and dropping slightly to 18.8% [under the Conservative government] in the early 1990s, and remaining around 19.8% in the late 1990s and into the 21st century [under the Left-of-Centre government] (Sotiropoulos, 2004: 268, Table 1).

offers opportunities for the abuse of the system. Two examples convey this point. The first example is the wide range of contributory conditions across different funds, but also the opportunities to abuse them due to lax regulations. Contribution evasion is a huge problem in Greece, especially in insurance funds where contribution rules are less stringent. For instance, a worker may be insured in a lower-income tier than the one they are supposed to be in, or a worker may not be insured at all (contribution evasion), or it may even be that an employer is receiving contributions from an employee but not paying them into an insurance fund (contribution theft). The problem of a lack of correspondence between revenue and expenditure is therefore exacerbated on a large scale. The second example is the abuse of invalidity pensions (Petmesidou, 2000: 307) –which account for approximately one-quarter of all pensions- due to lax eligibility rules (National Statistical Service of Greece, 2000). This is due to the categorisation of a large proportion of occupations in Greece as 'unhealthy'.

Pressure for reform: the usual and the unusual suspects

It is fair to say that the 'usual suspects' contributing to the pension problem on a global scale - changing demographic and employment structures- have exposed the strength of the more 'unusual suspects' in the Greek context. This means that factors that are drives for reform in other countries have exacerbated the demand for reform in the Greek case, but that the real problem to be solved in Greece is one of a clearly domestic nature. Global trends of an ageing population and changing employment structures result in fewer workers paying for the pensions of more retirees, while changing family structures have long-term effects for family support, income adequacy and long-term care in old-age (Sakellaropoulos, 1999: 43-51). The pension reform discourse that has dominated policy agendas around the world since the pro-active involvement of the World Bank and the IMF since the early 1990s, has repeatedly pointed to the multi-pillar model of pension provision as the panacea for every context (World Bank, 1994; Holzmann et al, 2003), including the Greek context (IMF, 2002: 14-16). Both these global demographic and structural changes, and the multi-pillar rhetoric have had an impact on the Greek context of welfare provision. It is true that the fertility rate in Greece is very low -it was 1.7 in 1985 and 1.3 in 2000, compared with the OECD average of 1.9 and 1.7 respectively (OECD, 2002). It should be noted that, despite the low fertility rate, the role of the Greek family as a support network is still very important. In this respect, family changes in Greece assume a very different nature and pace compared to Greece's Northern European partners. It is also true that female labour market participation has been increasing since the 1980s, but is still at a much lower level than other European –even other Southern European- countries. However, although these trends have indicated the seriousness of the pensions situation, and share common elements with the challenges faced by other countries, it is internal factors that have been exposed in the drive for Greek pension reform.

Three such factors should be noted. The first factor refers to the structure of the social budget as a whole, where pensions have consistently taken more than half of the share[7] (Provopoulos and Tinios, 1993: 326). Because of the fragmentation of the system, or the distinction in the system between 'insiders' and 'outsiders' as Venieris argues (2003: 134), the large part of the budget dedicated to pensions actually reinforces inequalities between different social groups. The second structural problem of the Greek system calling for reform is the structure of the Greek labour market. Despite the decrease in percentage of workers in agriculture, the increasing participation of women in paid work and increasing immigration, the Greek labour market has maintained a rigid structure. Part-time work, which has been dubbed a 'miracle' in other European models is still very low [5% of total employment], while unemployment was at 9% in 2003. At the same time, overall employment is low (just over 55% in 2003), while self-employment is very high (32% of total employment, compared with the EU average of 15%). Finally, the phenomenon of an informal economy is a considerable element of the Greek labour market (Sotiropoulos, 2004: 275). These characteristics place Greece in a difficult position vis-à-vis the quantitative goals set by the European Union in terms of employment and labour markets more generally. The third internal and probably most serious obstacle for reform is actually the fact that radical reform has not taken place for more than two decades. In other words, the very high resistance of Greece to pension reform has created accumulated costs –financial and political-, which on one hand are impossible to sustain but on the other hand no working generation (current or future) and no government is willing to pay[8]. The fact that the Greek system is of a predominantly Pay-As-You-Go nature makes it even more problematic to change, as it essentially threatens the 'contract' between current and future [shrinking] generations of workers (see Myles and Pierson, 2000).

The Greek political system, which exhibits a high degree of path-dependence, is responsible for a large part of this resistance of Greece to change in the pension system and welfare provision more generally. The Greek system is a rigid two-party political system (Conservatives and Left-of-Centre), in which both parties recognise the need for pension reform, but electoral calculations create few opportunities for a consensus. In this system, specific social groups representing distinct social class interests have maintained political ties with the government in power, in order to maintain their privileged position in 'protected' insurance funds (Sotiropoulos, 2004: 280). Over the course of time, this has created long-term commitments, which as Sotiropoulos (2004: 270) argues, have 'locked-in' policy-makers in the issue of pension policy. In this context, the only reform possible is 'reform by instalments' (Tinios, 2003). Another factor that acts as an obstacle is the negativity associated with

[7] National Statistical Service of Greece (2000) 'Expenditures of the social insurance organisations, by special categories of expenditures: 1990-1998' (www.statistics.gr)

[8] Tinios describes this problem as the 'missing generation' problem. The current generation of workers and the current generation of retirees have not resolved the issue of pension reform, leaving it to the future generation of workers to deal with (2003: 7).

pension reform, and the incapacity of the state to convey the advantages of reform, and the cost of inaction. Tinios (2003: 6) describes this as '...the wide gulf of understanding between 'experts' or 'technocrats' on the one hand and of public opinion on the other'. As a result of these characteristics, the Greek experience of pension reform has been described as 'parametric' by European and indeed global standards. Depending on one's viewpoint, three examples of successful parametric reform, or unsuccessful paradigmatic reform from the 1990s until today illustrate this point.

Three examples of successful parametric reform (or unsuccessful paradigmatic reform)

The Conservative government ('New Democracy') elected in 1990 aimed at passing pension reform in two stages: the first was to correct a collection of minor fiscal imbalances in the system, such as making adjustments to reduce the public deficit, and the second was to proceed with more major structural changes, such as the merging of insurance funds, which would direct the system towards greater transparency, uniformity and equality. Three laws were passed between 1990 and 1993[9], targeting the mounting deficit of specific funds and the public deficit, but the effective rationalisation of the system was postponed amidst strong union pressures. Financial liberalisation and a more general problem in the public finances were key characteristics of this period. The increase of pensionable age for civil servants, the rise in contributions, the cut of benefits for new entrants in the system, and the tightening of the eligibility criteria for invalidity benefits were important changes, but not adequate to reduce the degree of fragmentation and inequality in the system (Petmesidou, 2000: 309). After these minor adjustments, the largest union of workers (GSEE) emphasised the need for a unified pension system, indexing pensions to wages, and tripartite funding of social security (employer-employee-state). The multi-pillar model had already surfaced: (i) a universal scheme granting a guaranteed minimum pension and funded by general taxation, (ii) a compulsory supplementary pension scheme, funded on the basis of contributions, and (iii) a voluntary supplementary pension system based on private insurance (Provopoulos and Tinios, 1993: 339). This change, however, was too high a political risk for the government to take.

Policy history was repeated a few years later, when a similar attempt in two phases took place under the new Left-of-Centre government (PASOK or 'Panhellenic Socialist Movement'), which came into office in 1993. Pressure for convergence with the Maastricht criteria brought the public finances in the spotlight, especially with regard to the pension system[10]. The government appointed an expert committee ('Spraos Committee') to make recommendations for reform, however when the report of

[9] Laws 1902/90, 1976/91 and 2084/92

[10] Petmesidou (2000: 324) argues that it was actually this one-dimensional focus on fiscal discipline stipulated by the Maastricht criteria that produced the pressure for pension reform, rather than a wide consensus from social partners, driven by a strong culture of civil society in Greece. This reform was a good example of the limits of external empowerment.

the committee was published in October 1997, and amidst public outrage and union pressure, the government distanced itself from its findings. This initiated a process of 'social dialogue', which resulted in laws on contribution evasion and the merging of certain insurance funds[11]. The 'mini-pension reform', as it was characterised, had been passed, but the second wave of more radical reform was once again postponed (Petmesidou, 2000: 312).

The third and most recent incident of pension reform in 2002 is arguably the closest Greece has come to a paradigmatic reform of its pension system. This is evident from the gap between the initial proposals for reform and the final bill introduced in 2002. The initial proposal put forward in 2001 by the then Minister of Labour and Social Insurance Tasos Yannitsis promised a 'radically different' three-pillar system[12]. It provided for a low pension for all, a second pillar funded exclusively by employees and employers, and a third mandatory pillar. The retirement age was to be raised to 65 for all, gradually increasing from 2007, the replacement rate was to be reduced to 60% of reference earnings –calculated from the best 10 of the last 15 years of service-, and the minimum pension was to be raised but become means-tested. Most importantly, the number of years required for a seniority pension was to be increased from 35 to 40. Finally, the simplification of the system would start with the creation of eight main funds. This proposal guaranteed the survival of the system for an additional 25 years. On the part of the Left-of-Centre government pension reform was an issue it had promised to tackle, but with an overarching goal of not causing confrontation with the parties involved. Amidst reaction from the unions, the political opposition and the public, the proposal was withdrawn and Tasos Yiannitsis was replaced by Dimitris Reppas. With the new law (Law 3029/02) the retirement age remained at 65 for both men and women who entered the system after 1993, the replacement rate was set at 70% of reference earnings, the minimum pension was fixed at 70% of the minimum wage, while the merging of funds with the largest insurance fund (IKA) was to take place on a 'voluntary' basis.

The law's provisions bared little resemblance to Yiannitsis' proposals a year before. They were also significantly 'watered-down' changes compared to the recommendations of the British Government Actuaries Department (BGAD)[13], who had been commissioned by the government through the Centre of Programming and Economic Research (KEPE) to make recommendations for the reform of the system. This legislation would be remembered as the most significant missed opportunity for change, as well as for the lack of wider consensus in producing it. Nevertheless it succeeded in taking the pensions off the political agenda temporarily, and especially as Greece's entrance into the EMU had not proven dependent on the resolution of the Greek pensions problem

[11] Laws 2676/99, 2703/99 and 2688/99 aimed at merging some of the funds, while Laws 2559/97, 2519/97 and 2639/98 targeted the huge problem of contribution evasion.
[12] Ministry of Labour and Social Insurance (2001a)
[13] Ministry of Labour and Social Insurance (2001b)

(Matsaganis, 2002: 118). It would also be remembered, in contrast to the previous legislative introductions, as the Greek 'contribution' or 'response' to the European Open Method of Coordination in pension reform that had begun to surface.

The European guidelines on pension provision

The Open Method of Coordination in the field of pension provision is the result of decisions taken during the European Councils in Lisbon, Feira, Goteborg, Laeken and Stockholm, with regard to the quality and sustainability of pension provision (SPC, 2000; EPC, 2001; CEU, 2001). The Pensions OMC has centred around three broad aims (CEC, 2001). The first one is 'financial viability', covering the sustainability of pensions, sound public finances, specified employment levels, the extension of working lives, inter-generational balance in terms of pension provision and the sound development of private pension provision. The second goal is 'pension adequacy', referring to the prevention of poverty in old age, inter-generational solidarity and the maintenance of living standards in old-age. Finally, pension 'modernisation' aims at the adjustment of European pension systems to changing employment patterns, promoting gender equality and system transparency, as well as promoting consensus in the debate on pension reform.

In the field of pension reform the jury is still out on the strength of the OMC, but the evidence to date appears to portray this method as little more than a promise. Natali and de la Porte's (2004a, 2004b) analysis of the effect of the Pensions OMC in the French and Dutch pension systems, for instance, highlights the importance of national contexts on a normative, cognitive as well as procedural level. They conclude that '…the pensions OMC could…only support Member States in their reform efforts if the [National Strategy] reports…change from report on past activities to forward-looking policy documents' (2004b: 17). This point was certainly evident in the Greek report on the national strategy for the attainment of the goals set by the Pensions OMC [14]. The legislation introduced in 2002 –a transformation of a much bolder initial proposal- was presented as a multiple contribution to all three OMC aims of financial viability, pension adequacy and pensions modernization. Yet by most accounts, this legislation was an addition to the list of small, incremental reforms -or aborted radical reform in the name of electoral survival. The burden of effective pension reform has been shifting from one government to the next. For instance, the report referred explicitly to a 'window of opportunity' until 2015, by which time a 'coherent strategy' on pensions would be put in place. This alone was a declaration of postponement by the government in power. The European Council and the Economic Policy Committee had long known the extent of the Greek pension problem (EC/ECP, 2002), yet the process of monetary integration (EMU) that had started in the 1990s proved a missed

[14] [Greek] Ministry of Economy and Finance, Ministry of Labour and Social Security (2002)

opportunity for the Greek reform –in contrast to the Italian case for example (see Reynand and Hege, 1996). The European Council's response a year later was measured: it recognised the 2002 reform as 'laying the groundwork for further reform efforts', but also warned that 'there is substantial scope for improvement…by gradually developing second-pillar schemes, …stabilizing expenditure growth, … curbing contribution evasion, …and raising employment rates as required by the Lisbon and Stockholm quantitative targets' (CEU, 2003: 128).

Although the most recent pension reform did not have the scope and nature required for the Greek case, a number of European policy tools have, according to some accounts, infiltrated the formulation and monitoring of social policy in Greece. These include neo-corporatist structures of consultation among social partners, expert committees, the establishment of new institutions [and their importance at least on a cognitive level], and the adoption of National Action Plans (Sotiropoulos, 2004: 273-5). All of these tools have emerged in Greek social policy, however the European theory on pension provision has not really fed into practice on the Greek level. In other social policy areas the piecemeal approach to reform, largely due to the European pressures, has produced better results. Within the labour market, for instance, specific measures were adopted through the 2003 National Action Plan for Employment in order to encourage more part-time work, to promote gender equality in the labour market and to expand child-support infrastructure. As far as social assistance is concerned, two new social-assistance benefits were introduced by the Left-of-Centre government in 2000-1, but have been less successful due to low take-up rates (Matsaganis et al, 2003: 644). The first was a social security rebate for minimum-wage earners, and the second was an unemployment benefit for older, long-term unemployed on low incomes. In both these areas, the Greek response to European warnings has been more genuine compared to pension reform. The 'external empowerment' (Featherstone et al, 2001) of the European Union has been 'felt' more in areas such as employment and social assistance, compared to the area of pension reform, which has rather felt the 'limits' of this empowerment. This is not surprising given the peculiarities of the Greek context. The parametric nature of pension reforms since the birth of the Greek welfare state reflects the fragmentary structure of the pension system itself and of the Greek welfare state more generally. In addition, old-age and invalidity pensions, as already mentioned, represent the largest part of social expenditure in Greece, and that has not changed significantly in the last twenty-five years (Sotiropoulos, 2004: 270, Table 3). This means that it is in the interests of the social groups who benefit the most from the *status quo* –such as the public sector employees-, to prevent a paradigmatic change of the pension system. For the less influential groups –such as private sector employees or part-time workers-, who benefit less from the *status quo*, pension reform is more crucial but harder to attain. The heavy politicisation of industrial relations in Greece has thus far ensured that the 'insiders' have a greater influence in the debate and the policy process than the 'outsiders'.

Conclusions

It is of course a combination of external and internal pressures that call for the reform of the Greek pension system, but the balance between the two is unequal. The rules that govern the Greek welfare state have not changed significantly since Greece's accession in the European Community in 1981, and this is reflected in the inherent fragmentation and inequality that still burdens its pension system. As far as reform goes, this has been consistently constrained throughout the 1990s. Reflecting on the institutional rigidity of the Greek welfare state, one could argue that, in line with the Greek tradition of two-stage reforms, 'paradigmatic' reform in Greece would mean something rather different to what 'paradigmatic' reform means in the rest of Europe. It would mean a domestic mobilisation for the rationalisation of the existing, mainly PAYG system in order to tackle the internal paradoxes of pension provision. As the Greek Report admits in its very first sentence, the trust of the citizens in the pension system must be restored, so that the system acquires new authority and credibility. The evidence so far on Greek public attitudes to pension reform suggests a dissatisfaction with and lack of confidence in the Greek pension system. The Greek public recognises the need for reform, yet remains optimistic for the future and does not view the problem as having an effect on a personal, individual level. O' Donnell and Tinios (2003: 276) argue that this inconsistency may result from the design of the system itself, in which case public attitudes '...not only represent a constraint for reform, they are endogenous to the system itself and a vicious circle is created in which a flawed system generates public opinion that supports the system and blocks reform'. What is to be done?

Greek pension reform appears to be at a dead end. On one hand stands the sclerotic Greek system, which has increased its path-dependence over time and has not allowed reform to take place. On the other hand stands the European Union, which through the OMC provides space for learning among partners, but not necessarily for policy change. Indeed the EU and the OMC carry high hopes for Greece in the form of greater consistency between theory and practice of policy among European partners (Sissouras and Amitsis, 1994: 258; Tsoukalis, 2000; Tinios, 2003: 13). Petmesidou (2000: 324) argues that a radical reform in Greece will be the result of a new social contract between the civil society and the state on one hand, and the political processes and the economy on the other. Featherstone goes further to point to the lack of a systematic 'technocratic input' into the reform process, in the form of independent and expertise policy advice (2003: 11). These factors are related to the Greek domestic context, and the external pressures and challenges common with other developed countries can only serve as stimuli for pension reform mobilised 'from within'. Barr (2004: 119) argues that the funding mechanism of pension system is a matter of secondary importance, and what matters in pension reform is 'effective government' and its ability to bring about necessary and politically risky

reforms. This is especially true given the weakness of the OMC in the field of pensions, according to Natali and de la Porte. In the Greek case, and as the Greek Strategy shows, the OMC could even prove a dangerous tool of claiming reform when reform has not really taken place. Part of this problem lies with the nature of the pensions OMC, which does not consist of concrete quantitative goals accompanied by real sanctions. The remainder of the problem lies in the Greek context, and that is where the renewed commitment to pension reform must come from. The identification of a strategy to achieve this is a task to be based on a historical study of the Greek political economy, which must look into the long-term future of pension provision while being informed by its unique past and origin.

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