**The practice and ideology of New Public Management (NPM): The Greek NHS at a time of financial austerity**

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**Declaration of Authenticity**

This thesis is submitted in fulfilment of the requirements of the Degree of Doctor of

Philosophy at the University of Stirling

The present work has been conducted exclusively by myself and has not been previously submitted for examination at any other degree at any other university. Where part of the work described in the thesis has previously been incorporated in the work of other authors, this has been identified and acknowledged in the thesis.

**Signed:**

**Date:**

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***When you set out on your journey to Ithaca,  
pray that the road is long,  
full of adventure, full of knowledge….***

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***Wise as you have become, with so much experience,  
you must already have understood***

***Ithaca has given you the beautiful voyage.***

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|  |  |  |
| --- | --- | --- |
| **Acronym** | **English**  **LIST OF ABBREVIATIONS** | **Greek** |
| ASEP | Supreme Council for Civil Personnel Selection | Ανώτατο Συμβούλιο Επιλογής Προσωπικού (ASEP) |
| COCOPS | Coordinating for Cohesion in the Public Sector | Συντονισμός για τη Συνοχή του Δημόσιου Τομέα |
| CR | Critical Realism | Κριτικός Ρεαλισμός |
| DRGS | Diagnostic Related Group System | Κλειστό Ενοποιημένο Νοσήλιο (ΚΕΝ) |
| DYPE | Health Regional Administration | Διοίκηση Υγειονομικής Περιφέρειας  (DYPE) |
| EC | European Commission | Ευρωπαϊκή Επιτροπή |
| CE | Conformité Européenne | Σήμα Συμμόρφωσης της Ευρωπαϊκής Κοινότητας |
| ECB | European Central Bank | Ευρωπαϊκή Κεντρική Τράπεζα |
| ELSTAT | Hellenic Statistical Authority | Ελληνική Στατιστική Αρχή (ELSTAT) |
| EOPYY | National Organisation for Provision of Healthcare | Εθνικός Οργανισμός Παροχής Υπηρεσιών Υγείας (EOPYY) |
| ESPA | National Strategic Reference Framework, NSRF | Εθνικό Στρατηγικό Πλαίσιο Αναφοράς (ESPA) |
| ESY | Greek National Health System | Ελληνικό Εθνικό Σύστημα Υγείας (ESY) |
| ETAA | Unified Fund of Independent Employees | Ενιαίο Ταμείο Ανεξάρτητα Απασχολούμενων (ETAA) |
| EU | European Union | Ευρωπαϊκή Ένωση |
| FEK | Government Gazette | Φύλλα Εφημερίδας Κυβερνήσεως (FEK) |
| GDP | Gross Domestic Product | Ακαθάριστο Εγχώριο Προϊόν |
| GP | General Practitioner | Γενικός Ιατρός |
| GRD | Greek Drachma (currency) | Ελληνική Δραχμή |
| GSEE | Greek General Confederation of Labour | Γενική Συνομοσπονδία Εργατών Ελλάδος (GSEE) |
| ICT | Information and Communications Technology | Τεχνολογίες Πληροφορικής και Επικοινωνιών |
| IKA | Social Security Institution | Ίδρυμα Κρατικών Ασφαλίσεων (IKA) |
| IMF | International Monetary Fund | Διεθνές Νομισματικό Ταμείο |
| IOBE | Foundation for Economic and Industrial Research | Ίδρυμα Οικονομικών και Βιομηχανικών Ερευνών (IOBE) |
| KEPE | Centre for Planning and Economic Research | Κέντρο Προγραμματισμού και Οικονομικών Ερευνών (KEPE) |
| MoU | Memorandum of Understanding | Μνημόνιo Συμφωνίας |
| MP | Member of a Parliament | Βουλευτής |
| NAT | Mariners’ Retirement Fund | Ναυτικό Απομαχικό Ταμείο |
| New Democracy | Liberal Conservative Party | Νέα Δημοκρατία (New Democracy, ND) |
| NGO | Non-Governmental Organisation | Μη Κερδοσκοπικός Οργανισμός |
| NHS | National Health Service | Εθνικό Σύστημα Υγείας |
| NPM | New Public Management | Νέα Δημόσια Διοίκηση |
| OAED | Manpower Employment Organisation | Oργανισμός Απασχόλησης Εργατικού Δυναμικού (OAED) |
| OAEE | Small Businesses and Trades Insurance Fund | Οργανισμός Ασφάλισης Ελεύθερων Επαγγελματιών. |
| ODIPY | Organisation for the Management of Health Funding | Οργανισμός Διαχείρισης Πόρων Υγείας (ODIPY) |
| OECD | Organisation for Economic Cooperation and Development | Οργανισμός Οικονομικής Συνεργασίας και Ανάπτυξης |
| OGA | Organisation of Agricultural Insurance | Οργανισμός Γεωργικών Ασφαλίσεων (OGA) |
| OPAD | Civil Servants Health Insurance Fund | Οργανισμός Περίθαλψης Ασφαλισμένων Δημοσίου (OPAD) |
| PAT | Principal-Agent Theory | Θεωρία Εντολέα-Εντολοδόχου |
| PASOK | Socialist Party | Πανελλήνιο Σοσιαλιστικό Κόμμα (PASOK) |
| PESY | Regional Health Systems | Περιφερειακά Συστήματα Υγείας (PESY) |
| PFY | Primary Healthcare | Πρωτοβάθμια Φροντίδα Υγείας (PFY) |
| POEDHN | Pan-Hellenic Federation of Public Hospital Workers | Πανελλήνια Ομοσπονδία Εργαζομένων Δημοσίων Νοσοκομείων (POEDHN) |
| PPP | Public Private Partnership | Σύμπραξη Δημοσίου-Ιδιωτικού τομέα |
| SFEE | Hellenic Association of Pharmaceutical Companies | Σύνδεσμος Φαρμακευτικών Επιχειρήσεων Ελλάδος (SFEE) |
| TEVE | Greek Fund for Craftsmen & Small Traders | Ταμείο Επαγγελματιών και Βιοτεχνών Ελλάδος (ΤEVE) |
| TSAY | Insurance Fund for the Health Workers | Ταμείο Συντάξεων και Αυτασφάλισης Υγειονομικών. (TSAY) |
| USA | United States of America | Ηνωμένες Πολιτείες Αμερικής |
| UK | United Kingdom | Ηνωμένο Βασίλειο |
| WHO | World Health Organisation | Παγκόσμιος Οργανισμός Υγείας |

**Abstract**

This study explores the practical and ideological implications of the New Public Management (NPM) paradigm as introduced in Greece by the so-called “Troika”, a sobriquet referring to a triumvirate comprising representatives of the IMF, the European Union, and the European Central Bank. In the past, attempts had been made by Greek officials to implement managerial practices within the Greek National Health Service (NHS) and the hospital sector in particular, albeit at a more leisurely pace than that of other countries’. On arrival to Greece the Troika imposed a number of changes to improve the country’s public services; and set a brisk pace to accelerate their implementation. The present doctoral thesis seeks to critically evaluate the issue of whether those reforms, especially those salient to the Greek NHS system, are true manifestations of a shift in the NPM paradigm or whether they represent yet another archetypal Greek public sector restructuring. It will also evaluate responses to and outcomes of the successive reforms in the Greece’s NHS system, ascertain the factors contributing to and/or impeding the adoption of those reforms, and identify new opportunities for growth.

In order to gain access to a more profound insight into the Greek context, the collection of secondary data provides, among other things, an historical background of Greece’s public healthcare system; reviews the system’s characteristics in terms of healthcare policies, and probes into the state of working conditions within public hospitals. The heightened managerial spirit prevalent in Greece at the moment and brought about by the Troika’s tenure, has made it necessary for the literature review of the present work to focus on the ways that managerial practices and ideologies are imposed on other countries so that their public sector dysfunctionalities may be rectified. Drawing on the literature reviewed, the study develops an integrated analytical framework anchored in NPM, so as to test it in the Greek case and contribute to understanding the Greek NHS organisational realities as well as to evaluating how the new changes have been evolving and faring within Greece’s healthcare organisations. The framework is comprised of a review of the NPM paradigm so as to contextualise the Greek reforms in terms of ideology and practices; a review of Principal-Agent Theory (PAT) for illuminating the interrelationships and involvement of the key actors with the reforms; and a review of Critical Realism (CR) for assisting to reveal the underlying mechanisms and structures that bind the actors with the organisations and their development. Apart from providing the conceptual basis of the thesis, the framework also serves in informing its methodological design (i.e., generating the interview schedule), analysing the findings, and steering the discussion.

The study adopts an in-depth, qualitative research approach that views social life within organisations in terms of processes, events, actions, and activities between key actors as factors unfolding over time. To that purpose, semi-structured interviews were conducted with the key stakeholders of the Greek NHS system: State hospital doctors, hospital managers, and policymakers.

The contribution of the study is an in-depth analysis of reform implementation as carried out in Greece’s medical system which now stands, within a turbulent economic and political context. By means of that analytical framework, it is shown that Greece is a *sui generis* case whose context and historical background are altogether different than those of other countries’. Moreover, the framework demonstrates that, despite the fact that NPM is firmly ensconced, as far as practice and ideology go, it is too soon to be drawing any conclusions: NPM is still in its infancy and reforms to the Greek NHS system have yet to be finalised as they continuously stumble on the inefficiencies and blunders of the past which hinder them from functioning properly. Last, the thesis does possess one more unique feature: it delves into the thinking, manoeuvres, and behaviour of the Greek healthcare professionals as a group, a world rarely if ever explored by empirical studies.

**Chapter1: Introduction**

**Healthcare in Crisis**

There is no doubt that the healthcare sector is one of society’s most important sectors. Debates on healthcare in Greece and even further afield often centre on the percentage of public spending a nation allocates to the healthcare arena. The height of that percentage carries implications for shaping public and governmental perceptions as well as health policies and reforms which are increasingly seen as the key to modernising and improving the effectiveness of a country’s health system.

Throughout history, medicine developed alongside other sciences and has been all too often used in demonstrating a country’s level of growth and social evolution. All primitive communities had to find ways to cope with illness and safeguard the sound continuation and quality of human life. Still, even though modern medicine has made impressive strides in offering humankind new methods of diagnosis and treatment, evidence from around the world indicates that even the most developed countries, are still facing a daunting challenge: how to provide integrated healthcare services.

An integrated healthcare system may be defined as one which combines resources and their management targeting the delivery of health services to a specific population (Roemer, 1991). A more concrete definition highlights the notion that a healthcare system is “all the structures and infrastructures that produce health and prevention services based on institutionalised rules of organisation and operation by the State, and aiming at maintaining and promoting public health” (Theodorou and Mitrosili 1999, p.16). Worldwide, governments have been exerting themselves in order to develop better and more efficient healthcare systems so that their respective citizens may enjoy a high standard of living. Many are the places where access to healthcare is a citizen’s right, with exceptions such as the United States of America where healthcare is not explicitly provided by the Constitution. Nevertheless, not all countries face the same problems in terms of their healthcare systems. Therefore, established policies vary and so do methods of financing and means of developing a healthcare system which also present differences. Certain of those systems, such as the UK’s NHS, are of long standing, while others, such as those in African countries, are still undergoing development. Whatever the differences, all countries have the same pressing issue to resolve: how to provide high quality healthcare to all citizens by properly coordinating resources, all the while keeping costs low. In view of the today’s harsh, global economic environment, that is no mean feat.

The grave financial crisis which erupted in 2008 led to substantial losses in all sectors of society; greatly impacting on national and local systems alike. What began as a financial failure in the industrialised world turned into a multi-faceted crisis akin to wildfire. The reverberating, adverse effects of that challenge went far faster, wider, and deeper than anyone ever expected with governments now concerned with the impact of the financial crisis on the healthcare standards of their countries. Poorer and developing countries with newly minted healthcare systems are faced with funding shortages due to reduced social insurance as a consequence of high unemployment and lower wages. In line with that, social protection, welfare, and the healthcare services of developed countries, such as Greece, Italy, Spain and more have been gravely afflicted by the necessary evils of austerity measures and reduced spending on public services. Consequently, healthcare costs are likely to increase because of demographic ageing, a scarcity of resources, and the diminution of investments resulting from inflationary pressures. Adding insult to injury, the surge in demand for essential healthcare services, which is something usually brought on by a recession, often inundates and devitalises healthcare systems and their institutions, rendering them incapable of offering even the most basic of lifesaving functions

The crisis in question staggered Greek economy, causing a chain of devastating reactions in all sectors of society: high unemployment rates, stringent austerity measures, decreases in income, shortage of resources, and other consequences have exacerbated the physical and mental health of citizens. As a result, the demand for healthcare services has risen sharply (Kentikelenis et al., 2011). Given that, for decades on end, the health sector in Greece has been in urgent need of incisive, across-the-board, structural reforms, that demand represents for Greece a situation that has reached critical mass.

The magnitude of a crisis is dependent on the availability of resources of each nation and that nation’s readiness in dealing with an unpredictable and epoch-making event. The challenge confronting the world at this point is how to stop an economic failure from becoming a social and healthcare disaster. Undoubtedly, the key issue is to ensure that public resources are utilised in a cost-efficient manner so that the above risks may be minimised and serious economic repercussions may be avoided. It is also essential that proactive management action and conscientious policies be provided so as to ready a healthcare system to respond to adverse circumstances as the ones described above. Strengthening staffing, acting proactively when faced with potential threats such as shortages of medical supplies, and identifying opportunities (e.g. synergies and mergers) are some of the actions that should be taken in order to invigorate a healthcare system and equip it to respond to change (WHO, 2012). Admittedly, bringing healthcare into every household and to each and everyone regardless of where they live (urban centres, cities, towns, and villages) is an intimidating challenge. Yet, governments need to face that challenge during the present period of financial instability. In that context, research into the healthcare services field is invaluable and shows an impressively promising potential.

Past experience has shown that financial crises usually serve as a motive for reform (Olsen and Peters, 1996). Case in point, the Chinese word *wei-chi* which means “world crisis” and is a composite of two words: ‘danger’ and ‘opportunity’. If applied to the Greek situation, it is obvious that now, more than ever before, is the time to transform the current clear and present dangers into opportunities. In his capacity as the Chairman of the National Organisation for Medicines, Tountas noted that the external environment of the country is favourable because of the requirements for change that the economic crisis imposes (Tountas, 2011). Similarly, Karamanoli (2011, p.304) argues: “Perhaps the debt crisis is a chance for healthcare in Greece to progress after all”. In the same report, Theodorou, General Manager of Evangelismos Hospital in Athens, points out that “the financial crisis may be a chance for the national health system and Greece in general to reboot and operate effectively again” (Karamanoli, 2011, p.304). In other words, casting off its conservative, lumbering, bureaucratic structure and adopting innovative managerial practices as introduced by the neoliberal spirit of the Troika is a challenge of paramount importance to the Greek healthcare sector. As mentioned in the abstract, the Troika is a three-party committee comprising representatives of the International Monetary Fund (IMF), the European Commission (EC), and the European Central Bank (ECB). The purpose behind the Troika’s presence in Greece was to provide financial and technical support to the country and, subsequently, rescue Greece from bankruptcy. In return, Greece has been forced to adhere to the toughest and most scathing austerity programme in European history ([Yannopou](http://www.athensnews.gr/issue/13389/21877)los, 2010).

So far, the so-called New Pubic Management (NPM) paradigm has offered practitioners and scholars alike a means of analysing public sector reforms (Osborne and Gaebler 1992, Borins 1994, Hughes 1998, Philippidou et al. 2004, Van de Walle and Hammerschmid 2011). It demonstrates the attempts by the state to offer high quality of public services to citizens by minimising waste and maximising efficiency through the application of mechanisms and tools borrowed from the private sector (Hood, 1991, 1995, Pollitt 1993). The reforming process also entails ideological alterations such as neoliberalism, privatisation and marketisation of public services, which often undermine their public values (Pollitt et al. 2007a). Greece represents one of the countries where that type of reforms has not fared well in the past. The reasons will be discussed in another part of the thesis but we may herald them by mentioning the deeply-rooted, state-driven, and politically manipulated policy that has created strong obstacles impeding innovation and change (Minogiannis, 2012). Though many a study entails the reforms of the public healthcare systems worldwide, few studies provide empirical insights into the actual change (Di Mascio and Natalini, 2013). Even fewer and far between are studies investigating the case of the Greek NHS system. In short, this is the first empirical study on NPM as a practice and ideology brought to Greece by the Troika and the IMF in particular, in order to ostensibly revitalise the country’s public sector so that it may cope with the crisis. The worth of the present thesis is that it records the changes at a critical historical juncture and within an unstable political and economic context.

**Aim and Main Objectives**

The main aim of the study is to serve as a way of fathoming the implementation of New Public Management, as practice and ideology, in the Greek state hospital services, a key element of the Greek NHS system during the times’ financial austerity. An analytical framework is conceptualised and tested in the Greek case to illustrate whether and how the reforms imposed by the Troika are finding their way into the Greek NHS.

Specifically, the objectives of the study are to:

**a)** Detail the characteristics of the Greek public healthcare system in terms of health policies and working conditions within public hospitals.

**b)** Investigate and critically evaluate the success or failure of the successive reforms in the Greek NHS; and track the formation of a National Health Service and implementation of NPM as a political project.

**c)** Identify those factors which contribute to or impede the adoption of New Public Management by the Greek NHS system.

**d)** Explore the impact of the crisis on the present and future development of the Greek NHS system and look into the opportunities for reform.

In order to determine the current state of Greek healthcare and evaluate the lines of influence and the reforms brought about by NPM in order to reorganise the sector, the study next examines the literature on the historical development of the system from its inception to the present. Legislation on health policies will not only show the forms of efforts that Greek governments has made so far to modernise the NHS, but will also bring front and centre the crucial role that politics have played, and still play, in healthcare. The research is underpinned by a novel framework that brings together all the necessary parts to analyse the Greek case, namely reforms, human actors and organisational structures. The NPM paradigm is at the heart of the framework, integrated by the Principal-Agent Theory and Critical Realism. PAT provides insightful views of how employees of different power manoeuvre in organisational contexts; and CR offers a way to explore complex reealities in Greek hospitals, because it accounts for both beliefs and larger contexts and structures. Through the interviewing process, key NHS actors elaborate on their ideas and perceptions. They will also provide empirical evidence on the success or failure of past as well as current efforts towards reform.

**Greece in Crisis**

The Greek NHS system evolved in a fragmentary manner, owing to lack of resources and to a political climate perpetually unfavourable towards the adoption of universalistic trends and innovation. Worse, the strong vested interests expressed by a number of stakeholders wielding power forestalled management reforms (Polyzos et al., 2008). Historically, every aspect of healthcare financing and provision has been strictly controlled by the Ministry of Health and Social Cohesion which has always frowned upon the notion of decentralising decision-making (Economou, 2010). Especially since:

*“the overwhelming presence of party-political competition and the weakness of any social and economic pressure has allowed the survival of political patronage and prevented the shaping of a professional and independent civil service organisation, such as represented by the Weberian conception of bureaucracy”* (Spanou 2008, p.152).

The political system in Greece is a bipartisan one, comprising a centre-right and a centre-left. The parties maintain opposing political orientations and, more often than not, engage in a fierce legislative tug-of-war (Dikeos 2011, Sissouras 2012). As a result, Greece has already attempted and failed several times to have its public service modernised (Kufidu et al., 1997, Zampetakis and Moustakis, 2007).

In 2008, health services in Greece secured their financing though a mixed system of funding comprised of public (60%) and private sources (40%) (OECD, 2009b). Public expenditure funding still stems from the state budget. It is accomplished through taxation and compulsory health insurance contributions made by insured members of the workforce while uninsured citizens came and still come under the umbrella of Greece’s social welfare services. Public health spending as a percentage of GDP rose from 5.7% in 2005 to 6.0% in 2006; and dropped to 5.8% in 2007, placing Greece in the rank slightly below the OECD average of 6.4% (OECD, 2009a). In the same category, the 2007 percentages for Germany, France, and the UK were 8.0%, 8.7% and 6.9%, respectively (OECD, 2009a). Private expenditure consisted mostly of individual payments and represented a rather high percentage of Greece’s total health expenditure which stood at 36.7 % in 2007, one year before the crisis erupted (OECD, 2009b). Similar statistics stood at 22.4% for Germany and at 20.7% for France (OECD, 2009b), making the Greek healthcare system one of the most privatised ones in the world (OECD, 2009c). Such private spending portrays the dissatisfaction of citizens with the healthcare system and represents enormous monetary sums spent by the Greeks in the hope that they will be met with healthcare of better quality and will avoid the dread of waiting lists (Thomson et al., 2009). Moreover, having absorbed €23 billion in public money in 2008 (€3 billion more than in 2007), the Greek public healthcare sector had come under extreme pressure to have reforms implemented. As to public and private healthcare expenditure in Greece, that was expected to decline in view of the harsh economic conditions and austerity measures.

When it came to Greek Greek hospitals, their organisational settings were plagued by cumbersome bureaucratic procedures, “informal” payments to doctors, and inefficiencies arising from poor management of personnel. Under the recent austerity measures, most hospitals have suffered from underfinancing owing to budget cutbacks by 40%, severe staffing shortages and lower salaries and poor living conditions for medical personnel working in rural areas (Telloglou 2011, Kalafati 2012). At the end of 2010, the press reported that the inability of hospitals to pay for purchased medical supplies had exasperated pharmaceutical companies to the point that they stopped providing their products. As a result, nurses had been instructed to suggest to relatives and friends visiting in-hospital patients that they bring along healthcare supplies, such as gauze bandages, disposable gloves, and antiseptics (Karamanoli, 2011). Some hospitals closed down one after another for a number of weeks due to a dearth in basic supplies and channelled patients to other healthcare organisations. That came as no surprise since closures and mergers of clinics had been one of the authorities’ priorities since 2011 so as to lower hospital deficits and recurrent costs (Kaitelidou and Kouli 2012, Polyzos et al., 2013).

In 2011, Greece had 6.1 practising physicians per 1,000 inhabitants, bringing the country to rank first among OECD members (OECD, 2013). Still, many were the doctors who remained without employment due to oversupply and the limited number of positions in the state hospitals of large urban centres (Kentikelenis and Papanicolas, 2011). A number of medical practitioners turned to the private sector which beckoned with higher financial rewards. Nevertheless, it should be noted that the picture of limited demand and excessive supply of medical doctors in public hospital posts is somewhat misleading. Research by Kalogeropoulos and Gregou (2006) estimated that only less than half of the authorised medical positions in the public sector were actually filled. The remaining posts stayed vacant and only certain vital posts and shortages in the rural areas and in certain laboratory specialties in hospitals and clinics were actually met. Another paradox that kept emerging was the dearth in nursing and midwifery personnel: there were no more than 3.3 nursing specialists per 1,000 inhabitants, a number that brought the country to rank last among OECD members (OECD, 2013). Some researchers have cited as reasons lurking behind that peculiar statistic the fact that 50% of those working towards a nursing degree had been withdrawing from their studies due to the low wages and unsafe working conditions awaiting them upon graduation (Polyzos and Yfantopoulos, 2000); and the discrepancies in distribution of nurses assigned to rural areas and those assigned to urban ones.

Another disconcerting issue pertains to a formal, yet highly subjective and gravely unproductive practice that the Greek public administration has of evaluating employee performance affecting also health organisations (OECD, 2009c). The procedure is a mere formality and is strongly affected by personal relations between staff and supervisors. The outcome of that evaluation is not linked to the reward system which is based only on the years of experience of staff members and foresees no incentives towards improving personal effort (Kufidu et al., 1997). Consequently, individual performance evaluation has actually become a bureaucratic and pointless exercise that both supervisors and staff members would like to eschew (Civil Service Union 1996, Kufidu et al. 1997). Overall, the lack of motivation, the level of personnel education and training which leaves much to be desired, the conflict between job roles, the lack of objective systems of promotion, and the inability to acknowledge and/or tout personal effort, as well as the shortage in resources (Boutsioli, 2010), often undermine the psychology of health professionals (Karamanoli, 2011) and, by extension, the well-being of patients (Sigalas et al., 1999). As a result, efficiency and quality of healthcare in Greece is sadly on a decline (OECD, 2009c).

As yet, no comprehensive approach to quality has been fully established. Governmental bodies and agencies assess infrastructure, regional authorities assess personnel and financial management procedures, but neither group evaluates the process of how care is delivered. Beyond the national responsibilities that the Ministry of Health as well as medical and other health professional associations may have, either at the national level or at the level of individual specialities, those authorities are also responsible for ignoring the need for formulated guidelines based on evidence extracted from clinical practices. Resource allocation mechanisms are parochial and entirely detached from performance and output. The result is that healthcare providers see little or no incentive in trying to improve productivity (Polyzos, 2002). With quality remaining critically dependent on individual motivation and willingness to contribute, it is no wonder that further development and innovation are daunted by a hostile climate.

If truth be told, were Greek public hospitals private organisations, they would have been forced to declare bankruptcy. Their debt to their suppliers increased from €1.15 billion in 2006 to €3.52 billion in 2009 (SFEE, 2012). In 2010, national hospitals owed approximately €6.5 billion to medical suppliers for their products and services, of which a staggering amount of €1.2 billion was owed to pharmaceutical companies (Karamanoli, 2011). That debt to suppliers may serve in explaining why the latter were reluctant to continue doing business with the public institutions. Further, hospital doctors were forced to sustain salary cuts which had escalated to an astounding 40% and to wait for months on end to be paid. Worse, the ‘second’ salary hospital doctors earned through their overtime shifts remained frozen for a period of five months (Gilson, 2012) while the Ministry of Health put a stop to all overtime. As a result, many underpaid doctors who were up in arms, seriously considered resigning from the Greek NHS system (Efthimiadou, 2012). Tsoukalos, Chairman of the Athens and Piraeus Hospital Doctors Association, claimed that (Gilson 2012, p.1):

“*These cutbacks are choking the national health system. We are facing more shortages in everything surrounding healthcare: medicine, medical supplies, biomedical equipment of hospitals and personnel. The system is inefficient. A simple order may require extremely time-consuming procedures”.*

The private health sector did not remain unaffected by the crisis: reduced household incomes, poor investments, and a host of other financial constraints, left the private health sector reeling and reporting a 30% reduction in patients in 2010 (Hellastat, 2010).

The repercussions of the crisis affected the health of the Greek population in various forms. For one thing, unemployment rose dramatically, from 8.1% in 2007 to 25.1% in 2012 (shown in Table 1) (Elstat, 2012). As a result, a high percentage of citizens could not afford health coverage and were left at the mercy of various illnesses.

**Table 1: Number of employed, unemployed, and non-working population July 2007-July 2012**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Month of July | | | | | | |
|  | **2007** | **2008** | **2009** | **2010** | **2011** | 2012 |
| Employed | 4.519.914 | 4.559.976 | 4.506.575 | 4.401.324 | 4.092.228 | 3.763.142 |
| Unemployed | 400.946 | 364.164 | 472.813 | 629.663 | 883.613 | 1.261.604 |
| Non-working Population | 3.411.283 | 3.406.467 | 3.328.726 | 3.290.326 | 3.358.512 | 3.356.276 |
| Percentage of Unemployment | 8,1 | 7,4 | 9,5 | 12,5 | 17,8 | 25,1 |

**Source: ELSTAT 2012 (Hellenic Statistical Authority)**

The mental health of the Greek population has also been affected. According to the 18th Hellenic Conference of Internal Pathology, 25% of men and 33% of women suffer from mild to serious depression (Saoulidou, 2012). In 2009, there was one suicide per day and in 2010, that number doubled (Andreadaki, 2012). As clinical psychologist Bouroukas points out, an increase of 3% in the levels of unemployment leads to an increase of 4.5% in suicides of unemployed people (Karavokiri, 2012). Violence also rose, with homicide and theft rates nearly having doubled between 2007 and 2009 (Smith and Boseley, 2011). In that respect, it can be argued that the implications of the prolonged and severe economic crisis, as well as the austerity measures demanded and imposed by the Troika have had a dramatic impact on Greek society and have resulted in acute public discontent.

Notably, alternative ways of healthcare provision appeared. Patoulis, Chairman of the Medical Association of Athens, has claimed that:

“*Four thousand uninsured citizens unemployed for a long time had been* *examined* *there* [in the Social Doctor Office established by the Medical Association of Athens and the Greek Orthodox Church] *in the last six months. [...] There were a considerable number of cases among them, when the people* *needed* *to be treated in a hospital. We sent a letter to the Minister of Health, at that time Andreas Loverdos, and received the reply that uninsured persons cannot be accepted for treatment in hospitals if they are unable to pay for it”* (Balezdrova 2012, p XX).

At present, the country operates under the supervision of the Troika; targeting the recovery of the national economy. A first Memorandum of Understanding (MoU) between Greece and the Troika was signed in 2010 and a second one was signed two years later in 2012 (Kentikelenis et al., 2014). Both the Greek government and the Troika were forced to admit that the health sector’s significant deficits were owed to mismanagement and corruption. In view of that, it became imperative to tackle expenses for the procurement of medical equipment and of medicines relating to the operation of hospitals and other medical units of Greece (Niakas, 2013). Emergency procedures were still in place so as to rectify the public sector by helping it to shed old, unproductive administrative habits; and re-invent it as a new model, one that would be more streamlined, client-oriented, and focused on effective management tools.

It is worth mentioning that the IMF’s implementation agenda has been discredited by a number of its critics. One such critique was levelled by Klein (2007) who claimed that by exploiting disaster-shocked peoples and countries, the ‘Chicago Boys’ promote a neoliberal policy in favour of the capitalist class. Along the same lines, economist and Nobel Prize winner Stiglitz (2002) argues that many of the IMF’s proposed policies, such as privatisation and open capital markets, have been inefficient and it has been the citizens who have been called to pay the piper. As Stuckler and Basu (2009, p.771) suggest:

*“there is sufficient evidence to indicate that IMF programs have been significantly associated with weakened healthcare systems, reduced effectiveness of health-focused development aid, and impeded efforts to control tobacco, infectious diseases, and child and maternal mortality”.*

At this point, it may be of interest to mention the view supported by Ruckert and Labonte (2012). It regards the interventions of the IMF in various countries on the verge of economic collapse. Overall, Ruckert, and Labonte argue that there is a gap between the IMF’s plans for reform and what actually happens. Through extensive research in a number of low and middle-income countries which had been subjected to the IMF’s interventions, the researchers reached the conclusion that, in the long run, the IMF failed to respond to the needs for healthcare services those countries had. The outcome was anything but auspicious: the reforms proposed by the IMF were either hard to implement or were doomed to resounding failure. Most economists agree that in the case of an economic crisis the demand for health services increases substantially. Surprisingly, the IMF failed to understand that. Instead, it promoted policies which incapacitated the healthcare services in those countries.

More recent research also made mention of a so-called ‘neoliberal hegemony’. For example, in the case of Argentina, the IMF practices and policies do not take into account local values but rely on implementing a neoliberal policy agenda come what may (Plehwe, 2009). Even though the specific dogma has led to failure and the demise of many economies, it seems that the neoliberal orthodoxy continues to dominate the economies of the western world. The paradigm spreads even to cases where the national economy of a country does not fit the concept of neoliberalism (Crounch, 2011). The outcome is a state which relies on numbers and budgets and not on values and ways of improving social welfare (Plehwe and Walpen, 2005).

The above findings may explain why implementation of IMF regulations and policies has been met with a global wave of negative response. Such is also the case of Greece where the Troika’s stringent demands and austere policies have given rise to a wave of discontent. In that regard, Chomsky (1999) mentions that foreign intervention, mostly led by US-based firms or political institutions such as the IMF, have been causing nothing but trouble for countries where it wielded influence. With that in mind, it may be necessary to claim that the IMF’s intention is not to help financially feeble states recover but to promote and further the interests of the foreign powers that be and the interests of firms and companies cloaked behind such powers.

In spite of the heavy criticism levelled against the Memorandum and the IMF, some of the literature tends to be less critical of and more lenient towards the IMF. As Ruckert and Labonte argue (2012, p.363):

*“The IMF has been somewhat more flexible in its crisis response than previously as it acknowledged the importance of shielding the most vulnerable from the crisis. On the fiscal front, the IMF has allowed marginally higher deficits during the brunt of the crisis, even though there have been significant variations between countries”.*

Another interesting critique has been made by Papanikos (2013) who favours the IMF and the Troika’s presence in Greece. In essence, however, Papanikos (2013) takes a position against the Greek Left. He argues that the Greek Left had been in a league of its own for years on end with a view to protecting the privileges bestowed by left-wing governments on public sector employees, instead of protecting the rights of the lower classes. Many have also been the instances, when the Left has fiercely protected the interests of unionists whose goal, more often than not, lay with furthering their own agenda instead of reflecting the rights of workers as they should have. Papanikos aptly notes that that ‘elite’ team acted as an obstacle to reforms –especially those closely linked to public services –when it came to the healthcare and other sectors. According to the same author, the volley of Memorandums comes to challenge Greek society’s ‘privileged elite’. Interestingly enough, he also argues that, had the Troika been tougher in its demands and measures it would have seriously impacted on the interests of the privileged classes, contributing thus to the development of a ‘healthier capitalism’, more beneficial to the non-privileged classes. It is clear that Papanikos takes a positive stance on the case of Memorandum since, in his opinion, such an agreement unmasks distorted tactics and to provide practices characterised by more transparency and accountability.

Indeed, reforms in Greece in the past have always been arduous and cumbersome. New Public Management (NPM) theory constitutes the most dominant paradigm closest and akin to public restructuring (Dent 2005, Pollitt and Dan 2011, Bezes et al. 2012). To that extent, Greek researchers view NPM as the potential background easing the transformation of the Greek public sector (Sotirakou and Zeppou 2006, Spanou 2008). According to Pelagidis (2005), the reform policies of the Greek public sector should aim at the selective application of managerial rules on public services such as competition, evaluation, monitoring and control. Several writers (Civil Service Union 1996, Argyriadis 1998, Makrydimitris 1999, 2003, Sotirakou and Zeppou 2006) also claim that consensus has already been reached by Greek politicians –regardless of political affiliation –businessmen, and academics that public administration must transform itself from a centralized inward-looking bureaucracy to a strategically thinking, open, transparent, and flexible organisation which shows outreach by satisfying the demands of all stakeholders. Government and special-interest groups such as professionals, funding agencies, and citizens constitute an important part of the public system. They are the ones who, directly or indirectly, decide on the policies and strategies that the public sector will follow and have a strong interest in that sector’s organisational performance.

Above all, NPM represents a neoliberal and managerial ideology which upholds that the public sector and its employees could be more productive by adopting managerial elements which have been shown to generate efficiency and cost effectiveness in the private sector. It is worth noting that the concept and elements of NPM are still being explored because of the variability its impact has had on different countries. In broader terms, NPM is concerned with specific practices adopted by the private sector such as performance management, plan outsourcing, cost retrenchment policies, management by objectives that can help public organisations improve their services and budgets. The present thesis seeks to challenge NPM both as an ideology and practice; and test the degree to which it has been embraced by the Greek healthcare system, specifically focusing on the hospital sector. It intends to show how NPM is being relied upon by the Greek NHS as a narrative for change.

In general, the study brings three concepts together; and develops a new framework with the purpose of using it as an analytical tool in the Greek case so as to demonstrate NPM’s embeddedness in the NHS system. Analysed as a practice and as an ideology, NPM sets the real context of the changes introduced into Greek state hospitals by institutions with strong neoliberal positions such as the IMF. In that sense, it illustrates the peculiarities of the Greek case in relation to other countries which internalised the NPM paradigm prior to the Greek case. Critical Realism assists in interpreting that reality, fully intending to unveil new insights into the organisational context, be it positive or negative, such as corrupt practices, improvements, efficient and inefficient work mechanisms as well as those parameters’ outcomes. Principal-Agent Theory highlights how the key stakeholders are involved with the reforms; and what their opinions and opportunities are on improving the effectiveness of the healthcare system. It also issues a caveat that, first and foremost, each party seeks to satisfy its own agenda of interests.

The study explores patterns of change and their variations thereof over time. It then sets them in the context of the pressure and influence exerted on Greece by the Troika not only in terms of tangible outcomes but also in terms of ideological alterations. It reveals some concealed realities of the health system by seeking the underlying reasons why major reform efforts have failed so far to achieve their goals. State hospitals were chosen as the site for the study’s empirical research because they absorb many of the healthcare system’s resources on a daily basis. What is more, the state of crisis in public hospitals is of long standing and has been cited with alarming frequency. Therefore, the study’s qualitative semi-structured interviews with doctors practicing in public hospitals probe deeply into those professionals’ values and their perceptions about the crisis and the changes that Troika has imposed. Another group offering revealing insights into those changes are hospital managers whose role is to implement reforms inside healthcare organisations. The semi-structured interviews also include politicians and policymakers due to the vital role they play in orchestrating reforms. Consequently, three discrete groups of Greek NHS stakeholders provide a range of narratives of change, invaluable in mapping the directions reforms in the Greek NHS have been taking.

The segments of the present thesis are as follow: Chapter 2 reviews the literature on health development and the Greek NHS not only in order to identify the key issues and evaluate the health reforms through the main policies’ analysis, but also to appraise critically the major changes made in the past. Chapter 3 introduces the review of NPM as a reforming paradigm, a model arriving with a new set of tools and ideology as far as the Greek public sector’s reorganisation is concerned. To a lesser or greater degree, it has been used so far by many countries and it seems that is by now an integral part of Greece as well. Chapter 4 analyses the integrated analytical framework and outlines its contribution to the thesis. Chapter 5 discusses methodological approaches and offers reflections on their limitations and the ways those may be resolved.

Chapters 6, 7, and 8 contain the study’s empirical findings. Chapter 6 discusses the problems and failures afflicting the Greek NHS system, as experienced by the key players. Chapter 7 informs the reader about the pace of progress and implementation of NPM managerial tools and practices within Greek public hospitals. Chapter 8 goes on to examine whether and to what extent the key stakeholders believe the reforms have been successfully implemented and whether a prosperous future guaranteeing recovery awaits the Greek NHS.

Next, Chapter 9 discusses the main issues and emerging themes. Last, Chapter 10 constitutes the conclusion and highlights the study’s empirical and theoretical contributions. It also touches upon the study’s main impact and queries whether the study may provide a springboard for the emergence of new research opportunities.

**Chapter 2: The Development of Healthcare and the Greek NHS**

**History of Health**

Understanding the historical roots of public health is essential to critically evaluate today’s health systems. The study is concerned not only with the living conditions of the past but also with the experiences, perceptions, and conditions of health through time and its relationship with other social values. Traditionally, researchers have displayed a keen interest in how health and health issues were dealt with in the past; in the beliefs and prejudices of primitive people and subsequent civilizations on health and ill-health; in the prevention methods practiced so as to have health maintained, managed, and enhanced both privately and publicly; and in how physical and spiritual health were defined.

The field of medicine began at the same time humankind did. Not only were primitive societies subject to the same diseases afflicting humans today, but they were also exposed to the host of dangers that accompany life in the wilderness and to injury while hunting for food or fighting their enemies. Without scientific knowledge and appropriate tools, wounds and illnesses could be treated only by using materials provided by nature such as leaves, soil, stone knives and, above all, magic (Majno, 1991). Broken bones encased in pots made from mud and exposing a patient to sunlight to heal him, were commonplace therapeutic techniques and relying on the passage of time for healing was a common method employed by primitive societies. Still, while coping with the hazards of their environment and dealing with the afflictions besetting human life at that time, primitive people succeeded in arriving at remedies and treatment solutions which, to the present day, continue to be effective.

As medicine continued to evolve hand in hand with the early civilizations, the first organised medical activities appeared in Egypt and Greece. Having emerged from its primitive state, the human species founded the oldest civilisation that we know of in the Valley of the Nile, roughly 60 centuries ago (Nunn, 2002). At the beginning, medicine was influenced by religious practices such as the mummification of the dead (Mann, 1993). A series of other highly informative writings called “papyrus” contained a plethora of incantations and therapeutic instructions written by the healers and meant to eliminate diseases caused by demons and ill-intentioned spirits. Those doctors-magicians enjoyed a superior social status and authority and eventually evolved into a mighty financial and political power (Siakotou, 2007). According to the Greek historian Herodotus, doctors of ancient Egypt held various specialties (Halioua et al., 2005). Certain groups of specialists were authorised by Egyptian dynasties to deal with the health problems of groups of workers who were exposed to a number of occupational hazards leading to illness and/or injury. These are considered to have been the first workplace physicians (Ziskind and Halioua, 2007). According to Tulchinsky and Varavikova (2000, p.8), “Egyptian medicine developed surgical skills and organisation of medical care, including specialisation and training that greatly influenced the development of Greek medicine”.

In Greece, the roots of scientific medicine can be traced back to the age when philosophy was at its zenith. Philosophers were the first to try and explain the world through a lens of logic wholly detached from religion. At that time, doctors also began developing a rational theory which, by departing from existing prejudices and superstitions, would veer towards observation and rational thinking for the first time. There is strong historical evidence corroborating the premise that, by the 6th century B.C.E., state social care and social insurance had already been well developed in Ancient Greece. Great emphasis was placed on public sanitation and practices stressing healthy living, a wholesome diet, and physical fitness (Tulchinsky and Varavikova, 2000). Being responsible for the wellbeing of their citizens, authorities ensured that the population was provided with clean water emanating from public pumps and had established proper public health measures. They had also established a disability pension for those who were incapacitated and unable to work but only on condition that they were re-examined by the Boule annually (Polyzos, 1999). It is therefore evident that the authorities had set in place practices salient to social and public care. With regard to public doctors, those were required to offer patients in need of medical treatment their services gratis as they were paid by local municipalities through the citizens’ compulsory contributions. The fact that medical practitioners of Greek antiquity enjoyed the same elevated status doctors have had since the beginning of time is also evident in the Homeric epics where doctors are cited as a special category of people; and in the works of Plato who classified doctors as craftsmen (Cormack, 2006).

Hippocrates, known as the “Father of Medicine”, is considered to have been the first Greek physician to apply to medicine the same outlook and principles his contemporaries had been applying to other sciences, such as philosophy and mathematics. He was the first to observe and point out that diseases were caused by the environment as well as by unwholesome dietary habits (Philips, 1987). What is more, he was renowned for his professionalism, discipline, and rigorous practice (Garrison, 1966). He believed that the paramount virtues of a physician were honesty, calmness, understanding, and seriousness. He emphasised that doctors should carefully observe the patients’ symptoms and take note of them. The Hippocratic Oath, written in Ionic Greek in the 6th century B.C.E. and historically taken by medical professionals, calls on physicians to pledge themselves to a number of professional and ethical standards such as adhering to "that system of regimen which, according to my ability and judgement, will be to the benefit of my patients,” and abstaining “from whatever is deleterious and mischievous": it was that the fundaments of the ethics governing medical practitioners had been established.

The passage of time from Antiquity to the Medieval Times was less turbulent for Greece than for the rest of Europe, possibly because it also involved the advent of Christianity in the country, a religion which set and still sets great store on charity. From the very beginning, Christianity would offer hospital care organised by monasteries and churches. Every diocese was in charge of the creation, funding, and, administration of its own hospitals which provided healthcare to the old and indigent, and represented the first decentralised organisation of hospital services. The “Hospital Law” was part of the Justinian Code whose implementation in Byzantium began during the 5th century C.E. (Siakotou, 2007).

During the Middle Ages, the rest of Western Europe was devastated by the so-called Black Death, a catastrophic plague which, between 1348 and 1350, decimated one quarter of Europe’s population (Austin, 2003). Faced with the economic disaster caused by the epidemic (closed markets, poverty, rising costs in hospitals and cemeteries) medical practitioners were forced to become public administrators in order to control the onslaught of the plague. The sick were moved to quarters well removed from urban centres; and laws requiring legitimate births to be reported were established (Porter, 1997). Those coordinated efforts by authorities of the times to protect public health serve as evidence of a bureaucratic health system that somewhat approximates modern ones.

The Renaissance imbued Europe with a new spirit of intellectual and scientific prosperity. The first medical schools and monastery hospitals were established throughout the continent with a view to advancing medicine through experimentation. By the 15th century, Britain had 750 hospitals (Tulchinsky and Varavikova, 2000). In 1506, London saw the establishment of the Royal College of Surgeons, closely followed by the Royal College of Physicians in 1528 (Jackson, 2011). The organised efforts by local authorities to combat illness led to the creation of the first municipal hospitals as well as of hospitals established by the various guilds wishing to insure their members’ health. In Greece, the Renaissance period was flagged by the fall of Constantinople in 1453 when the country fell under Ottoman rule for 400 years (1453-1821). That forced many intellectuals to migrate to Western Europe, and others to flee to mountainous areas, in order to avoid Ottoman domination, proselytism, and a law system that was hard to bear. As a result, systematic health and social care were left to the monasteries which offered treatment to those in need of physical treatment.

In the 19th and 20th centuries, medicine became the major beneficiary of technological innovations. First, the development of new drugs such as penicillin, the progress in anaesthetic and antiseptic surgery, and access to improved surgical and diagnostic equipment increased the efficiency of treatment, and made hospitals far more accessible to patients. From shelters for the indigent hospitals were transformed to formal healthcare settings where clinical investigation, drug research, and medical scientific diagnoses took place. The induction of new professional groups such as nurses, anaesthesiologists, and oncologists within hospitals made citizens feel safer and public trust in hospital treatment increased. Medical professionals of the times were the only ones with the right to decide about the patients’ admission to health organisations. That power over human life brought their status to an even loftier position and strengthened their professional power (Jackson, 2011).

The present section reviews the historical development of the Greek NHS and builds the healthcare context of Greece through analysis of the main legislation and other documented sources (newspapers, periodicals, books, scientific studies, etc.). The goal of the analysis is to provide an evaluation of the Greek healthcare system’s past reforms and synthesis of evidence and lead to the identification of the key issues which will be investigated through the study’s in-depth interviews at a later point.

**The Foundations of the Greek Healthcare System**

During the 20th century, the organisation of the Greek health sector developed alongside the growth of the country. However, while formal healthcare provision had been advancing by leaps and bounds in Europe, developments in Greece’s health sector moved at a sluggish pace due to a number of contingencies. Those included the Herculean labour of reconstructing the Greek nation after 400 years of subjugation under Ottoman rule, the Balkan War (1912), World War I, World War II and Greece’s Occupation by the Nazis (1941-1944), the Asia Minor Catastrophe (1922) and the subsequent population exchange between Greece and Turkey (1923), the Greek Civil War (1946-1949), and the military junta (1967-1974). The upheaval brought about by those historical events destabilised the country’s financial and political environment and resulted in a social system that was as incomplete as it was embryonic. To illustrate the point, Mouzelis (1986), as cited by Dent (2003a), argues that patronage and clientelistic networks were embedded in the political and cultural tradition of Greece as a result of the 400 years of Ottoman rule over the country. In view of all of the above, the state assumed an excessively interventionist role in an attempt to enhance the coherence and consistency of social policy. At that point, clientelism began acquiring alarming proportions and momentum, the result of the affluent and the ‘noble’ currying favour with the State; consequently, a climate of mistrust spread to the remaining, considerably less entitled population (Katrougalos, 1996).

Eleftherios Venizelos (1910-1932) was Greece’s first prime minister to try and organise the country’s health system during a particularly dismal economic and social situation in the early 20th century. The situation worsened when 1.5 million Asia Minor refugees of Greek descent arrived in Greece in the framework of the 1923 population exchange agreement between Greece and Turkey. Most of the returning refugees were in poor physical and mental health, as a consequence of the hardships they had undergone while fleeing the coast of Asia Minor and the adverse living conditions they had experienced while trying to reach Greece. In or about 1925, National Hospitals and clinics were built, specialising in the treatment of patients afflicted with tuberculosis. In 1917, two important events took place: the Hygiene and Social Welfare Ministry was established so that the state may tend to the refugees; and new laws were enacted so that authorities may control infectious diseases (Τheodorou et al., 2001). There were other important health organisations also established in Athens at that time, such as the Medical School in 1925; the first professional organisation of nurses in 1923; the Health Centre of Athens in 1929; the School of Community Health Nurses in 1930; and the People’s Hospital in 1933 (Papadakis, 1965).

At that time, Prime Minister Venizelos also proposed the creation of a Social Security Organisation in order to introduce the compulsory insurance of employees and the equal contribution principle between employers and employees. The law “On the Institution of Social Security”[[1]](#footnote-1) enacted the first and largest Social Security Institution (IKA) of Greece (Tragakes and Polyzos, 1996). The law was passed after the fall of the Venizelos government and the rise of the People’s Party in 1934 and came into effect in 1937 (Skoutelis, 1990). However, due to the low pension scheme provided by IKA, working groups continued supporting their corresponding fundraising agency in order to secure benefits for their profession or trade (Kontiadis, 1997).

In the late 19th to early 20th century, many were the insurance and supplementary funds developed as part of the newly-established professional groups providing their members with insurance coverage (GSEE, 2000). Some of the funds, created for the first time during the 1920’s, were those of health professionals, teachers, clerics, lawyers, and others (Mpenteniotis, 2004). The large number of insurance funds provoked significant variations in insurance systems in terms of revenue, benefits, and retirement (Provopoulos, 1987). Initially, funds had foreseen insuring their members in cases of ill health, work-related accidents, and old age and had the form of public entities since they fulfilled the government’s goals as stated by the law “On Compulsory Insurance of Workers and Private Employees”[[2]](#footnote-2) (Provopoulos 1987, General Secretariat of Social Security 2012). The funds were financed by employees grouped under the same category of profession or trade. The same law also introduced the principle of equal contribution between employer and employee (Skoutelis, 1990). It should be noted that the efforts made by Eleftherios Venizelos to create a central social security organisation were unsuccessful. Instead, a plethora of new funds (main and auxiliary ones) were created, burdening the social security system due to deficits and difficulties in the funds’ financial sustainability and amassing problems destined to plague future generations (Nikolopoulos and Yfantopoulos, 2010).

During the following years, Greece faced yet again poverty, death, and disruption because of the Second World War and the Nazi Occupation. As a result, improvements in the health sector were forestalled due to lack of resources. However, in 1953, the Legislative Decree “On the Organisation of Medical Perception”[[3]](#footnote-3) laid the foundations for the first organised and publicly funded healthcare system in the country. Some of the most important proposed plans included the decentralisation of healthcare through the creation of health regions, the organisation of hospitals, the establishment of the Health Monetary Fund, and the provision of financial incentives for doctors willing to work in the countryside’s peripheral regions (Niakas, 1993). Nevertheless, because of the political instability prevailing throughout the country, those plans never came to fruition: in an era when conservatism was dominant they were viewed as far too socialistic to implement. Official health policy was unclear as the government faced obstacles in giving the multiple funds that had sprung into existence a semblance of order. A small number of public hospitals were built in urban centres, with some older ones continuing under subsidisation through funds extended by various professional groups.

Eight years later, in 1961, the first Organisation for Agricultural Insurance (OGA) was created[[4]](#footnote-4) in order to provide medical help to Greek farmers. Establishment of that organisation was of signal importance as, at the time, farmers represented almost 51% of the working population (Dervenis and Polyzos 1995, Tragakes and Polyzos 1996). Insurance funds for other job categories such as civil servants, bankers, and more, also began emerging. The plan establishing OGA met with unqualified success and regional farmers were able to look forward to basic pensions and hospital care. However, OGA’s provisions proved unsatisfactory over time. For one thing, the agricultural communities of Greece had lofty expectations of their insurance fund, and for another, when the numbers of the agricultural workforce declined as a result of urbanisation, OGA’s membership lists shrank (Venieris, 1997).

Between 1967 and 1974, Greece was in the throes of yet another dictatorship –after the Metaxas Regime of 1936– which impacted negatively on any plans for political and financial stability. Nevertheless, during that time, a health reform plan was proposed by Patras, then Minister of Social Care (Patras 1969, Theodorou et al. 1995, Tragakes and Polyzos 1996). The plan promoted the institution of the General Practitioners (GP’s) that could strengthen the primary care sector; and the building of hospitals in peripheral regions of Greece. With regard to the GP’s, the plan foresaw their being paid a certain amount of money for each enrolled patient assigned to them (Mossialos and Davaki 2002), just as it happens in today’s UK healthcare system. Furthermore, the plan made provisions for a common fundraising system that could pay doctors and hospitals on a case-by-case basis. Even though the plan was not implemented due to military bureaucracy and controversial political interests, its proposals do seem to apply to the contemporary healthcare systems round the world.

Following the harsh dictatorship years in Greece, an urgent need for reconstruction of the health sector arose. To that purpose, the Centre for Planning and Economic Research (KEPE) designed a five-year programme (1976-1980) for regional development and submitted three proposals regarding the reconstruction of the health sector: the establishment of a unified National Health Service, the integration of the largest funds (IKA, OGA, and TEVE) into one, and the coordination of the smaller funds (Vagioti, 1989). The report published by KEPE pointed at substantial deficiencies in health resources throughout regional Greece. As a remedy, the report proposed the establishment of hospitals and health centres steered by the medical professionals assigned to the country’s various regional areas (Siakotou, 2007). As recommended by the report, the radical institutional changes such centres would require stirred strong political controversies and attracted the outraged reactions of health professionals. Still, the KEPE Report was the first scientific effort towards organising and building a sound national health system and was welcomed by both ordinary citizens and the scientific community (Economou, 2004). Its underpinnings would later contribute to the implementation of the Greek NHS.

In 1980, the Minister of Health Spyros Doxiadis, submitted to Parliament a health plan, which came to be known as “the Doxiadis Plan,” to be discussed and voted on as a new law. The plan was based on the philosophy fostered by the British NHS (Siakotou, 2007) and focused on creating a National Health Organisation. The plan included other matters of substance as well: the formation of a planning committee comprising the various stakeholders; the decentralisation of decision-making; allowing hospital department heads to maintain a regulated private practice in public hospitals, albeit to the exclusion of any other doctors working in hospitals; and the furthering of medical education (Mossialos and Allin, 2005). It also encompassed proposals that addressed the increases in health expenditure, the unification of all public funds; the development of primary healthcare; and the investigation of the level of quality within hospitals (Economou, 2004). Once more, the proposed initiatives rekindled the strong reactions of political and medical interests. Medical institutions in particular appeared vehemently opposed to the development of primary care as they believed that such a turn may potentially necessitate a great number of resources (Theodorou et al., 1995). It may be of interest to point out that the health sector’s medical professionals seemed continued to walk on a path of resistance against any and all potential changes.

The following sections will review the major reform plans which were either implemented or under consideration after the creation of the Greek Healthcare System, and offer a critical and empirical evaluation of them. In order to facilitate description of the historical development of health reforms over thirty years, six periods that tie in firmly with political regime change were identified and are complemented by Table 2, a summarising table depicting the main changes from the creation of ESY to the present.

**Table 2: Healthcare Reforms of ESY 1983-2012**

|  |  |  |
| --- | --- | --- |
| **Period** | **Laws** | **Main Provisions/Innovations** |
| **Period: (1983- 1989) Creation of ESY under the left-wing Government** | **1397/1983** | * **Establishment of ESY** * **Free and equal access of all to health** * **Focus on State interventionism** * **Blockage of private investments** * **Benefits and exclusive employment of doctors in the public sector** * **Strengthening regional health through creation of health centres, and hospitals** * **Establishment of Regional Health Authorities (PESY)** |
| **Period (1990-1993)**  **Right-wing and political liberalism** | **2071/1992** | * **Shrinkage of State interventionism** * **Political air of neo- liberalism** * **Patients freedom to choose hospital and/or doctor)** * **Doctors given choice to work part-time work in public sector and maintain their private practices** * **Initiating tickets for admission to hospitals** * **Private investment** * **Control and management techniques** * **Most of the measures abolished by the following socialist government** |
| **Period (1993- 2004): The long shift towards Socialism** | **2194/1994**  **2519/1997**  **2889/2001**  **3172/2003**  **3235/2004** | * **Brief and fragmented legislation** * **The Socialists’ comeback** * **Doctors’ full-time employment in ESY** * **Prohibition of practicing privately for public servants working under ESY** * **Foreigners’ committee investigates and proposes reform plans** * **Neoliberal influences arising from committee’s proposals** * **Primary care networks round the country** * **Enforced management in hospitals** * **Weakness of the government to implement changes** * **Global tendency towards reforms** * **Management teams in hospitals** * **17 regional health authorities (PESY’s)** * **Prolonged hospital service equalling combined with extra payment** * **Doctors’ full-time employment under ESY** * **Blockage of private practices maintained by ESY’s doctors** * **Definition of public health (State’s responsibility)** * **Establishment of the National Council of Public Health** * **Development of social medicine** * **Completion of the Public Health Map** * **ckets for admission to hospitals costing €3** * **Pluralistic character of health** * **Focus on primary care** * **Introduction of general practitioners** * **Development of digitalmedical records** * **Unfavourable political climate** |
| **Period (2004- 2009) Conservatism’s focus on administration** | **3329/2005**  **3370/2005**  **3580/2007**  **3754/2009** | * **PESYs change into to DYPEs (Health Regional Administrations) remain 17 in number** * **Each DYPE manages regional hospitals and social welfare institutions** * **Manager and board members administer each DYPE** * **Lack of incentives for managers/conflicts in administration** * **Hospitals outsourcing to private sector** * **Focus on public health** * **Creation of General Directorate of Public Health** * **Body of Public Health Officials- responsible for protecting and promoting health, preventing diseases, measuring effectiveness of measures** * **Reduction of DYPEs from 17 to 7** * **Efforts for administration and savings** * **Establishment of Health Procurement Committee** * **Non-compliance of Greek procurement system with EU rules** * **Need for integrated information system** * **Focus on organising doctor’s employment** * **Setting official working hours and complying with EU directives** * **Planning to recruit 2000 doctors** |
| **Period (2009- 2011) Socialists and Recession in Greece** | **3868/2010** | * **24/7 hospital operation (surgical and diagnostic sector)** * **Competition between public and private sector encouraged** * **Establishment of Citizen Support Office in major hospitals** * **Merging of social welfare institutions** * **Emphasis on local initiatives for healthcare** |
| **Period (2011- present): Next steps with the supervision of the Troika** | **3918/2011**  **4025/2011** | * **Pressure from Troika to limit public sending in health** * **Application of DRGS** * **Creation of EOPYY (National Organisation for the Provision of Healthcare)-Efforts for merging different funds** * **Reduction in public pharmaceutical expenditure** * **Focus on health promotion** * **Creation of Depts of Oral Health, Nutrition, Sports for All in Ministry of Health)** * **Centres of Rehabilitation integrated into ESY to facilitate monitoring and increase hospital revenues** * **Proposal for integrating internal auditing control in hospitals** * **Service Contracts for use of public healthcare and hospitals outsourced to private insurance companies** * **Emphasis on ideology not simply practice** |

**Development of the Modern Greek Healthcare System**

**Period 1983-1989:** Creation of Greek NHS under a Left Wing Government

In 1983, almost ten years after the dictatorship in Greece (1967-1974), the establishment a National Health Service (NHS) became a top priority on the political agenda. The political scene had shifted to the Left and the new left-leaning government increased spending on health during the 1980’s in order to make up for the underfinancing and discontent prevalent during previous decades. Within that context, the new left government proceeded to shrinking the private health sector and the corresponding private expenditure and made every effort to respond to the population’s need for health services. The Neo-Marxist ideology of the PASOK government, in tandem with the influences stemming from ‘Paternalistic Capitalism, a work by PASOK’s Chairman Andreas Papandreou, supported the party’s political approach and mainly aimed at increasing public resources, improving hospital conditions, and exercising control over the private sector (Tountas et al., 1995). As Yfantopoulos (2005, p.91) states: “there was collision between the ideologies of neoliberalism that wanted a health system based on an open market and the Marxist perception that a health system should fall within the framework of equality and access to healthcare services.” To some extent, that ideological divergence may justify the political football of health tossed between conservatives and socialists in Greece and their inability to reach a consensus, especially in the first ten years since the inception of the NHS (Sissouras, 2012). Though ideas and policies may adapt, the political instability associated with the various stakeholders’ interests, the clientelistic relationships between groups with political clout and political parties, and other fiscal constraints, hindered implementation of health public management innovations (Davaki and Mossialos, 2005).

The controversy and obstacles aside, in 1983, the left-wing government in power did give form to and realise the Greek NHS (Gr. E.S.Y. for Greek System of Health)[[5]](#footnote-5). The system was the first to lay the foundations of an organised public healthcare system in Greece and was based on the experience of established European medical systems, especially those of the United Kingdom and Scandinavia (Polyzos et al., 2008). Initially, it relied heavily on the German Bismarck model and the social insurance funds covering professionals of various sectors and then was structured as a more centralised system to be funded by government (UK Beveridge model). According to the OECD, the present Greek healthcare system is:

*“A mixture of public and private services and funding. The public sector comprises more than thirty sickness insurance funds, the largest of which operate their own networks of outpatient facilities, located primarily in urban areas. It also includes an integrated healthcare system administered directly by the State, the NHS, which delivers most hospital services as well as primary medical care in rural areas. Supplementing this public system is an abundant supply of private services provided by independent medical offices, diagnostic centres and hospitals”* (OECD 2009c, p.93).

The founding law was underpinned by forty-seven articles providing the basic regulations for a system which, in the foreseeable future, would be viable and beneficial. According to that law, there were two, main principles acting as anchors of the new system. First, the government was responsible for the provision of health services to one and all and, second, those services were to be distributed equally to all citizens, regardless of each one’s social, financial, residential, and employment status (Law 1397/1983, Theodorou et al. 2001, Kyriopoulos and Niakas 1993). The main purpose of that law was to promote health as a public good, offered and protected by the state (Kontiadis and Souliotis, 2010). In line with its left-oriented direction, the law prohibited the operation of private hospitals (Tountas et al., 1995). It primarily stressed the delivery of health in a decentralised manner by focusing on the division of Greece into nine Regional Health Systems (PESYs) which would be administered by respective regional councils. Plans for building new public hospitals in those regions were under way and emphasis was placed on hospital administration and improvement of quality.

Small, private hospitals were absorbed by the public sector. Doctors could only work in ESY as civil servants since the new law made it impossible for them to work anywhere else, let alone maintain a private practice (Theodorou et al., 2001). Doctors’ salaries and promotion scales were set according to the medical practitioners’ years of work experience (Law1397/1983). Benefits and special privileges such as contingency allowances, travel costs, and conference/research were also provided. Those substantial perks doubled the salaries of doctors who could also earn extra income by maintaining their private practice, something prohibited by the law but not fervently enforced (Tragakes and Polyzos 1996, Kouris et al., 2007). It goes without saying that the introduction of the above conditions and the permanent civil service status given to ESY doctors met with those medical practitioners’ enthusiastic commitment to their chosen profession.

At that point, it became obvious that cost retrenchment and efficiency policies were crucial in order to rationalise public investments but neither one came to pass (Karokis et al., 1992). Regional administration plans and implementation had also failed as a consequence not only of a formidable bureaucracy but also as a result of all power having been concentrated at the Ministry of Health (Kouris et al., 2007). Nevertheless, it was during that period that 172 health centres were built in regional areas; and three new university hospitals were established in the regional cities of Patra, Ioannina, and Heraklion. Their presence and operation led to an improvement of vital health indicators, such as childhood and infant mortality, which boded well (Polyzos et al., 2008).

**Period 1990-1993:** Right-Wing and Political Liberalism

In 1990, the political Right of the Greek Parliament won the elections as a consequence of the international climate prevailing after the collapse of socialism. The new government introduced an air of political neoliberalism to Greece by imposing laws and policies which reduced state interventionism. It also enacted a new law under the title ‘Modernisation and Organisation of the Health System’.[[6]](#footnote-6) As that title indicates, the health sector featured prominently in the new government’s plans. For one thing, it empowered citizens by giving them the right to choose the doctor and the health organisation (be it public or private) that would undertake their treatment. Secondly, it allowed the doctors of ESY to work part-time in the public sector while maintaining their own private practices. In tandem with that, the government also decided to introduce a ticket of admission for visits to hospital outpatient departments (Economou, 2010) where patients were free to choose their health providers. The ticket cost approximately 1000 GRD (~ €3) and covered the examination cost (Rizospastis, 2010a). It emphasised the free choice of patients had but also the increasing market ideology behind the provision of healthcare that the political party of the Right had ushered in.

It also gave the green light to the establishment of independent private clinics (Kyriopoulos et al. 2003) and enabled private doctors to participate in primary care as consultants (Kalokairinou and Sourtzi 2005). Funding of health centres came from the centres’ respective prefectures instead of stemming from the hospitals' own budgets (Theodorou et al., 2001). That reform had not been in the stipulations of the previous law and was a way for the new government to control the expenditure of major hospitals and provide better administration and adaptation to the local needs of each health centre. Other managerial measures introduced included: “the creation of hospital chief executive posts; new management techniques; and financial accountability and audit systems*”* (Economou 2010, p.24). It is obvious that the law had a conservative approach which aimed at public management and at the expansion of the private health sector throughout the country. As a result, private health expenditure increased to almost 4% of the GDP (Polyzos et al., 2008). Apart from those arrangements, ethical standards common to all medical professionals were enacted and the establishment of a National Council of Medical Ethics was in the works.

**Period 1993-2004:** The Long Shift towards Socialism

The next reform of ESY took place two years later, in 1994, when the political Left was again governing the country. Surprisingly, most of the articles of the previous law were eliminated, triggering questions concerning the applicability of that older law. Was it a matter of an immediate political reaction by the Socialists or conservative myopia? Theodorou (2002, p.30) argues that “each health minister has found it politically more attractive not to implement any law approved by his predecessor putting forward instead new legislation which, in turn, is destined to be subjected to changes by successive ministers”. Nothing could be more apt than that in trying to describe a practice religiously followed since the first days of the Modern Greek NHS in 1983. More often than not, ministers entering the cabinet in replacement of a former minister ushered out, hasten to change their predecessor’s law not only because they think it expedient but also because they wish to live behind a legacy in the form of a law that bears their last name (e.g. the Doxiadis Plan). Notably, it has been stated by the OECD (2009a, p.24) that “On average, during the last 25 years, a [Greek] Minister of Health has stayed in charge for no longer than 18 months”.

The purpose of the new brief and fragmented law ‘Rehabilitation of the Health System and other Provisions’[[7]](#footnote-7) was to change the Conservative direction 180 degrees until it resembled an entirely new proposal. Doctors were returned to their old working status as public workers of ESY and health centres were returned to the jurisdiction of hospitals. That meant that any doctor who had invested in a private practice had to close it down within two years if s/he wanted to continue to be allowed to work in National Healthcare. Alternatively, doctors could keep working illegally as private doctors in the afternoons (Mossialos et al., 2005). If truth be told, doctors were not strictly prohibited from practicing privately (Tragakes and Polyzos, 1996), a fact that denoted their strong professional power. As to the operation of private clinics, the new law altered nothing, allowing the private health sector in Greece room for greater manoeuvring and expansion.

Due to inefficiencies and the belated development of the Greek NHS, a group of healthcare professionals comprised of Greek and foreign health experts and headed by London School of Economics Professor Abel-Smith convened and tried to provide multisectoral and grassroots solutions leading to a feasible healthcare system. It would be based on such characteristics as exhibited by the Canadian, UK, and US health systems (Abel Smith et al., 1994) by stressing the liberal philosophy in health (Abel-Smith et al., 1994). Two different reform projects were developed. The first was known as the Kremastinos Plan and had been conceived by Kremastinos, Minister of Health and Social Care under the Socialist Party government in the period 1993-1996; and the second was the Peponis Plan compiled by Peponis, Kremastinos’ successor.

Neither one of the two proposed reforms made it on its own. Instead, a blend therefore was decided upon and a new law surfaced: ‘Development and Organisation of ESY, Organisation of Health Services, Pharmaceutical Regulations, and Other Provisions.’[[8]](#footnote-8) The law promoted new ideas influenced by foreign health systems. It aimed at establishing Primary Care Networks throughout the country with a view to enhancing health promotion and health prevention actions and programmes (Kalokairinou and Sourtzi, 2005). It also aimed at implementing the Institution of General Practitioners whose operations were expected to make a substantial contribution to garbing the operation of ESY with the vestments of rationalisation. Under the new law, general practitioners were considered the key people to provide primary care services and keep records of their patients on file so as to curb pointless visits to hospitals but also to reduce the number of days of in-hospital stays. Other provisions of the law included the establishment in all hospitals of an agency conducting research on health and its quality and of a citizen communications office. Both represented far-reaching measures relating to the quality of care, standardisation of procedures, and protection of patient rights. Some of the regulations embraced monitoring the cost expenditure of hospital prescription lists, in other words, the catalogue of pharmaceutical drugs each hospital used. Others dealt with the necessity of having appointed to the Board of Directors of each hospital a Chief Executive, making it compulsory for that high-ranking official to have long-standing and proven experience in health administration.

Even though the law appeared promising, most of its stipulations were never realised because of severe operational and financial problems (Zilidis 2005, Aletras et al. 2007): in the three-year time period that transpired after the enactment of that piece of legislation, neither were any Chief Executives to each Board of Directors ever appointed, nor were any primary care networks –which could guarantee patients equal access to hospitals and conserve financial resources –ever established (Moraitis, 2000). Implementation and political stability were sideshows directly affected by the death of Prime Minister and President of the Socialist Party Papandreou and by the equivocation and uncertainty that ensued in government circles.

It was obvious that there was an on-going process of planning and voting in health reforms but there was no progress in implementing them, or at least there was only a nugatory amount of activity taking place. As stated by Polyzos et al. (2008, p.96) “Unions and members of political parties were entering and leaving the planning or policy process, with no continuity, consistency, serious dialogue, or formulation of contingency plans”. Hospital doctors also voiced their concern over issues, arguing that a neoliberal management change in their workplace could affect their status and working conditions (Sanidas, 2000). It is evident that neither efficient management policies in resource use and evaluation nor other European neoliberal initiatives were destined to find suitable ground in that era (Kyriopoulos et al., 2000). Moreover, it was visibly noticeable that, so far, there had been no serious organised effort to set in place a system for the systematic collection and measurement evaluation of data regarding implemented policies, practices which would have been useful in revealing the extent that reforms have helped in improving healthcare in Greece (Sissouras, 2003).

Two years later, in 1999, the Presidential Decree “Minimum Requirements for the Organisation of Working Time, in Compliance with EU Directive 93/104/EC” [[9]](#footnote-9) was issued by the President of Greece with a six-year delay (Varnavas et al., 2003). Important regulations such as a mandatory daily rest of 12 hours for every 24 hours of work and weekly rest periods for doctors were set. The decree stipulated 48 hours of working time (including overtime) per week and night shifts which should not exceed eight hours every 24 hours, in a one-week period. It may be of interest to note that none of the above regulations were included in any subsequent reforms: for one thing, no government minister aware of the political cost involved would sign a law that would reduce the salaries of hospital doctors by eliminating their overtime. For another, even if the competent minister were to sign that law, the state could not cover the need that would arise in additional medical staff (Varnavas et al., 1999). The message was as loud as it was clear: doctors did not want their overtime work reduced as they would lose a considerable part of their income and the ministry wished to keep them content. A further stumbling block hinged on the competent ministry’s procrastination over the enactment of the Directive because of the staff shortages, especially in nurses and doctors, at regional health centres (Gakidis, 2008). Again, it may be safely deduced that the time for management policies potentially effective in controlling resource use and offering evaluation, together with other neoliberal initiatives, had not yet arrived (Kyriopoulos et al., 2000).

Nevertheless, it certainly could be argued that, in theory, health reforms were improving as they were increasing in content and becoming more complex and sophisticated. Case in point was the 2000 “Health for the Citizen” reform plan unveiled after the Socialists’ re-election. It proposed “200 Issues in Need of Reform” (Ministry of Health and Welfare, 2000) and was supported by Prime Minister Papadopoulos. Among other issues, proposals included the institution of General Practitioners; the development of a decentralised system; new hospital regulations; the establishment of a national health institute responsible for assessing health research developments, quality, and training; and the strengthening of social welfare.

A common fundraiser that would be known as ODIPY (Organisation for the Management of Health Funding) was also proposed. However, that initiative gave rise to a host of reactions partly due to conflicting interests fanned by each insurance fund and partly because no scientific study had been carried out to corroborate the feasibility and functionality of such a plan. That organisation would not come into existence until a few years later. In addition, the plan called for the prospect of hospitals operating their outpatient clinics in the afternoons, a practices, in the long run, would eliminate long queues and waiting lists in hospitals and clamping down on the “informal” payments to some doctors. Amusingly so, those informal payments were euphemistically known as ‘fakelaki’ (Gr. sing: small envelope stuffed with bills) and represented bribes by patients to doctors, a phenomenon with social and historical roots which is still alive and well in the public sector even today (Dent, 2003b). Two are the messages hidden behind that clandestine transaction: on the one hand, the patients benefit by informally paying doctors in the hope that they are the recipients of better treatment and quality of services, such as bypassing waiting lists and, on the other, the doctors benefit by accepting that unreported form of income which, in a way, compensates them for lack of incentives offered by the state. Both parties reap the advantages of under-the-table payments and, through perpetuating that fandango, they denote the system’s extent of inequity and inefficiency (Liaropoulos et al., 2008). It should be reminded at this point that if those practices were to be abolished the income earned by Greek medical practitioners would be all too low (OECD, 2009c). That may well be one of the reasons why the unethical practice of the ‘fakelaki’ is still in place (Dent, 2003b) and why the reform plan also placed emphasis on the on-going education and training of healthcare employees through incentives offering motivation for further progress.

For yet another time, the political will to implement the reforms plans was either absent or there was no one brave enough to risk bearing the brunt of the political cost. The proposed unification of insurance funds met with the strong resistance of the trade unions but also of the health workers’ unions which opposed the bill’s generalisability and the lack of programming and evaluation of the potential changes (Economou, 2004). In turn, hospital doctors reacted with strikes opposing the hospitals’ monitored activities and afternoon clinics (Mossialos and Allin, 2005). In combination, all reactions prevented the bill from being voted in. As Mouzelis et al. (2005) put it, there are some elite groups which strengthen the power of particracy in order to protect their vested interests.

One year later, in 2001, a new healthcare law, “Improvement and modernisation of ESY,”[[10]](#footnote-10) was voted in as a means of regulating the previous year’s bill. At that time, there was a global tendency for more efficient and modernised health systems that facilitated reforms worldwide without any interference (Papadopoulos, 2001). The driving force behind such reforms emerged from the support provided by European funds geared mainly towards hospital investments (Theodorou, 2002).

Decentralisation of healthcare had become a priority of paramount importance and constituted the first article of that law. Under the provisions of Law 2889/2001, Greece was divided into seventeen regional health systems called PESYs. Their purpose would be to provide an integrated and efficient health service system responsive to regional needs; and embrace primary hospital care, after-hospital care, and in-home care. Further, state-financed hospitals and health centres which belonged to the peripheral area of each PESY became managerially and financially autonomous with each PESY in charge of organising and communicating the policies issued by the Ministry of Health to them (Kouris et al. 2007, Kontiadis and Souliotis 2010). The law also included a detailed plan of organisational structure and responsibilities for PESYs and hospitals and required the creation of a Public Health Map of Greece that would show at a glance the local needs for health across the Greek population (Nikolentzos, 2008).

An entirely new initiative promoted by the above law was the introduction of management teams in each hospital (Aletras et al. 2007, Boutsioli 2010). It depicted the efforts by various political actors to promote professional management within hospitals. In the past, hospitals had been traditionally managed by “politically determined inexperienced appointees” (Theodorou, 2002) whose qualifications and competences were of dubious distinction. That should come as no surprise since it was common practice for the ministers of each new government to pick and choose their own ‘crews’ destined for hierarchical and privileged posts which ranged from General Secretaries in Ministries to Assistant Directors and Directors of Hospitals. As the President of the Hellenic Health Services Management Association, Stathis remarked (2012, p.5):

*“It is impossible to practice scientific management with unsuccessful candidate politicians, brothers of ministers, trade unionists doctors and other exotic flowers. It is also impossible to succeed in the recovery of hospitals with head members that are theologians, foresters, gym instructors, air traffic controllers, simply because they are compliable party executives. At this point what is required is the recruitment of the best applicants who are usually displaced because they have strong opinions”.*

However, that new initiative was determined to change the game by setting requisites for managers and stipulating a strong academic and professional background directly related to hospital administration. Appointees could remain in their post for no longer than a five-year term and would have to sign a “Contract of Performance” whose goals would be defined as of the outset of each appointed manager’s term. Responsible for recruiting the best applicants amongst the eligible candidates was the Committee of Evaluation and Selection of Senior Managers for Health Services (Kostagiolas et al. 2008, Gogos 2011). Management teams which were comprised of five members were placed at the top hierarchical level. Among other things, the teams’ responsibilities included ensuring that the hospital they were in charge of operated seamlessly; drafting and submitting their respective hospital’s operational plan; overseeing the rational use of resources available, and making the necessary procurements. For the first time ever, employees in the Greek public sector’s top hierarchy were not connected with the ruling political party (Davaki and Mossialos, 2005). It was a significant step towards progress as it was designed to limit the power of political decision-making and introduced within hospitals professional managers without any party links to political interests.

Another important provision established by that particular law was the prolongation of hospital services to afternoons and the new employment relations status of hospital doctors who, through their respective hospitals’ afternoon clinics stood to augment their salaries. The purpose behind the extended hours of hospital services to citizens was to decongest hospitals and provide better quality of healthcare; stem the flow of informal payments to doctors; avoid the parallel exercise of private practices in the market (control of tax evasion); and make hospitals more profitable (Sarafidis and Stafilas, 2004).

Depending on a doctor’s rank, afternoon outpatient visits to hospitals incurred additional, fixed yet steep charges, depending on each doctor’s rank (FEK B 1643/2001). Fees ranged from €90 per visit for medical staff of senior rank to €45 for medical doctors of junior rank, and €35 for specialists. Of those payments, 60% went to doctors and the health staff working with them, and 40% was rendered to hospitals (Boutsioli, 2010). No insurance fund undertook to cover the fee involved in a visit to a hospital doctor. Nevertheless, should the need for additional laboratory examinations arise, those were covered by the funds and only in the case of insured citizens. Uninsured patients had to pay those fees out of their own withered means (Sarafidis and Stafilas, 2004).

As to hospital doctors, they were expressly forbidden from maintaining a private practice and, if they wished to hold tenure within ESY, they were required to have three successful evaluations and ten years of full employment in the Greek NHS, and sign a five-year contract (Theodorou 2002). It may be of some worth to mention that although the law was supposed to include provisions on the issue of reduced working hours for medical professionals as decreed by EU directives 93/104/EC (48 hours/per week), it did not, an omission or oversight that could potentially generate grave consequences.

The policies above represented some evidence of a growing market economy in healthcare delivery. Doctors were treating patients as clients in public hospitals at prices which were highly competitive to those of the private sector’s (Aletras et al., 2007). Such strategies benefited affluent patients, while less fortunate ones were excluded from the ‘auxiliary’ public health system and left in the lurch. In view of the fact that it was a socialist government that employed managerial initiatives favouring wealthy people, the above practices may appear startling. However, their main purpose was to generate additional revenues for public hospitals, improve the quality of healthcare, and make more rational use of resources. In that sense, it seems that, in terms of efforts to strengthen the public sector, the team of Abel-Smith had succeeded in passing the message. All that was left to do was turn theory into practice.

It came as a pleasant surprise to everyone that, this time, most of the plans foreseen by the law were actualised. The afternoon operation of hospitals generated €13.8 millions in revenues for the public sector, funds which, otherwise, would have gone to the private health sector (Liaropoulos et al., 2004). In spite of the law’s successful application, productivity and efficiency of some of the policies were marked by progress that was all too slow (Kaklamanis, 2003). Most hospital managers found themselves pitted against apathetic bureaucrats and against hospital employees who, reflecting the interests of their respective organised unions, showed marked resistance to change (Zilidis 2005, Kostagiolas et al., 2008). Faced with such fierce opposition, hospital managers were unable to honour their “Contract of Performance”. Additionally, some of the managers were found unsuitable for their posts due to their lack of pertinent knowledge, skills and/or experience. In view of the law’s stipulation for filling the managerial posts with the candidates best suited to the job, that raised some eyebrows as to the fairness of the selection process organised by the Committee.

Other problems that inhibited implementation of the law were the technologically outdated IT and accounting systems used by hospitals: both hardware and software were in such an obsolete state that control over medical equipment and overcharging was an impossible task, leading to orders placed by the hospitals’ procurement departments which were either wasteful or entirely unsuitable (Kaklamanis, 2003). Since hospital authorities have always been responsible for monitoring costs incurred during medical actions so that they may apprise public and private insurance funds, installing a state-of-the-art IT system in each hospital stood to good reason: the more comprehensive and detailed the data collection, the more reliable the results produced and the more accurate and informative the estimate of a hospital’s outputs and inputs (Dimopoulou, 2002). The technical problems notwithstanding, the establishment of extended hours of operation of outpatient clinics into the afternoon created social inequalities and unfair competition between private and public sector, provoked an ethical dilemma and led to heated political debate.

During the same year, in December 2003, another law concerning ‘The Organisation and Modernisation of Public Health’[[11]](#footnote-11) was voted in. It focused on public health targets such as an increase in life expectancy and on such action plans as promotion and protection of health activities. The new law defined public health as “the organised activities of the State and Society that aim to improve quality of health and increase the life expectancy of the population. Public health protection and prevention is the state’s responsibility”.[[12]](#footnote-12) In the matter of implementation of health policies and programs, most of the law’s regulations regarded the establishment of new councils and coordination teams. More specifically, the law foresaw the creation of a National Council of Public Health (Pavi et al., 2011) and of councils corresponding to each Greek region, all working in a synchronised manner to manage matters relating to public health services.

The law also required the creation of Public Health Directorates which would be responsible for public and environmental hygiene, health promotion and protection, such as offering medical checkups by public health services (Kontiadis and Souliotis, 2005). It was obvious that efforts had been concentrated on the organisation of health services in an effort to facilitate strategies which could potentially improve the population’s quality of health. The law also promoted the field of social medicine by stipulating that specialised staff be appointed. Due to the instability of the prevailing political background at the time, the measures were never put to practice (Zilidis, 2005). Another stipulation that the law raised was the completion of a Health Map that could illustrate the needs of the Greek population and allow for resources (human and financial alike) to be allocated efficiently (Law 3172/2003). Even though the reform’s process in the period June 2002 to March 2004 may be characterised by an overall climate of inactivity, establishment of national and regional councils was indeed accomplished (Davaki and Mossialos, 2005). In the same year, the social government adjusted the hospital admission ticket (imposed by the Right-wing government in 1991) to €3 because of the change in currency from Greek drachmas to the Euro (1000 GRD=~3 EUR, FEK B 53/23.1.2003). In the meantime, the managers of the two main children’s hospitals in Athens extended the policy of admission tickets valid for outpatient clinics to emergency services (Rizospastis, 2010a).

For a nation, reaching a solid level of primary healthcare is a major challenge. Such a high level requires a holistic and pluralistic approach to health, continuity, consistency of health services offered to the public, and development of promotion and protection of health programmes. With regard to that, another important part of the Greek NHS legislation was a law[[13]](#footnote-13) which focused on primary health services with a view to giving healthcare a pluralistic character. Equally significant were the economic and social benefits associated with. First, regulatory mechanisms would control the demand for health services, reduce medical examinations, and avoid the overzealous use of technology. Moreover, the number of citizens in good health would increase because of a steady supply of diverse health prevention and health education programs championing nutrition, the environment, and pharmaceutical and clinical guidance (Kalokairinou and Sourtzi, 2005).

In particular, the law specified programs of promotion and protection of health aiming at healthcare that would be independent of hospital treatment (Kontiadis and Souliotis, 2005). The purpose was to facilitate primary health services and orchestrate the triage of patients within the system, thereby wasting neither resources nor effort (gatekeeping). Some of the most crucial provisions of that law were: (a) the 24-hour operation of ESY health centres and social insurance institutions that also offer primary care services; (b) the introduction of the General Practitioner who would be able to provide primary care in order to control and reduce the number of visits to hospital; and (c) the integration of a digitalised medical records system which would provide vital information on a patient’s history, treatments, and prescription drugs, always in accordance with the decisions made by the doctors. Unfortunately, the unfavourable pre-election climate prevalent in the country prevented the law from being implemented. Interestingly enough, even though the political power seemed to be fully aware of the problems plaguing the Greek NHS, the policies it promoted were far from reaching their goals and remained trapped under the burden of Greek bureaucracy, particracy, and a legislative tug-of-war (Mouzelis et al., 2005). As Kickert advocates:

*“An important explanation for reform failure in Southern European States is the long polarization between left and right-wing political parties. After an election, the new incoming government does not only replace officials en masse but often also cancels the reforms of the previous government and replaces them with its own”* (Kickert 2011, p.815).

New elections were about to take place with a new conservative government coming to seize the reins (Zilidis 2005, Kouris et al. 2007, Polyzos et al. 2008).

**Period 2004-2009:** Conservatism’s Focus on Administration

The new Conservative government that emerged from Greece’s national elections in March 2004 tried to keep its political pre-election promises and presented a renewed social agenda in the context of several social initiatives, unsurprisingly including a new health reform. The law “ESY and Social Welfare”[[14]](#footnote-14) was voted in and, this time, expectations were that it would be implemented. The new law changed the name of the PESYs (Regional Health Systems) into DYPEs (Health Regional Administrations). Duties and responsibilities remained almost the same with one major difference: each DYPE became a public organisation under the direct control of the Ministry of Health. In line with the DYPEs, hospitals and social welfare organisations became public institutions controlled by each DYPE (Adamakidou and Kalokairinou, 2009). Again, the governance of health institutions had come under the direct control of the Ministry of Health and its central decision-making process, with no room left for encouragement of local initiatives.

The law also stipulated that DYPEs as well as hospitals would each be administrated by one manager and each hospital’s Members of the Board. The number of Board members was changed to nine for larger hospitals (>400 beds) and to seven for smaller ones. The problem was that appointments of Board members were still left to the discretion of the Minister of Health. It is not difficult to glean that implementation of decentralisation was encountering difficulties due to the fact that decisions were at the mercy of central administrations and politics overall. The organisational charts for all DYPEs were designed to be identical and also required the presence of an occupational doctor and a safety engineer in each DYPE. On perusing those organisational charts, one may see at a glance that their design was a spurious one which did not take into consideration the fact that each DYPE had its own individual character and that centralised DYPEs had different and increased organisational needs when compared to the decentralised ones. Furthermore, coexistence of the manager, the deputy manager, and other governing bodies, such as service directors, in one and the same DYPE led to more conflicts and to administrative paralysis (Poedhn, 2005). In an effort to disentangle hospitals from centralised bureaucracy, the law 3329/2005 authorised hospitals to plan their own budgets on condition that they be approved by each competent DYPE (Antonopoulou, 2008). It goes without saying that the entire process would have been more successful if it had been backed by a more reasonable and feasible techno-economic study that would ensure the efficacy of budgets.

Other important provisions embraced the organisational and administrational affairs of DYPEs, hospitals, and social welfare institutions. For instance, each hospital was given the opportunity to contract diverse agreements with private companies and to outsource some of its services such as safety, catering, and cleaning (Adamakidou and Kalokairinou, 2009). The rationale behind that provision, was to improve hospital services, increase patient satisfaction and make hospital amenities more competitive in terms of financial and organisational performance, and pointed at a somewhat right-leaning approach. Moreover, the law decreed that a Customer Service Centre be established in each DYPE. Once more, the main concern was ostensibly patient satisfaction despite the fact that, once implemented, the regulation led to the risk of increases in the cost for health, especially in the case of certain decentralised DYPE’s where there was no urgent need for such a centre.

Within the same year, 2005, another important health reform pertaining to the Organisation and Operation of Public Health Services[[15]](#footnote-15) and other provisions was introduced. That initiative indicated that the new government had made its first priority to solve the existing problems of healthcare at a central as well as regional level. In doing so, the government was attempting to stop patients from defecting into the private sector. According to Siskou et al. (2008), it is insufficient public funding and the corresponding deficiencies of primary care services (Mossialos et al., 2005) that ‘force’ households to look for their care needs in the private sector where upgraded facilities and new technology are a given. Thus, attaining a high standard of health in the regions remained a daunting challenge. Staffing needs had been met only by half and budgets of insurance funds either did not suffice for health promotion programmes and activities or were ineffectively used by the DYPEs when it came to the same task. Especially in the Greek provinces where bureaucracy and inexperience were deeply rooted, such changes were next to impossible to implement. Additionally, the law did focus on prevention programmes that would promote and improve public health but, at the same time, required the formation of new governing bodies staffed with specialised personnel which would manage the DEPYs (Siakotou, 2007).

That was how the General Directorate of Public Health was established (Ministry of Health, 2008). Again, the new directorate would fall under the jurisdiction of the Ministry of Health and its purpose would be to carry out activities within the framework of the National Plan of Action for Public Health. It was also responsible for monitoring other agencies, supervising those of their services connected to public health activities, and updating as well as adhering to the relevant policies issued by the European Union and the World Health Organisation. One more development was that the Public Health Directorate of the previous law had had its name changed to that of Regional Directorate of Public Health. Its main goals were to implement policies, carry out interventions of the National Public Health Plan of Action in the geographic area it was responsible for, and design special programmes for the protection and promotion of public health in collaboration with other health organisations (Explanatory Memorandum 3370/2005). It could be argued with some certainty that the government of Conservatives was politically shifting to centre by promoting initiatives that championed and protected public health and upheld the basic tenets of a welfare state. According to some researchers, it is also possible to explain that direction in the light of political desirability (Dikeos, 2006).

Regional Public Health Councils where council members were offered three-year terms were also established within each DYPE and were in charge of coordinating at a regional level the implementation of national public health policies and priorities (Economou, 2010). They were required to send the competent Ministry an annual report on the health programmes carried out by the DYPE under their jurisdiction. The findings of those reports were expected to provide a reliable way of assessing the health indices of their respective regions. Councils were also given the authority to develop proposals on regional health initiatives and answer to the Ministry of Health in cases of enquiries launched by the Ministry on the provision of health services in the region. However, neither regional public health councils nor the General Directorate of Public Health were ever implemented (Economou, 2010). The latter’s establishment and significance for public health issues awaited the reforms of 2010.

Another important provision of the legislation involved the institution of public health officials. Those were defined as health experts of impressive credentials and qualifications who would be assigned to various regional areas. The selection procedure, their competences, and their compulsory on-going learning were specified and detailed by the relevant law. Together with other governing bodies, they would provide such public health services as: protecting and promoting health; preventing diseases; defending the health needs of vulnerable populations; assessing the quality and effectiveness of health services; and prioritising as well as intervening on matters of health (Ministry of Health, 2008). The list of those jurisdictions reveals a tendency by the government to organise regional health by acknowledging and becoming the champion of the public character of health.

At that point, the Conservative government, under the guidance of the new Minister of Health Avramopoulos, decided to reduce the number of DYPEs from seventeen to seven (Tzebelikou, 2006). By that time, the country’s Health Map had been completed and proved instrumental in specifying and localising the Greek population’s needs for healthcare. According to an interview given by Avramopoulos:

*“the annual operating costs of 17 DYPEs was 50 million Euros. With the decrease of their number into 7, there is the expectation that costs will be reduced to 15 million Euros. Moreover, 400 out of 750 workers who worked in DYPEs will move to hospitals which experience staff shortages”* (Economou 2012, p.23).

As noted, the evidence of discord between former and new government appears strong, as the new conservative government focused on administering the regional health services by asserting its authority through a decrease in the number of regional authorities established by the previous socialist government in 2001, ostensibly to sustain financial resources. At the same time, it was sending a message to its socialist critics that a new wind was blowing, bringing in not only NPM practices but also a neoliberal ideology.

Lack of transparency and efficiency in the health procurement processes led the Greek Parliament to creating and voting in a new law called “Procurement Procedures of Bodies Regulated by the Ministry of Health and Social Welfare”[[16]](#footnote-16). It is noteworthy that the procurement system of public hospitals had been in a critical state for over three decades. Its traits were those of an old-fashioned, outdated system: bureaucratic and inflexible, spurring corruptness and opacity on (Chatzigakis, 2007). Taking those characteristics into account, the principal aim of that law was to create a Health Procurement Committee that would monitor the money spent for provisions; and evaluate the need for and quality of the products procured, with a view to establishing long-term savings (Kastanioti et al., 2013). Other provisions of the law encompassed the creation of three public companies of limited responsibility which would function under the supervision of the Health Procurement Committee in order to ensure the quality of the procedures and help the Committee in its task as monitor. It was also proposed that an inventory report be compiled prior to the time the law would go into full effect in order to facilitate coordination and programming. In the case of large hospitals (>500 beds), a new post was foreseen for an individual responsible for ensuring that the new system would work effectively.

This time, emphasis was placed on savings and quality, ultimately neutralising the black hole of corruption and opacity in that sector. Such lofty plans are indicative of the neoliberal ideology of a Conservative government that employs NPM elements in order to promote efficiency. Minister of Health Avramopoulos (2007, p.15) declared that “everything is ready for the application of the new system as of January 1st, 2009 which may bring in about 500 million Euros on an annual basis”. However, that proved not to be the case. In 2010, one year after the law was enforced, the European Commission referred Greece to the EU’s Court of Justice. The grounds were non-compliance with EU regulations on common safety standards governing products and violation of public procurement policies by rejecting offers from suppliers of medical equipment bearing the CE mark (Press Release European Union, 2010). Apart from the hefty fines that Greece had to pay, the phenomenon of corruption continued rampant. Once more, the health reforms planned had failed to fulfil the prerequisites set. In addition, President of the Health Procurement Committee Arabatzis stated that:

*“it is not possible to manage the procurements of 140 hospitals without the existence of an integrated information system that will be connected with the seven DYPEs and with hospitals nor it is possible to work with 26 employees (23 of them have a service contract), when we need at least three times more employees”* (PFY 2008, p.1).

The Arabatzis statement signified that the law for reform necessitated a preliminary feasibility study prior to its enactment. That oversight had occurred before, during previous restructuring attempts and explained why reforms had been taking such an unfavorable turn so far (Papoulias and Tsoukas, 1994).

Two years later, in 2012, a new law on “Employment Regulations for doctors of ESY and other provisions”[[17]](#footnote-17) was drafted so as to provide solutions to important issues in the workplace such as: working conditions of public hospital doctors; duration of on-call duty; staff shortages; and wages as well as staff selection procedures. It was high time: the flexibility of working hours under which doctors had been basking for so long had become unchecked. All doctors who wished to boost their salary had to do was extend their overtime during on-call duty without having to account for it. Worse, prolonged on-call duty meant that doctors on the verge of exhaustion often made erroneous medical diagnoses and mishaps. The new law restricted that arbitrary flexibility, calling for implementation of an organised plan for all doctors’ duty calls and the subsequent normal hospital operation that would be facilitated through such implementation. In connection to the law’s stipulations, along came several studies, all indicating that long working hours were responsible for the physical and mental pressure health professionals were subjected to. The studies also indicated that such pressure may lead to poor quality of work (Visser et al., 2003). Nevertheless, the income of doctors in Greek public hospitals was shaped to a great extent by the extra payments they received for overtime during on-call duty, a practice that exacerbated the burden on healthcare expenditure overall.

In line with EU directives 93/104/EC, 2000/34/EC, and 2003/88/EC (Euro Info Centre, 2004), the law defined official working hours as no more than seven hours per day and five days per week for hospital doctors; and stipulated a 24-hour rest period following an on-duty call period. That arrangement pertaining to doctors’ working hours had already been successfully applied by other European countries, such as the Netherlands (Sprangers, 2002); Sweden (Ihse and Haglund, 2003); and the United Kingdom (Morris-Stiff et al., 2005). Such regulations are a certain sign of the managerial ideology and monitoring tools fostered by the EU. As such, they had been adapted by other European countries as well to fit each one’s individual profile. Greece also seems inclined to adapt to that managerial philosophy but at a more gradual and slower pace. To that extent, the law also called for recruitment of 2,000 doctors for the needs of ESY since doctors’ on-call duty periods were about to be reduced to no more than seven per month, leading to staff shortages (3754/2009). Once more, it was evident that the law lacked careful planning or, worse, had not taken into account all economic, social, and political parameters possible. In 2011, two years after the law went into effect, only a handful of the staff requirements had been realised. The most pressing of the staff needs were found to be located on the Greek islands and other remote areas and mostly concerned specialties such as paediatricians, surgeons, and cardiologists (Papadopoulos, 2011).

**Period 2009-2011:** Socialists and Recession in Greece

The subsequent health reform law called for “Improvements of ESY and other provisions of the Ministry of Health and Social Solidarity”[[18]](#footnote-18). Socialists had emergent triumphant from the 2009 elections and, one year later, they availed themselves of the opportunity to rectify, yet again, the Greek healthcare system. As already mentioned, previous reforms were habitually abandoned for the sake of any new political expediency.

One of the requirements of Law 3868/2010 called for the hospitals’ day-long operation at regular intervals. That provision was an expansion of the stipulation made by the previous law which established the afternoon outpatient clinics. This time, the new law set the parameters for operation of laboratory diagnostics and invasive surgical procedures in the afternoon outpatient clinics (Rizospastis, 2010b). It hinged on two main objectives: first, to strengthen the public character of health by making full use of medical equipment and human resources; and second, to shorten the lists of patients waiting to be admitted by hospitals. (Petropoulou 2010, Explanatory Memorandum 3868/2010).

The law’s rationale was that the above option could bring more profits to hospitals. It was a unique opportunity in a number of ways: for one thing, uninsured patients would foot the bill out of their own pockets since insurance funds issued refunds for their insured members only and still be content since medical examinations in private clinics were far costlier. For another, insured and uninsured patients alike avoided the tedium of long waiting lists so common in the public sector by opting for the afternoon clinics. Even more importantly, by operating in the afternoon, hospitals would justify the need for utilising the entire medical staff which, in turn, would obtain higher remuneration for charging patients’ visits and undertaking minor surgical operations (Petropoulou, 2010). Prices had the competitive edge over the exorbitant sums charged by private clinics and were dependent on each doctor’s hierarchical rank but also on the hospital’s location. Doctors in hospitals of remote regional places were required to charge €30 per visit regardless of their medical rank. On the other hand, doctors who worked in hospitals in metropolitan areas but also taught at universities could charge as much as €90 Euros per visit (FEK Β 1851/25.11.2010); a price that was considerably lower than the €120 euros charged by private practitioners. Furthermore, the law made provisions for laboratory diagnostics: patients to public hospitals were given a 20% discount on prices charged for diagnostics by the private sector. The cost of the discount would be borne by insurance funds and ESY. It was a way of making public health services more attractive to public and private insurance funds (Petropoulou, 2010). The law also envisaged contracts with private insurance companies.

Without a doubt, the above measures promoted the marketisation of health services while shrinking those services’ public character. They were also an indication that a Socialist government showed visible signs of compliance with neoliberal ideology. Moreover, they signalled that Greek political parties, Conservatives and Socialists alike, were trying, however gradually to reach over time a consensus on their respective policies. In that regard, the Conservative party was trying to establish measures that would protect public health and the rights of citizens and sustain a broad umbrella of healthcare provisions in the public sector. It is noteworthy that, in this instance, it was a Socialist government that tried to promote hospital management and private sector practices within public hospitals. As Deputy Minister of Health Timosidis stated at the time: “ESY is not changing its public entity; it was an attempt to empower the public sector, make it more competitive in relation to the private sector, and turn it profitable by making efficient use of human resources hospitals have at their disposal.” (Petropoulou, 2010) He was not far off the mark: revenue from the hospitals’ afternoon operation rose to €6.8 million in January and February 2012 (Mpouloutza, 2012).

No sooner had Timosidis made that statement than Zekeridis, President of the Medical Association of Kavala, a town of 65,000 inhabitants in northern Greece, reacted:

*“Given the composition that regional hospitals have in medical, nursing, and administrative personnel, their day-long operation is inapplicable. If one wants to be in the philosophy and spirit of ESY, one should better think of revoking the regulation about hospitals offering afternoon services”* (Zekeridis 2011, p.1)

Following suit, the Medical Association of Athens alleged that “the fact that patients pay for their visits in the hospitals of ESY, results in the complete alteration of the public character of ESY” (Healthview, 2010). And it is statements such as the ones above that strikingly show the fierce opposition of the medical profession to the successive efforts of any reform carrying neoliberal aspects.

The law also foresaw special incentives such as a 10% wage increase and promotional benefits, offered to doctors willing to transfer and work in regional hospitals. In order to achieve managerial flexibility and economic efficiency, the law lowered the number of members on Management Boards by two. It further established Quality Committees in large hospitals in order to safeguard those hospitals’ seamless and proper operation, along with an “Office of Citizen Support”. That office would be responsible for receiving patients, briefing them, carrying out any financial transactions of theirs with the hospital, listen to their complaints and, in general, be the patients’ advocate. The above measures aimed at introducing within hospitals managerial instruments that could reduce arbitrariness and contribute to the awareness of dysfunctions.

One year later, in 2011, most of the hospitals throughout the Greek territory had implemented the Citizen Support Office regulation with resounding success. It was one of the Socialist government’s crowning achievements and a vital accomplishment since it took the public seriously, placing it at the very heart of the healthcare system. The influence of Abel Smith’s recommendations in 1994 was evident since the new project emulated the provisions of the UK’s NHS where citizen’s preferences contribute a lot to improving the quality and services (Hutton, 2007). According to Theodorou, General Manager of Evangelismos Hospital in Athens:

*“The Office of Citizen Support is an innovative idea, which was initiated recently, and its competence is to face the problems of patients or relatives of patients that are linked to the operation of the hospital. They contact the Office and their problems are solved. We appreciate severe criticism in order to be able to learn from our mistakes and become better. Our objective is to become an entity that learns from its mistakes; our wish is to change the organisational culture, with regard to our work within hospitals and in relation to the plans that we determine”* (Gagiogiakis 2011, p.1).

Other issues that the law meant to address were those that pertained to primary healthcare. It required each Municipality to promote programmes of public health and social care. In other words, the political attention started to focus on the local level by directing health promotion and prevention activities towards citizens and, in that way, decentralise decision-making, and gain in efficiency. Such initiatives had been known to benefit the citizens of other European countries. For instance, in Denmark, studies at the time had shown that almost all municipalities have complied with the formulation of health promotion strategies and the overall reaction has been very positive (Euro Health Net, 2012). Similarly, Swedish municipalities had organised local health promotion programmes since the 1980’s which resulted in raising awareness over issues of public health and sharpened public focus in matters of various determinants of health (Jansson and Tillgren, 2010).

In line with the above provisions, the new law banned smoking in public places and entertainment areas and determined the fines for potential infringers. Even though primary care was a priority, the law also contained an obligation by public welfare institutions co-existing in the same region to merge. The intention was to conserve resources and monitor primary care activities more effectively. Again, the law’s employing NPM practices driven by neoliberal ideology pointed at an over-arching strategy by the socialist government to bail the Greek public sector out of its stagnation. In reaction, the POEDHN (Pan-Hellenic Federation of Public Hospital Workers) argued that the government’s decisions were controversial and expressed its concern over the future of public workers and the political intention to support the private sector and non-governmental organisations (NGO’s) (POEDHN, 2011).

The law additionally encompassed regulations for the General Directorate of Public Health. It pointed out that the directorate had never been established and that it had become imperative to acknowledge its pivotal role when framing a national strategy. Some of the most important delegations of the directorate would be to monitor scientifically public health institutions; compile an annual report on the health situation of the Greek population; and, among other things, give its expert opinion on the strategy for public health, on research and development priorities, and on quality evaluation plans.

**Period 2011-present:** Next steps Under the Supervision of the Troika

The reform discussed next coincides with the financial and organisational support given to Greece by the European Commission (EC), the IMF (International Monetary Fund), and the European Central Bank (ECB), in the form of a supervising tri-partite committee, mainly known as “the Troika”. In May 2010, owing to Greece’s staggering public debt and deficit, the Greek government had been forced to agree to accept the Troika as overseer as a means of resolving its difficulty in honouring the country’s debts. The agreement with the triumvirate foresaw a planned programme for stabilising Greece’s economy, gaining competitiveness in the markets, and restoring confidence in the country. It also came with a financing package of €110 billion paid at the outset of the agreement. Two years later, in 2012, a second bailout of €130 billion was also agreed upon between the Troika and Greece (Kentikelenis et al., 2014). In return, Greece had to sign the two Memoranda of Understanding (MoU) and follow “the toughest and the most painful austerity programme in the history of Europe,” as Finance Minister Papakonstantinou ([Yannopou](http://www.athensnews.gr/issue/13389/21877)los, 2010) frankly put it. Some of the austerity measures included limited public spending, retrenchment of wages and pensions, tax increases, lay-offs to reduce the size of the public sector (Vasilopoulou et al., 2014), and the weakening of certain professions such as taxi drivers, accountants and others, by opening them up to competition. The list enumerating those professions included dentists and doctors who promptly reacted through intense strikes, arguing that health is not a supermarket product but a social good (Newsin, 2011).

In order to immediately start controlling public hospital expenses, the Ministry of Health implemented the measure of the Diagnosis-Related Groups System (DRGS) without allowing for the time necessary in applying such a plan and without any preparation that could sustain it.[[19]](#footnote-19) Substantial efforts were put forward to change the pricing system of services within hospitals. Until that time, it had been the social security funds which had refunded hospitals for expenses incurred by those they insured, based on hospital invoices issued for medical supplies and medicines going towards treatments and days of hospitalisation. Yet, the time when that pricing practice was going to change was fast approaching. On December 1, 2012, the Ministry of Health imposed the DRGS (Gr. KEN) per treatment category of illness. That new method stipulated a single price per illness category corresponding to a predetermined sum of the hospital services addressing treatment of that specific illness. The price remained the same for all hospitals and did not depend on the case-by-case use of medical materials or the days of patient hospitalisation as was the case with the previous system. The method’s main purpose was to stabilise expenses in order to curb the cost of expensive operations and avoid wasteful use of hospital resources. A team of German consultants visited the KAT Hospital in Athens which specialises in trauma and orthopaedic cases, and monitored the function of the DRGS. They did remark that the hospital operated in a way not unlike the one employed by German hospitals, but they also noticed that, instead of the Ministry of Health being the sole monitor of hospital activities, there should be a team of inspectors based in each hospital so as to tighten control. Their observation was aptly highlighting the problem of instituting efficient management practices in healthcare (TO VIMA, 2012). The German team of experts’ concerns aside, the pricing policy was deemed equally useful in determining the 2013 hospital budgets (Kaitelidou and Kouli, 2012). In reiterating, it should be stressed that, as of the beginning of its tenure, the Troika has been advocating and advancing sound NPM practices in Greece such as market competition, cost cuts, auditing controls, and more in order to bolster Greece’s financial activity.

The law that followed, together with the measures that it stipulated, was passed while the Greek government feeling all too painfully the stifling pressure exerted by the foreign powers comprising the Troika and in the context of a highly unstable political and social climate in Greece. The law’s motif echoed: “Structural Changes in the Health System and Other Provisions”[[20]](#footnote-20). Due to the colossal hospital debt that had accumulated and the unbridled spending on public health, priority was given this time to the procurement system. The law’s regulations were described in specific, in-depth detail and deemed mandatory in complying with European Community Law. Financial resources for health had to be monitored and each public health organisation was called upon to provide each DYPE with a plan that specified a certain budget with the provisions needed for the following year. The plans from all DYPEs would be collected and checked by the Ministry of Health. At the same time, stiff fines were set in place by the law for those deviating even by surgical gauze from the approved budgets. As to suppliers to whom payments were in arrears, the law was reassuring: immediate settlement arrangements would be made through the banking system. In order to safeguard the proper law application, the use of authenticity films was required not only for medicines but also for medical devices as well. The goal was to make medical supplies easy to audit by the tax authorities and, thereby, rein in expenditure and effect considerable savings in medical equipment and money.

Another crucial provision of that law was the creation of the National Organisation for Provision of Healthcare (EOPYY) (Goranitis et al., 2014). It was one more effort towards merging the existing social funds (Voudouris, 2011). To be fair, the previous reform laws had stipulated the same but, in their case, the establishment of such an organisation had never been implemented. The reasons lay with the difference in benefits that each Health Insurance Fund provided its insured members with; and the enormous, by Greek public sector standards, organisational and administrative exertion that such a task entailed. As the Troika was keeping a wary eye on developments this time, it came as no surprise that EOPYY did, in fact, take shape. It had the form of a public entity, was supervised by the Ministries of Employment and Health, and was managed by one Governor, two Deputy Governors, and a Board of seven. All were jointly selected by the Ministry of Employment and the Ministry of Health. The governor of EOPYY would be mostly responsible for the uneventful functioning of the new organisation. He also had to monitor the primary care network’s operation and be in synergy with the regional health departments. The seven members of the Board would be involved in matters pertinent to EOPYY’s administration and financial matters and would be the ones to decide on the implementation of projects and the compilation of studies as necessary. With a view to increasing savings, the law stipulated that two hospitals located in the same region be managed by only one manager. Managers administering two hospitals would see their incomes increased by a fifth.

According to the law, successful implementation of EOPYY could potentially: (a) ensure equal access of all insured citizens to a healthcare system common to all which would lead to the promotion, improvement, and subsequent sustainability of healthcare; and (b) group all primary care institutions into a unified network which would thus operate more effectively. Further, the plan anticipated the integration of all major insurance funds (OGA, IKA, OPAD, OAEE, NAT, ETAA Health [former TSAY]) into one superfund that would provide all those insured under the unified funds with health benefits in an egalitarian manner (Antonopoulou, 2014). EOPYY was the first successful attempt to integrate the multiple funds by providing health insurance at first place. That would be the precursor of the complete funds unification later on.

The organisation was designed with one central and seven regional departments which corresponded with the seven DYPEs. There would be one Coordinator per DYPE who would act as representative of the central administration. The law included articles which provided the regulations necessary in harmonising the unification of three, discrete funds into one. It also contained regulations defining EOPYY resources, the manner in which social security contributions would be paid by the funds’ insured members, a schedule for a smooth transfer process (financial and fixed assets, and human resources), the structure EOPYY would have, and details on other issues. It is worth mentioning that, as stipulated by a previous law (3868/2010), doctors absorbed by EOPYY could also contribute to the day-long operation of hospitals that had belonged to ESY (3868/2010). However, an exception to this unification was requested by the Fund of Health Employees (ETAA Health, former TSAY) which insures doctors, dentists, pharmacists, and veterinarians (Unified Insurance Fund of the Independently Employed, 2012). The request was subsequently accepted by Roupakiotis (Ministry of Labour and Social Security, 2012), and conspicuously displayed once more the power held by the medical profession. In the end, the health professionals’ fund, together with the funds insuring other professions joined EOPYY on November 4, 2012 (Unified Health Insurance Fund, 2012): one of Troika’s demands had been finally fulfilled (Ekathimerini, 2012a).

Further provisions of that law concerned plans for the retrenchment of public pharmaceutical expenditure. For instance, in order to shrink the budgets planned, the law stipulated that social care bodies and other public organisations under EOPYY purchase medicines at a reduced price. In addition to that, it envisaged a decrease in the profit of pharmaceutical wholesalers through having them reduce the price of their medicines by 2.4%. With regard to private clinics, the law came with the amendments necessary towards facilitating the clinics’ technological and biomedical advancement. It is from this particular set of stipulations that one may deduce that there was a rising need for private healthcare due to the fact that the public sector was unable to provide quality and/or innovative healthcare. Emphasis was also given to health prevention programmes. In that regard, the law stipulated the establishment of a Nutrition Department within the Ministry of Health as health indicators for obesity in Greece were showing a record high.

In 2011, a second law was introduced regarding the “Reconstruction of Institutions of Social Solidarity, Centres of Rehabilitation, Reformation of the National Health System and Other Provisions”[[21]](#footnote-21). The aim of that second law was to reorganise social care institutions by either abolishing or merging them. That was linked to endeavours to conserve financial resources by achieving economies of scale (Explanatory Memorandum 4025/2011). It required that all institutions cooperate and be in synergy with one another (e.g., cover one another’s needs in staff) in order to function properly. However, that requirement was next to impossible to achieve due to administrative constraints and staff shortages.

All social care institutions in possession of rehabilitation equipment to spare became part of ESY to facilitate and accelerate the recovery process of patients, thereby reducing operational costs. It was also an excellent opportunity for increasing hospital revenues by attracting customers from private funds (Explanatory Memorandum 4025/2011). Up to that point, insurance funds had been paying approximately €52 million to private sector clinics for rehabilitation treatments, not to mention the exorbitant sums spent on rehabilitation centres abroad. That option was underpinned by Minister of Health Loverdos who, together with Deputy Minister of Economic Affairs Sahinidis, decided to concede 556 ESY’s hospital beds to private insurance companies for patients (SKAI, 2011a). Evidently, that was viewed as additional revenue for public hospitals and was linked to the NPM practices adopted by the Greek NHS of outsourcing to the private sector. Emphasis was also given to having of hospitals that were modernised and in possession of cutting edge equipment. The relevant report indicated that Tzaneio Hospital belonged in that category of lure, since the hospital had just obtained ESPA (NSRF) approval to renovate its premises, and establish other patient-oriented facilities such as a Cardiology Section, a Haemodynamic Unit, and fatigue diagnostic and ultrasound laboratories (SKAI, 2011a).

Based on competition principles, the above scenario was about to benefit the private insurance companies as well. They would have to pay less to ESY than to private hospitals on behalf of their clients. For instance, routine surgery such as a tonsillectomy cost €2,500 in a private hospital (anaesthesiologist and surgeon’s fees included), while the price for the same operation in ESY went no higher than €525. The issue of internal control within Greek hospitals was another concern of that second law which foresaw staffing each public healthcare organisation with one to three internal auditors who would oversee administrative, financial, and operational matters. The auditors would have to submit to the hospital manager reports on financial and operational issues relevant to the hospital of their jurisdiction. However, it should be noted that the law decreed that auditors serve no longer than a three-year term, an all too short a period of time for an internal auditor to appraise the breadth and width of an entire public organisation, given the severity of the situation in Greece.

Issues pertaining to medical staff were also included in that law’s stipulations. One such issue under regulation was work arrangements for regional doctors: the law made it clear that their years of service in regional areas counted towards promotional career opportunities. It also invited any and every doctor under contract with EOPYY to contribute to the operation of hospitals when those were on 24-hour, on-call availability. Doctors who were university professors could contribute to their respective hospital’s 24/7 operation for at least two days a week. They could maintain their private practices on condition that they practiced in the afternoons and once they had completed their morning shifts at ESY’s University Clinics (SKAI, 2011b).

It thus appears that both the Greek government and the Troika were fully aware of the fact that the health sector had opened a Pandora’s Box of tremendous deficits due to mismanagement and corruption. In view of that, it had become urgent to trim expenses incurred by Greek hospitals and other healthcare units when procuring medical materials necessary for their operation (Niakas, 2013). The Explanatory Memorandum contained a number of relevant interventions including a reduction in the price of raw materials, supplies, and medicines. To achieve this, it imposed the implementation of managerial tools enhancing the NPM paradigm within the country’s public sector. Such a tool was the establishment of an electronic procurement system along with further changes on the pricing of medical supplies including a watchtower mechanism for comparison of prices. More specifically, application of that measure would ensure that the prices quoted by medical suppliers would be among the lowest in the EU (IOBE, 2011).

Other interventions included the introduction of a public hospital admission ticket at a price of €5 (later increased to €25 euros but still the subject of heated debate). Authors such as Kaitelidou et al. (2012) have observed that many are the patients accustomed to visiting hospitals without any serious complaint, a habit that doctors take advantage of by prescribing unnecessary examinations which only serve in the doctors’ feathering their own nests. By imposing a €5-25 admission ticket, the government was making certain that such wasteful traditions would be curtailed. Moreover, clinics and hospitals, when and where appropriate, would merge while the surplus of personnel would be transferred to other healthcare units (Lambrelli and O’Donnel 2011, Niakas 2013). Overall, the aim of those changes was to create a more efficient public health system which, in the long run, would reduce spending and eliminate rampant deficits.

Other innovations dealt with the introduction of ICT equipment into the health sector. The equipment would include e-prescriptions, a digitised watchdog monitoring the number of prescriptions and medical examinations prescribed by doctors to patients. Another surveillance tool was ESY.NET, a web-based application which collects monthly financial information from all public hospitals (Polyzos et al., 2013). It was designed so that the Ministry of Health and the Troika may observe in real time and obtain useful information on hospital revenues and payments, consumptions, expenses, payroll, and staff mobility. At the sight of discrepancies or anomalies either organisation could then intervene. Those managerial tools would help the Greek government and the Troika to monitor procurements in order to avoid cases of overruns and/or corruption (Lambrelli and O’Donnell, 2011). Overall, it is estimated that, at present, a plethora of electronic tools are already in operation inside Greek healthcare organisations. Related to that issue, the manager of the country’s largest hospital reported that, “Soon Evangelismos will be the first e-hospital in Greece. Everything will be recorded digitally and will thus be easily verified” (Karamanoli 2011, p.304).

**Conclusion**

To reiterate, by looking at the history of the Greek NHS and at the current context, what we observe is that, since its inception, Greek healthcare has been a political concern between a two-party system, (Conservative-neoliberal and Social Democratic), presenting many similarities to the two-party political system of the UK (Dikeos, 2011) however hindering most of the times the implementation of the voted reforms. As time went by, both parties started meeting each other halfway on policies which promoted the marketisation of health and emphasised more broadly on imposing managerial practices in healthcare sector. It may be argued that changes in the Greek public sector did not appear out of thin air. Despite its sluggish pace, managerial philosophy had been gradually introduced and had started replacing the old administrative way of thinking (Kettl 2000, Pollitt 2003). Still, during the economic crisis and under the watchful eye of the Troika, reforms had become a great deal speedier. In that regard, evidence gleaned from the literature shows that true, epoch-making changes are only possible when a hard external crash occurs such as a crisis, a disaster, or a revolution (Kickert, 2011).

It may be of some value at this point to provide ahead of the evaluation in a subsequent chapter an assessment picture of the changes so far. As stated in Spiegel Online (2013):

*“There were some significant successes, the IMF says. Greece has been able to stay in the euro zone and the spill over effect on the global economy was relatively contained. Yet the report on Wednesday also concludes that the IMF and its partners in the bailout significantly underestimated how much various austerity measures, such as spending cuts, layoffs and tax increases, would impact the Greek economy”.*

To put it bluntly, the Greek people were being forced to pay the price. Another review remarks:

*“Despite tough sacrifices being demanded from Greece, the policy program will not address the key problem of getting sovereign debt dynamics under control. At the same time, with a policy of generalized cuts in the pipeline (public sector cuts, pension cuts and cuts in private sector wages), Greece could fall into a period of prolonged stagnation coupled with deflation”* (Janssen, 2010 p.7).

Hence, the answer as to whether NPM is beneficial for the country or not depends on the context in which NPM is used. Most assuredly, Greek society is running the risk of collapsing if the market mechanisms intervene to a large degree within the public sector. Such an approach will only diminish social welfare.

To support the main aim of the present research, an integrated analytical framework will be used, with NPM being its core. As far as the reform of the public sector is concerned, the study offers food for thought. Based on a thorough review of the critical literature and the experiences of other countries that have made full use of the NPM, the analytical framework will facilitate one to actually compare, test, and critically evaluate how reforms are now being applied in Greece and what changes are now being introduced. However, it is not only the managerial practices that play an important role in state reform. Strong emphasis is also given to the ideology of the neoliberal agenda that comes with the NPM and the IMF. Arguably, it is more difficult for a state to alter the ideology of its public sector than to change some of the practices. It may, therefore, be the case that the sustainability of public sector reforms may have to rely on both transformations. The framework is founded on the ontology of Critical Realism which helps illuminate the organisational structures and reveal hidden mechanisms and the Principal-Agent Theory that illustrates the actions and games of power between the key NHS actors. Both are indispensable in understanding how NPM reforms have been developing in Greece. The following chapter provides an overview of the New Public Management paradigm not only in terms of practices but also in terms of ideology. Trajectories from other countries following a similar path are identified, while their implementation strengths and limitations are highlighted. The integrated analytical framework is presented analytically after the chapter discussing the NPM.

**Chapter 3: Towards New Public Management in Healthcare Organisations**

**Introduction**

Though the current recession is severe and its impact has been sudden, the role of the welfare state to protect its citizens and honour its liabilities is strongly questioned. Remedy measures might be characterised as either strict and painful or somewhat more moderate, depending on the intensity of the phenomenon and the state of each country’s economy. In any case, the NPM approach represents the most recent global organisational theory that aids in the transformation of the public sector by using management techniques tried and tested in the private sector (Matei and Flogaitis, 2011).

According to Hood (1995), NPM is a movement on the part of the public sector to become more like private business with practices borrowed from the open market. NPM is not a mere collection of tools and methods, it also brings technocratic ideology within the public organisational setting (Edwards, 1998). Common regulatory mechanisms include improvement of efficiency, the reduction of public spending, and the establishment of performance-related methods. All of them have the same purpose behind the NPM cadre: to foster economic and managerial values within the public sector in order to harvest productivity. Lapsley (2009, p.19) advocates that “the current global financial collapse intensifies the importance of NPM to reforming governments. The financial crisis underlines the significance of NPM for the next decade at least”. And even though emphasis is given to efficiency of the economy, the question remains whether changes can be implemented and bring about efficiency in society as a whole without altering the role and nature of the civil service. Indeed, many have been the critics so far who have argued that public and common good values have been undermined due to the dominance of the business-oriented and competitive values that NPM promotes (Rhodes 1994, Ormond and Loffler 1998, O’Flynn 2007, Gorsky 2008, Diefenbach 2009a). An equally important point is that the results of NPM are difficult to assess quantitatively because the methods used to that purpose are not good enough (Christensen and Lægreid, 2001).

In Greece, even years before the crisis reared its head, the progress of public sector reforms (health reforms included) has always been cumbersome and without significant results. Potential remedies were mainly constrained by political competition and bureaucratic structures, as well as by the lack of managerial planning (Sotiropoulos 1996, Pelagidis 2005, OECD 2009d). According to the OECD’s most recent survey (2011, p.5):

*“Greece needs to modernize its economy by adopting structural reforms that move its public sector, labour and product markets closer to international best practice. Public services need to improve and confidence needs to be restored between the Greek citizens and their government”.*

While that suggestion is theoretically correct, it fails to take into consideration the country’s socio-economic dynamics. However, it does depict the prevailing perception that the Greek public sector needs to rectify and align its operations more closely with internationally benchmarked standards, something usually considered the private sector’s domain.

**New Public Management Origins**

NPM emerged in the USA, where sociologists such as Shils and Parsons challenged the empirical tradition of that time (Hasley, 1982). It then spread to the United Kingdom, Australia and, especially, New Zealand, and then to Scandinavia and Continental Europe. NPM is part of a managerial revolution that has grown around the world. It was gleaned from the neoliberal ideology that market economics are more efficient than state regulation (Turner, 2008) and has been implemented by many countries, although to degrees considerably different between and among them.

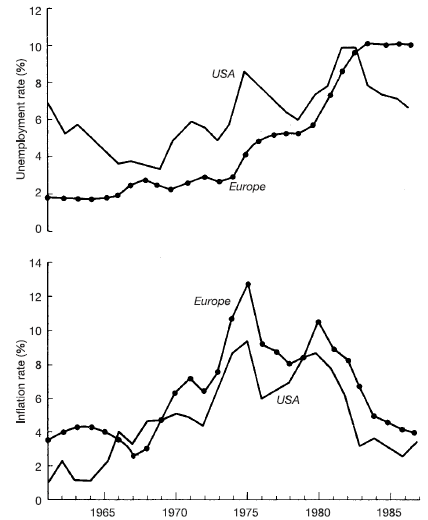
If the differences that exist in the use of the above paradigm are to be understood, it may be of interest to refer to the taxonomy provided by authors so far on the association between countries and the use of NPM. Hood (1995) distinguishes country leaders from country laggards according to the chronological order of NPM use. Bach and Bordogna (2011) critique the above distinction by arguing that it is of no great importance which country implemented NPM first, what mostly matters is the level of adoption by each country. They assert that there are many varieties as far as reform characteristics are concerned, but they accept the ‘first mover’ countries (USA, UK, New Zealand and Australia) or ‘marketisers’ (Pollitt, 2007) which pursued the NPM reforms enthusiastically in the 1980’s. Those countries are now seeing the changes becoming the norm in their public sectors (Dunleavy et al. 2006, Turner 2008). Further, the two authors claim that many European countries, such as Germany and France, did adopt NPM practices, albeit to a more moderate degree than the first core group, due to the ingrained Weberian traditions they had shaped. In that case, changes were not too turbulent because they were gradually adapted to the existing, classic public administrations. The authors call that group of countries “the neo-Weberian states”. Admittedly, most continental European countries have had in the past and still have their public sectors attached to state-controlled traditions. In relation to political regimes, Bach and Bordogna (2011) argue that, as far as the UK and the USA are concerned, NPM was inspired by Conservative governments but in the cases of Australia and New Zealand the same paradigm was initially implemented by Socialist governments in a modest manner at the beginning and on a more intense level by their Conservative counterparts.

It is worth conducting a brief historical overview so to trace the NPM’s origins and follow the evolutionary thought and development of management as pioneered by the private sector and as adopted –gradually or forcefully–by the public sector. The aforementioned paradigm was initiated as an ideological rationalisation, a so-called ‘answer’ to rigid bureaucratised practices that were prevalent in the public sector of the Western world in or about the 1970’s (Stoker 2006, Diefenbach 2009a). In the UK, the classic public administration and the bureaucratic paradigm remained unchanged until the late 1970’s (Gruening 2001, Pollitt and Bouckaert 2004) when, under the supervision of the IMF, an intervention into the country’s public sector through reforms was organised (Dunsire and Hood, 1989).

Hence, from the 1980’s on, a new approach began to be discussed and to gain prominence in the UK and the USA. The fiscal crisis, the inflationary stagnation, the oil crisis, long-term unemployment, and failure of the state as an institution to protect and provide for its citizens had seriously assailed governments and the public (Olssen, 2009). The diagram below illustrates the severity of the economic situation in the USA and Europe during the 1970’s. Similar trends are observed in unemployment and inflation rates between the USA and Europe. Curves reached their peak between 1975 and 1980 (Diagram 1).

**Diagram 1: The economic crisis of the 1970s: inflation and unemployment**

**in the USA and Europe, 1960–1987**



**(Diagram source: Harvey D., 2005, p.14)**

Citizens began voicing their resentment by asking for a return on the money they had paid in taxes for public services and benefits (Borins, 2002). The protests were followed by a host of scandals and dramatic failures in public services which reduced the public’s confidence in the state (Ackroyd et al., 2007). In that light, the Keynesian welfare state was viewed as an inefficient mechanism and its role disputed. It was time its position was challenged by a new ideology under the newly coined term ‘neoliberalism’, supported and disseminated by neoliberal economists such as Friedman, Hayek, and the theorists of Public Choice in the USA (Olssen, 2009) who showcased neoliberalism as the only orthodox answer to a ‘series of gyrations and chaotic motions’ of that era (Harvey, 2007).

On the one hand, there was a lumbering, lethargic, and uncreative bureaucracy in the public sector and, on the other an air of change and productivity swept through the private sector (Savoie, 2006). Endeavours to copy the managerial paradigm from one sector to another seemed logical and potentially feasible. Admittedly, the matter was in the hands of the two most powerful Conservative leaders of that époque. The waning trust in the state and the growing public need for accountability created a broader shift in rational management. Ronald Reagan on one side of the ocean, and Margaret Thatcher on the other were the “right” pioneers to propose and start using market models in order to stimulate the public sector and refurbish public services. The trick was to increase efficiency and maintain, if not reduce, public budgets (Klein, 2010). Some commentators argue that the two politicians used the ideology of the NPM as political propaganda and as a means of wining public confidence over (Haque 2004, Savoie 2006).

Since those times, the world started altering in terms of socio-economic development. On that change, there is a high volume of rhetoric. Aucoin (1990) points out that the NPM approach coincides with the globalisation of economies. Along similar lines, Osborne and Gaebler (1992) describe the NPM as a global paradigm that was needed as the basis for transition from inefficiency to entrepreneurial spirit. Thatcher (1993) highlighted the need to shrink the public sector by cutting public spending and by introducing managerial and economic values in order to reform it efficiently. Her vision to battle the ills of the public sector (Osborne and McLaughling, 2002), together with Reagan’s vision to instigate a war against waste (Lynn, 2006), denote the need for changes in the public sector. The Weberian public bureaucratic model began moving towards a more neoliberal, consumer, and market-oriented framework (Haque, 2004). A process-oriented organisation was being gradually replaced by an outcome-orientation public enterprise which applied private sector management techniques and tried to respond to market competition in order to survive. Change was not any easy path. There was strong opposition and resistance from impersonal bureaucrats who were unwilling to rise from their seats to meet the new challenges. As Ackroyd et al. (2007, p. 11) mention “Public services were to become managed services, efficient and performance oriented. A key aim of the reform was to reduce (if not eliminate) the autonomy and independence of the professions”. Still, it was not only managers but also the strictness of procedures and monitoring systems which limited professional independence (Ward, 2011). Viewed in those terms, the NPM seemed a threatening paradigm and not the best way of introducing change seamlessly. Hence, not only did those conditions prevented a dynamic organisational culture, but they also thwarted employees’ enthusiasm to work towards change (Crouch, 2003).

Nevertheless, a historical shift gradually started taking place after the crisis of the 1970’s. It was mainly characterised by the monumental transformation away from state control to free market economics. A radical wave of reforms was emerging as a reaction to financial crisis and to unproductive, inflexible organisations (Pollitt, 2002). Technological advancements (IT, transportation, communications, etc.), market completion, emerging clientele, and other factors pushed the organisations into gaining their flexibility. Flatter hierarchies and decentralised decision-making were about to improve organisational efficiency (Radcliffe and Dent, 2005). At that time, the NPM appeared as a new theory for reform with universal applicability (Radcliffe and Dent, 2005). Since then, the NPM has been holding strong, becoming an unquestioned paradigm of public sector reforms. The crucial point here is that the NPM provides a set of tools and methods and does not represent a single choice. Pollitt et al. (2007b) liken it to a shop where you can buy select products. Those illustrations reflect the NPM’s distinctive features, such as flexibility and adaptability and, to some degree, may explain its universalistic appeal and use to the present.

**New Public Management as a Practice**

As of its inception as a managerial paradigm, NPM has been concerned with building on goal-orientation, competition, performance appraisal, thorough follow-ups, and freedom of choice within organisations in order to avoid bureaucratic and time consuming processes (Almqvist and Skoog, 2006). Managers within public entities use the appropriate tools to achieve improved service, value for money, and cost-effectiveness in order to gain greater accountability in the face of demands for results achieved made by funders, stakeholders, and clients. One of the first theorists who categorised and described the main principles behind the NPM is Christopher Hood in his article ‘A Public Management for All Seasons’ (1991). His model is particularly useful in describing the practical dimensions of the NPM and in that respect it contributes to evaluating public sector reforms. In brief, NPM’s seven dimensions are: stress on discipline and parsimony in resource use, disaggregation of public organisations, competition in the public sector, private sector styles of management practice, hands-on managers, emphasis on output controls, and measurable standards of performance (Hood 1991; 1995). Another analysis provided by Ferlie et al. (1996) identifies four distinct variants of the NPM: the efficiency drive, downsizing and decentralisation, in search of excellence, and the public service orientation. In the table below, Thomas Diefenbach (2009a, p.894) provides a broader overview of NPM’s basic practices and core elements emphasised in five main areas (Table 3)*.*

**Table 3: Core elements and Practices of New Public Management**

|  |  |
| --- | --- |
| AREA | CORE ELEMENT |
| 1) Business environment and strategic objectives | assumption of strong external pressure, of a much more challenging and changing business environment |
|  | conclusion that there is a need for a new strategy and that there is no alternative for the organisation but to change according to larger trends and forces |
|  | market-orientation: commodification of services under the slogan of ‘value for money’ |
|  | stakeholder-orientation: meeting the objectives and policies of strong and influential external stakeholders |
|  | customer-orientation: service delivery from a customer’s perspective |
|  | increased organisational efficiency, effectiveness, and productivity defined and measured in technological terms |
|  | cost-reduction, downsizing, competitive tendering, outsourcing, privatisation of services |
| 2. Organisational structures and processes | decentralisation and re-organisation of organisational units, more flexible structures, less hierarchy |
|  | concentration on processes, that is, intensification of internal cross-boundary collaboration, faster decision-making processes and putting things into action |
|  | standardisation and formalisation of strategic and operational management through widely accepted management concepts |
| 3. Performance management and measurement systems | systematic, regular and comprehensive capturing, measurement, monitoring and assessment of crucial aspects of organisational and individual performance through explicit targets, standards, performance indicators,  measurement and control systems |
|  | positive consequences for the people working with and under such systems such as increased efficiency, productivity and quality, higher performance and motivation |
| 4. Management and Managers | establishment of a ‘management culture’: management is defined as a separate and distinct organisational function, creation of (new types of) managerial posts and positions, emphasising the primacy of management compared to all other activities and competencies  managers are defined as the only group and individuals who carry out managerial functions |
| 5. Employees and corporate culture | empowerment and subsidiarity, staff are expected to develop ‘business-like’, if not entrepreneurial, attitudes |
|  | idea of leadership and a new corporate culture |

The table portrays the key areas of the NPM and the core competences used in strengthening public services. A vital factor here is the degree to which those practices are embedded in the public sector. Some of the changes may be applied forcefully and others may need to be subjected to a step-by-step process in order to give managers time to implement them and people time to evaluate them, so as to decide whether to accept or reject them. The choice of NPM instruments that a country uses and the rate of their application reflect the variety in patterns of reforms and the discrete historical and cultural traditions of each public service. It is worth analysing briefly some of those applications, at least the most distinctive ones, in order to identify the various reform paths and try to critique whether the changes under implementation in Greece at the moment may be characterised as pieces of NPM. As Pollitt and Dan (2011) highlight, many scholars confuse the NPM with public administration reforms and that the only way to differentiate between the two types is to match the characteristics of the actual reform agenda with the characteristics of an NPM paradigm.

The first NPM principle heralds the act of decentralisation and places the focus on delegation of authority since, according to Deifenbach’s table (2009a), decentralisation is a key component of the organisational process. That aspect of the NPM is concerned with eliminating bureaucratic procedures and turning public organisations into enterprises which are flexible and managerially autonomous. The rationale here is to decentralise decision-making by rolling back the government and, instead, defer power to local authorities (Klein 2006, Ormond and Loffler 1998). In practice, that means that local needs are better responded to when leading to a growing investment at the local level not only in terms of financial resources that could support such needs but also in terms of a workforce in possession of the appropriate skills. The impact of decentralisation in the UK has been discernible. Between 1997 and 2002, the number of managers in the NHS rose from 21,400 to 30,900 (Ackroyd et al., 2007). In view of that, Thatcher succeeded in her goal to transform “the centrally planned and administered NHS in favour of managed localism” (Klein, 1995). Indeed, it was in 1988 that regional health services had already developed and internal competition within the centrally planned NHS was engendered. Those facts undermined the power held by trade unions and, at the same time, fortified the competition of labour. They also indicate that the role of policymakers in reforming a public sector is indispensable. As Kirkpatrick et al. (2013, p.56) assert:

*“the nature of rules in a given context – how much leeway they leave for local interpretations and deviations from the template–will depend upon elite perceptions of the desirability and feasibility of reforms. With regard to desirability, it is often noted that the level of commitment of policymakers in different countries to the restructuring of public services has been highly variable”.*

Therefore, it may be assumed with some certainty that one of the factors influencing the implementation of reforms is the game of power between key stakeholders. Suffice to say, the willingness and serious engagement of political actors in establishing feasible reforms play a leading part in the game.

Equally important is another NPM principle: customer orientation. An integral part of the business environment, it is a vital weapon in the armoury of strategic objectives. In this case, it becomes even more important as stresses the importance public users have for healthcare systems. When Parker and Dent (1996, p.335) refer to the managerialistic change in the British NHS they denote that “businesses have found that making the consumer the focus of organisational goals provides a meaningful and internalised philosophy common ground which all organisational employees can relate to equally”. In other words, customer needs and service quality are in the central ambit of each organisation, public or private, and strategies are to be formed respectively. That reminds the “Consumer as a King” motto cited by Bolton (2002) where it is noted that the new NHS plan and NPM philosophy embedded in the UK required entrepreneurial attitudes towards customers and consumers. Aberbach and Christensen (2005) illustrate the same point by talking about “customer sovereignty” explaining that it is of great importance for public organisations to satisfy public needs. In a similar manner, Dent (2006) highlights that the new managerial reforms give power to the customer who is free to choose; and force professionals to work harder and compete with each other in order to satisfy customer expectations. However, the power of the customer depends on the freedom extended to professionals so that they may exercise that power. As Christensen and Lægreid (2002, p.283) assert “The rights of a customer are really quite minimal compared to those of a citizen and the relationships to public service providers are short-term and temporal in nature”. In the same vein, Cohn (1997) claims that NPM brings in an opposite mentality to the Keynesian welfare state and focuses only on protecting the market from the citizen rather than the other way round. Further, it is apparent that NPM reforms imply large-scale cost reductions which, to a certain extent, fragment and limit the range of public customers’ choices.

Cost reduction represents one of the most prominent aspects of the NPM. Any time there is a discourse on recuperation of the public sector it usually revolves round money. As Bolton explains (2002, p.131) “The target of the financial efficiency remains at the heart of management reform”. To achieve that type of efficiency managers usually summon forth techniques such as budget controls, modernised accounting systems (Le Grand and Bartlett, 1993), outsourcing or contracting-out, privatisation of services (McKendrick, 2002), and investments in greater productivity, to name but a few. Admittedly, that kind of change has to be rigorously implemented in order to rectify money shortages; and provide better information on the sustainability of fiscal policies, and a stronger basis for accountability and transparency (Torres, 2004). Needless to say, setting formal financial indicators and turning to specialised auditors who will record and control the whole process is implied.

Outsourcing –or contracting out– is a NPM element that deserves special mention since its merits include the promotion and furthering of competitive behaviour in the public sector. It usually refers to public and private sector partnerships with the purpose of gaining mutual benefits. Studies have estimated that public costs can be reduced by 20% by using this practice (Ormond and Loffler, 1998). On the one hand, private companies strive to establish business relationships with an important public sector customer and, on the other, the public sector benefits from quality, competitive prices, cost-savings, and efficiencies provided by private enterprises. Some common types of outsourcing so far employed include: consulting services, cleaning and catering, buildings and grounds security, and other specialised operations. It is precisely that element of NPM which has endowed the public sector with a new marketised system of service provision (O’Flynn, 2007).

Performance appraisal is an NPM element whose purposes are threefold: it sets and determines the standards of good performance; measures and evaluates outputs; and, proceeds to administer rewards for success and sanctions for failure. Its importance may be gleaned in the examples of Finland, the UK, Sweden, and the Netherlands, where all reforms implemented included the modernisation of those countries’ performance appraisal systems. According to Pollitt and Bouckaert (2000) the approach reflected a convergence between the nations in terms of the tools they have used to reform. Further, the literature insists on the method of performance management as a means towards modernising public organisations and evaluating reforms (Durst and Newell 1999, Zeppou and Sotirakou 2004).

With regard to the appraisal systems of reward or punishment Ward (2011, p.7) argues:

*“this approach utilized market-based incentives through direct awards made to individuals whom they or auditing reports deemed meritorious. Sometimes these incentives appeared in innocuous forms, such as ‘Employee of the Month’, ‘Awards for Excellence’ or ‘Teacher of the Year’, in other situations, however, they involve more elaborate incentive systems such as merit based pay increases, discretionary release time, or other performance-based incentives. These incentives were designed to create a competitive environment that, like the entrepreneurial environment of the marketplace, would spur motivation, while punishing and shaming the lazy and unmotivated”.*

To that extent, it may be estimated that professional collective power weakens when internal competition between individual professionals is forged. Referring to the performance management in the health sector of the UK, Klein (2006, p.214) argues that “Hospitals would be rewarded for the operations they carried out so that good hospitals would attract more patients and more funding”. However, one might argue that the pursuit of more and more patients may diminish the quality of treatment and performance. It is important to stress here, that each country, depending on its internal needs, can use different key performance standards. Apparently, international benchmarking has set some common performance indicators for each type of public sector. For instance, in higher education some common performance indicators for universities include, among other things, the number of Ph.D.’s awarded each year, the number of scholarly books published, and the number of research scholarships granted (Schmoch and Schubert, 2010).

Management culture is at the very foundation of NPM as it makes the latter’s status crystal clear. No efficiency is viable in an organisation unless all proposed reforms are supported by the right culture accompanied by the appropriate organisational values. As managers are the most appropriate ones to solve problems and bring about efficiency, they are given the power and responsibilities that elevates them to the status of agents in charge of change (Diefenbach, 2009b). They actually try to change the culture in an organisation by pushing back the professional groups and by duelling within their own culture. Emphasis is given more to managerial skills than policy exercise due to the fact that the change in the public sector requires the implementation of new managerial practices and establishment of output objectives (Schimank, 2005). To that extent, Cleveland (2000) advocates that good performance can be achieved only if managers are free to manage implying the importance of moving from central administration towards a more public self-regulation model. However, even in that case, one might question if the above might result in a degradation of flexibility at work and the promotion of autocratic practices.

Edwards (1998) identified four core competences of managerialism: efficiency, faith in managers, class consciousness (common values between managers that contribute to their class maintenance), and managers as moral agents. The work of managers in that case involved not only changing the values of employees but also satisfying the public as customers. Evidence has shown that managers are motivated by the power and value that is given them in order to bring about efficient changes for the public good (Lapsley and Oldfield, 2001). Obviously, the hidden aim of any movement based on the NPM is attitude and mentality change in the public sector, namely the alteration of the organisational culture and the way in which people are accustomed to working and thinking of their work commitment (Parker and Gould, 1999). All of the above demonstrate that a manager’s focus is not merely on improving employees’ performance but also on changing the employee mentality of how public service is offered to customers rather than patients.

**New Public Management and Factors of Adaptability**

As previously mentioned, NPM flourished in countries such as the USA, the UK, New Zealand, Australia, and Canada and was partly adopted by others. Some of the factors that tended to favour the extended use and adaptability of the NPM paradigm in some countries are worthy of examination.

Notably, many scholars take into consideration the concepts of a country’s culture when researching its public sector development (Granovetter 1992, Katrougalos 1996, Perry et al. 2010). As Granovetter (1992) maintains, institutional reforming and development is highly affected by social and cultural conditions. For instance, a major war as in the case of Greece, and the country’s subjugation by the Ottomans for 400 years (1453-1821, can deeply affect a country’s dynamics. On that important issue, Christensen and Lægreid (2007, p.7) assert that:

*“Different countries and different political-administrative institutions within them have developed along different paths determined by the context in which they were established and their historical roots. This has led them to evolve a distinct culture through a gradual adaptation to external and internal pressure. When reforms come along, the question of compatibility between a country’s cultural traditions and the content of a given set of reforms will be crucial. Reforms that are culturally deviant will easily be bounced back or changed, while culturally compatible reforms will quickly be implemented”.*

However, adaptability to change does not only depend on the compatibility between the culture and the change but also on the will and power of the citizens and political actors to improve the efficiency of their state. As argued by Pollitt and Bouckaert (2011), the spread of managerial reform is highly dependent on the perceptions of policymakers who have the power to measure and understand what is feasible and rational to be implemented in their country. Case in point, Greece which, together with Spain and Portugal, belong to a group of countries reluctant to reform so far, due to a number of reasons such as lack of political will, but also because of the strong resistance exhibited by various professions. On the other hand, the UK and Australia had the political will and the power to focus intensely on the organisation of their state as well as on managerial values that could facilitate and sustain the reforms.

Another factor influencing the adoption of NPM principles is the extent and level at which the state intervenes and applies the reins. As Sotiropoulos (2004) argues, there is no doubt that public governance relegates to protectionism, autocracy, ownership, legalism, and bureaucracy. The same author asserts that the above characteristics are common between the Southern European political models and even though they have declined in intensity, they do not leave enough space for drastic NPM reforms. That holds especially true of Greece. Philippidou et al. (2004) echoes Sotiroupoulos’ claim and stresses the fact that bureaucracy in Greece acts in an inhibitory manner on innovation and personal commitment. As for Spain and Italy, there is evidence of a co-existence between the Napoleonic state model and managerial reforms (Ongaro 2008; 2009).

Another factor that constitutes a setback for new reforms and characterises the political and social life of Southern Europe is patron-client relationships. Known as clientelism, it may be defined as “the misuse of public power for private personal or party gain” (Ongaro 2009 p.227). Mostly, it portrays the relationships that exist between political appointees and politicians. Each benefits from the other; in particular, politicians raise their popularity by offering jobs to their voters who occupy public posts regardless of their capabilities and knowledge. For instance, in Greece many of the hospital managers are political appointees and as a result the efficiency of the potential reforms is questioned (Liaropoulos et al., 2012). Obviously no politician wants to break that “balance” and for that reason they try to brush aside new policies and reforms that threaten it. As stated by Featherstone (2015, p.5) “these traits are both drawn from wider society and promoted within it by the state itself, with one feeding on the other”. Dent (2003b) correlates clientelism with familiarism (political heirs of friends and family members in dominant public sector posts) arguing that both practices might result in corruption and inefficiency. According to Dent, the phenomenon is so embedded in the European South, that governments are ineffective and incapable of protecting the welfare state from those forms of illegitimate practices (Dent 2003b). Seen in the light of the Greek context, the insinuation that the jurisdiction system is not strict enough with the offenders is clear as day (Economou 2010, Smith 2014, Kwok 2015)

Another prism through which one may explain clientelistic practices in the political and social life of the country is the historical and cultural traditions that the Ottoman Empire imposed on Greece for 400 years. As Dent (2003b, p.144) puts it:

*“This was the outcome of a transition to a parliamentary system of government without any organised populist movements…and with its intolerance of a civic society which survived into the country’s modern era”.*

Interestingly, the issue of the importance of a civic society has also been raised by the political scientist Robert Putnam. By conducting a social experiment in Italy he identified differences in the political, economic, cultural, and social life between Northern and Southern Italy, which he attributed to the more collectivist nature of the society developed by the Northern Italians. To be fair, their Southern counterparts did not have the chance to develop in the same way due to the invasion of their area and subsequent occupation by the Normans in the past. The implications of Putnam's findings are profound and seem to fit the Greek case which shares similar historical experiences. In that sense, Putnam et al. (1994, p.88) argue that:

“*The more civic a region, the more effective its government… citizenship in the civic community entails equal rights and obligations for all. Such a community is bound together by horizontal relations of reciprocity and cooperation, not by vertical relations of authority and dependency. Citizens interact as equals, not as patrons and clients or as governors and petitioners”.*

In a nutshell, spiritual freedom and civic participation nurture the development of all aspects of human life.

Among the many obstacles reforms have to override before attaining successful implementation is availability of resources. Pollitt (2010) denotes that the level of “sacrifices” and the success of the new reforms in a country depend on that country’s assets at hand. The appropriate knowledge (know-how) and the right people in the right positions also constitute factors crucial to the whole process as does the role of leadership. To illustrate, Margaret Thatcher in the UK and Ronald Reagan in the USA pioneered the public sector transformation whilst driving a public agenda based on a new political regime. As Philippidou et al. mention (2004, p.332):

*“it is generally accepted that changing an organisation is really about changing people’s behaviour and culture. Thus, we can assume that leadership plays an important role in the implementation of public sector reforms because it involves two of the most important aspects of reforms: change and people”.*

Nevertheless, while that suggestion is theoretically correct one might wonder who the leaders are in this case. Are all the managers capable of being change agents and leaders? Or is the role of leadership set aside for the politicians who enact laws and formulate policies for the public sector? From the point of view of Greek standards, the difference is obvious and discernible. Politicians have shown so far that cannot assume the leadership role: they change far too frequently, due to the lack of political stability in the country, and are far afraid of the political cost they would shoulder by imposing transformational changes on Greek society.

Some authors claim that a crisis is a ‘window of opportunity’ for reform. However, there are two sides to the crisis coin. On the obverse, when a crisis emerges, authorities are placed on the alert and try to find efficient solutions in order to overcome it. Indeed, Manuel Barroso, the president of the European Commission insists that the current difficult financial situation represents a “wake-up call” for all European countries. They must undertake the necessary changes in their public sectors and collaborate with each other in order to promote economic integration and growth (Donelly, 2013). In addition, history has shown that the pivotal crises throughout the world have been the starting line for major reforms. To illustrate, it is worth remembering the way the world changed after the terrorist attack of September 11, 2001 on the World Trade Centre. Another example comes from Japan which, after World War II, was transformed from an agrarian society into a country massively industrialised and urbanised. New Zealand also saw the financial crisis of the 1980’s as an opportunity for radical reforms despite the fact that they were introduced by the Labour Party (Aberbach and Christensen, 2002). On the reverse, the coin upholds that the crisis itself does not provide the appropriate climate for facilitation of changes: attempting to make radical reforms in a turbulent economic and political environment without the appropriate resources remains a key issue.

**New Public Management in Health**

The impact of NPM initiatives has been especially felt in the healthcare sector. Over the last forty years, many developed westernised governments began building healthcare systems by investing a significant amount of financial resources as a matter of public pressure for equal access to health services but also for improved quality. As the population grew, the needs for healthcare increased and resources started becoming scarce. At that time there was a need for change. As Bolton (2002, p.29) points out “NPM has been given the task of changing hospital culture and making service provision more efficient, effective and accountable”. Dent (2005) contends that this change was more managerial oriented than professional, and influenced many healthcare systems of Europe in the 1980’s and 1990’s. Most of them placed the emphasis on adapting NPM characteristics without altering their existing traditional public administrations.

In 1994, the Greek NHS system did receive a number of proposals regarding managerial initiatives from the scientific committee led by Abel-Smith in 1994. Some of them were institutionalised over the following years. They included tickets of admission to hospitals, managers in hospitals, public-private sector partnerships, and more. Nevertheless, their implementation was arduous. For one thing, there was no political support to sustain them and, for another, they met with strong resistance to change. Radcliffe and Dent (2005) believe that NPM ideology reflects the need for more rational spending in healthcare and is considered the answer to the increased professional power of doctors. Their allegations resonate with two of the main problems that impede the development of the Greek NHS: fiscal constraints; and strong professional reaction to new reforms.

Daniel Simonet explains (2008, p.619):

*“Similar to its practice in many other public arenas, the application of New Public Management to the healthcare sector has several features: using market forces to serve public purposes; demanding organisational performance; fostering greater accountability and transparency from providers; increasing patient financial responsibility; looking for savings; providing higher-quality services; bringing resource allocation closer to the point of delivery; using contracting-out; and enlarging the coalition of players”.*

The above points make it clear that the movement of new public change relies on ideas and tools of the private business such as management being brought into the public sector of health with a view to making the latter being more competitive in the market (Ehsan and Naz 2003, Mongkol 2011).

In fact, there are some prevailing tendencies in society that do contribute to the expansion of marketisation in health. For instance, health consumers feel compelled to pay for services offered by private hospitals so as to obtain better quality of care without having to wait too long, despite the fact they would certainly prefer good quality in public healthcare that is free. That tendency has its roots in people’s diminishing disposable income, the growth of the civil society and the ensuing demands for public services as well as public failures. Globalisation and the expansion of medical tourism and the mobility of patients across borders in pursuit of medical treatment institutionalise the competition between health organisations in international contexts. It is on this platform that information technology comes to contribute its mite by playing a vital role in the modernisation and transformation of public hospitals. As Parker and Dent (1996) argue, the introduction of IT in the NHS serves many purposes such as ensuring accountability of managers but also of doctors, providing a key monitoring tool for budget use, aiding in administration of hospital departments, and collecting important information of patients (i.e. medical records). Medical equipment and health technology are also pushing market elements into the health ring, as they consist of costly investments, especially for public hospitals. Their technical support and service is also of major importance. Therefore, partnerships with private companies are encouraged. Nonetheless, there is a tendency for private hospitals to be more technologically advanced than their public counterparts, in the hope of attracting more customers and thus gain the competitive edge not only over other private hospitals but also over public ones.

Government policies seeking to tidy up public health expenditure are a key driver. Public health organisations consume a large part of a government’s budget. Contracting out hospital services, cost-sharing policies, tickets of admission to public hospitals, and selling off public services to private companies are some of the strategies used by public hospitals that are reminiscent of an NPM approach and pertain to efforts to save valuable resources. Another tendency is privatisation in general as a predominant ideological phenomenon linked to wider political and social developments. As Maarse (2006, p.1006) supports:

*“privatisation should be considered an embedded process that is heavily influenced by wider developments in public policy making, in particular a paradigm shift from state planning to market competition, individual responsibility, consumer choice and so on”.*

In so doing, the limits between the private and public sector are minimised to serve as the basis of efficient partnerships between them. However, there is the danger that the character of public goods such as health and education are undermined if they become privatised, as they induce social inequalities by burdening free access to services.

**Trajectories of New Public Management in Health**

Many countries experiencing problems of inefficiency and corruption in their public health sectors in the past were more likely to have used a business-focused paradigm, i.e., New Public Management, in order to reform. An interesting case is that of British hospitals, where the NPM paradigm has been given the task of changing hospital culture by creating cost-effective service provision and quality-conscious health workers (Bolton, 2004). According to Pollock (2005), management consultants tried to change the doctors’ working culture within hospitals and steer them towards thinking more like entrepreneurs who had limited job resources. More importantly, recent reposts in the UK emphasise the internationalisation of the UK’s NHS (BBC News Health, 2012):

*“High-profile NHS hospitals in England are to be encouraged by the government to set up profit-making branches abroad to help fund services in the UK. This could include everything from setting up and running new hospitals to advising on aspects of healthcare. Funding for such ventures would come from private investment, not NHS cash, and any profits would be used for UK services”.*

Not only that but the reforms in the UK’s NHS have come with another upside, as they have heralded internal competition between hospitals (Gaynor et al., 2010), with patients being free to entrust their care to the hospital of their choice. The implication here is that public healthcare organisations compete with one another in order to attract more customers and increase their profits. Moreover, recent studies reveal that hospital competition has increased clinical quality (Cooper et al., 2011) and hospital efficiency (Cooper et al., 2010). Nevertheless, conflict still remains at the core of the relationship between health professionals, the State, and the managers (Marshall 2008, Brown et al. 2011) signifying the critical point of how long the change process of public health bureaucratic structures can last and how successful those changes may be. Klein (2001) argues that attempts to make doctors think as entrepreneurs were lukewarmly successful while, according to Dent et al. (2004), the emphasis on discipline and financial stringency came as a shock to professionals and employees alike.

Portugal is another interesting case. In an effort to rectify the country’s public health Portugal established an Experimental Payment System (EPS) of General Practitioners in 1999 (De Sousa and Pisco, 2007). Twenty groups of physicians, nurses, and administrative staff accepted the new method of payment which was adjusted to the number and nature of cases they had to deal with, and the treatment duration each case involved. The initiative, although an experiment not legislated by law, worked quite well. All twenty groups worked in primary care centres and developed strategies of autonomy and collaboration which improved their efficiency significantly. Five years later, the results of their evaluation showed an increased number of treated patients with better health indexes, and a retrenchment of expenditure due to savings in diagnostic examinations and prescriptions. More than that, it was expected that 175 more groups of General Practitioners would join the primary care of Portugal by the year 2008. Still, it should be pointed out that, although hugely successful, that system runs the risk of doctors shaping their decision making according to monetary motives rather than according to their patients’ real needs.

Spain, on the other hand, developed a strong health system with seventeen Autonomous Regions across the country, giving rise to seventeen different policies on the quality of care. The aim of that plan was to decentralise healthcare and adapt different strategies at the local level so as to maximise the quality of care. The competent Ministry of Health played a supportive role and acted as a guide and adviser to the regions. Each Regional Health Service approved a quality programme containing explicitly stated objectives which were linked to indicators and would be collected by public healthcare institutions. Not surprisingly, evaluations have revealed positive results, such as patient satisfaction, covering areas of primary healthcare, hospitals, and emergencies (Sunol, 2006). Evidence has also shown that in some regional hospitals such as Galicia and Cataluña, patients who were paying out of their own pocket for the hospital of their choice were formally invoiced and competition between the two health institutions increased (Ormond and Loffler, 1998), something that obviously inhibits the public character of health. It ascribes market elements and makes healthcare a private good for which two hospitals compete with each other to attract patients and make profits.

Publicly operated hospitals and primary care centres in Sweden, began improving their services by treating patients at a higher personal standard. In effect, those reforms introduced the possibility that public institutions can operate at the same high standards typically associated with the private sector, while still maintaining universal access (Saltman et al., 2002). In the neighbouring country, Norway, the 2002 hospital reforms brought in a new management system based on a decentralised enterprise model (Christensen et al., 2006); and five regional health enterprises with separate professional boards were established. Also 33 local health enterprises were created and 250 health institutions of different types had to be managed. The goals of that reform were to enhance coordination and make rational use of recourses through better control of the hospitals’ financing. The reform process was characterised as an entrepreneurial effort to remove hospitals from classic public administration and convert them into enterprises with greater managerial autonomy. The reforms did accomplish their goal of shortening waiting lists (Haagen and Kaarboe, 2006) but tension between the regional authorities and the central government regarding matters of funding continued unabated (Haagen and Kaarboe 2006, Magnussen et al., 2007).

One of the contracting-out services in German hospitals was management consulting. It entailed private enterprises offering business consulting solutions to public hospitals to help them improve their efficiency (Maarse, 2006). Moreover, German gatekeepers tried to prevent patients from getting second and third opinions from doctors for their medical condition, achieving in that way a reduction in costs and better use of resources (Gress et al., 2004). As laudable as that practice may seem, it still resonates with ethical issues such as the issue of restricting patients from claiming their right to protect their health by consulting as many doctors as they wished; and the potential of an increase in medical errors due to discouraging patients from seeking additional consultation. In fact, those very medical errors could be the reason why it became mandatory for German doctors to further their training at five-year intervals. The reform was partially subsidised by public funds with a view to ameliorating quality of healthcare and helping doctors keep at the forefront of new health technologies and practices.

In Italy, the 1992 health reforms gave rise to an entrepreneurial model that employed market mechanisms through which modern management practices were applied to the public provision of care. Decentralisation was one of them. The country was divided into 600 local health units where each one was responsible for covering effectively the local population’s health needs as well as focusing on entrepreneurial initiatives (Simonet, 2008). Those units developed into small sanitary enterprises providing healthcare for the local population either in their practices or by contractual agreements with other clinics (Del Torso et al., 1997). Care-provider integration was strengthened and quality was improved but the project encountered difficulties in trying to monitor and assess results (e.g., health indicators) for 600 sanitary units.

As for France, recent reforms concentrated on hospital performance (Minvielle et al., 2008). The Hospital 2012 plan introduced many elements and values of NPM in French healthcare institutions. It focused on improving the current situation in hospitals according to health and safety standards as well as on upgrading their information systems technology (Guerrero et al., 2009). It is interesting to note that only 50% of the project was subsidised by national funds. The remaining 50% was based on each hospital’s financial resources and disposable income (Minvielle et al., 2008), something that denoted those hospitals’ managerial autonomy. Following suit, hospital stakeholders appeared keenly interested in the performance of their health organisations and in values relating to organisational and human resources (Minvielle et al., 2008). As far as doctors are concerned while competition between them has often been encouraged, it has been slow to be fully applied (Landrain, 2004).

In Switzerland, health provision is organised in regional settings (cantons). Cantons have increased authority as they are responsible for subsidising the hospitals within their jurisdiction and making up for any possible deficits. With the recent reforms in 2004, health demand and supply were supported through the establishment of financial motives which strengthened competitive mechanisms (Moresi-Izzo et al., 2010). For instance, higher user charges were established and, as a consequence, the bar of competition was raised higher for both providers and purchasers. New and improved quality criteria were also introduced to better monitor the operation of hospitals but also to protect patients. Finally, the success of the Swiss healthcare networks was rather lukewarm in increasing organisational efficiency since the excessive focus of the Swiss on interaction between insurer and provider stripped the reform of one important factor: improvement of in the care delivery management (Moresi-Izzo et al., 2010). Again, here, the public character of health being undermined by market rules is clearly visible.

In Brazil, the local government of Bahia commissioned a private company to manage twelve public hospitals (Kondilis et al., 2008). The firm is responsible for all clinical services and has signed contracts with Brazil’s social security funds. Further responsibilities include recruitment of staff as well as provision of quality standards in all hospitals. In return, the public sector pays for the medical services rendered for a specific, agreed upon number of patients. Further, the private company’s contract specified that unless at least 80% of the specific number of patients has been successfully served, no refunds will be issued. According to Taylor and Blair (2002), the company continued reaching its target most of the time, often surpassing it by 30%.

**Criticisms and Limitations of New Public Management**

Even though introducing managerial concepts and practices from the private sector into an antediluvian public sector is possible to some degree (Frederic 1998, Pollitt and Bouckaert 2000, Lane 2000) the majority of academic discourse shapes a negative picture of NPM. More than that, the efforts to implement and establish NPM ideology has created strong resistance from professionals. To illustrate the criticism, Pollitt (1990, p.55) argues that “Change management initiatives on the basis of NPM often lead to decentralization but only in a few areas, usually those areas and tasks which are either operational, of secondary importance, or unpopular”. Christensen and Lægreid (2006) suggest that the devolution and deregulation caused by NPM often create new regulations at work with close monitoring and strict surveillance. Other studies have shown that not only is there an issue regarding country-specific limitations concerning the adoption of NPM principles, but also the issue of different public services within the same country requiring different administrative contexts depending on various factors such as ‘if it is a redistributive, service delivery or a truly sovereign task’ (Ormond and Loffler, 1998). In other words, the complexities of the public system do not guarantee the success of the NPM paradigm. As Ormond and Loffler (1998) put it, there is no optimal “one size fits all” solution and the best way to perceive NPM is as a menu from which different choices may be made (Turner 2002, Manning 2001). Similarly, Simonet (2008, p.617) emphasises that:

*“NPM was not a panacea: it advanced at different paces across nations, with some aspects of NPM being more appropriate in some countries but less so in others. It led to greater inequity and more bureaucracy in some, but not in all countries”.*

Indeed the severe economic downturns that took place in the 1980s in the UK and the USA, and the more recent global crisis, might signify NPM’s failure as a universal reform remedy.

Other criticisms in the NPM literature pertain to the failure of NPM to rectify public inefficiencies, especially “in the face of a changing and confusing environment, NPM represents a moment of uncertainty in an uncertain world” (McAuley et al. 2000, p.96). Further, Connell et al. (2009) do not see any real positive impact of NPM. On the contrary, they point to the plethora of critique amassed against it. Minoque (2001), for instance, identifies that managerial independence in the public sector has pushed toward shadowed accountability and corruption. Ormond and Loffer (1998) also agree that corrupted behaviour might be created by managerial autonomy due to the fact that managers seek opportunities in the free market and their engagement with business relationships promotes their self-interests. There is also the risk of making arbitrary use of money due to their autonomy and the expertise to ‘administer’ the operating costs of a public organisation. Evidence is also provided by Ackroyd et al. (2007) which shows that many professionals have exploited the changes to further their own interests. All of the above solidify the thought that NPM might not represent a rational and authoritative paradigm, as its authenticity is obscured in the terrain of opportunistic behaviour. Yet, it is questionable whether the performance-related payments promoted by NPM can serve in minimising the managers’ misconduct as Bach and Bordogna (2011) argue. In the same vein, as Simonet (2008) and Groot and Budding (2008) assert, the transparency NPM provides so that new reforms may gain ground in the public sector, is becoming blurred.

Further, the NPM approach of contracting-out represents a difficult case as it involves much conflict between the two parties such as the private contractor’s financially exploiting the public sector or breaking the contract in the middle of an agreement. To illustrate this, let us assume that there is only one company supplying all hospitals with a particular medicine. Should the government decide to reduce the prices of certain medications the company may stop supplying them. That obviously reflects how proactive and pivotal the role of authorities should be in order to avoid similar incidents. The above issue is also noted by Lane (2000, p. 173) who argues that:

*“The creation of an economy-wide competition mechanism could become the starting point for increasing state intervention, resulting in excessive over-regulation. Reregulation may involve not only enforcement of rules about competition but also the inspection of market structure and firm behaviour”.*

Were we to elaborate further, we could arrive at the conclusion that some NPM applications may lead to more bureaucracy and state interventionism rather than less. In any case, the state represents all of its citizens and must act rationally for their benefit.

Much of the pertinent literature comes from cases of NPM implementation in the UK. That clearly suggests that in the countries which have adopted a much more holistic approach the potential for severe consequences of such implementation is higher. For instance, a study on the NHS reform in the UK found that the efforts to tackle health expenses by using contractors in hospitals negatively affected their quality, as an expansion of nosocomial infections was observed (Dunleavy et al., 2006). NPM is also found to create more inequalities between patients and the problem of waiting lists in hospitals still remains (Landrain, 2004). Not only that, but the NPM project is alleged to focus exclusively on retrenchment of expenses and makes rational decisions in order to achieve it, without considering the patient as a human being with special needs (Parker and Dent, 1996). To illustrate the point, it is argued that UK general practitioners given a specific budget by authorities to treat people, tried to avoid costly patients so as not to deplete their given fund (Lapsley, 1994). Another study of NHS staff conducted by the Healthcare Commission indicated that 63% of the sample was working overtime due to heavy job requirements (Ackroyd et al., 2007). By taking it further, Mannion et al. (2007) argue that doctors in the UK would like, and need, more stability, less administrational work and closer contact with patients and colleagues. They also seemed to react against the implementation of new performance appraisal measurements.

Another thorny issue is the coexistence of managers and doctors within hospitals, an issue where literature discourse is particularly vehement since the mentality of managers is quite different from the mentality of health professionals (Exworthy and Halford, 1998). To make matters worse, managers were given the authority to impose their rules on strong professional groups (i.e., nurses and doctors) and within working places of long historical and organisational traditions such as the public hospitals in the UK (Lapsley, 2009). To illustrate the point, Pollock (2005, p.118) argues:

*“Clinical staff regularly complained of not being able to be innovative or pioneering, and of becoming increasingly inured to the fact that quality was falling because of the decline in nurse numbers and increased use of outsourcing. Clinical care became a constant struggle. Efficiency savings resulted in hundreds of cuts, weakening the morale of staff and severely impairing the quality of day-to-day work and interaction. Surgical teams would operate without lunch because the theatre no longer provided food”.*

On this reading, it is not difficult to imagine how much of a challenging and arduous process it is for staff and patients to become accustomed to a new ideology introduced into the NHS, especially when it is mainly characterised by strict surveillance and cost cutting.

It also turns out that the lack of resources, especially in the health sector does not leave room for luxuries such as administration protocols or customer service procedures. Interestingly, Noordhoek and Sanner, (2005, p.40) claim that “Revamping a government in a more customer-oriented style can bring great benefits, but will it be enough to win the trust of the real audience? There are no real examples that it does”. Arguably, money should be spent on doctors and not on managers. In that regard, it can be estimated that the NPM paradigm brings a lot of steering but not much rowing into health (Day and Klein, 1997).

Ackroyd et al. (2007) see a mixed picture of transformation. Similarly, Bolton et al. note (2011, p.686) that “it is a matter of continuing debate as to how successful reform initiatives have been in controlling healthcare professionals and infusing a managerial rationality into their work”. Obviously, fear of losing their status and impact at work, was the underlying reason behind the fierce resistance of health professionals (Davies, 2009) who remained sceptical over the new adjustments thinking that the reforms would not have the positive result of previous reforming attempts (Parker and Dent, 1996).

Criticism has also been levelled by other countries trying to put the NPM paradigm to full use. To illustrate, a study in Norway by Ostergren (2006) revealed that performance measurements demotivated staff because of the focus on goals rather than on quality. Another testimony about the negative impact of NPM comes from Australia where Australian nurses were subjected to complications and difficulties in clinical leadership which resulted in their providing insufficient patient care (Newman and Lawler, 2009). NPM ramifications are further corroborated by an example coming from Spain, where the budget cuts in health in order to rationalise costs implied not only a reduction in nursing jobs but also a reduction in university students enrolling in nursing schools (Zabalegui and Cabrera, 2010). As to Switzerland, the system of electronic medical records providing information on patient’s treatments and medical examinations and successfully performed in other countries was met with resistance coming from citizens due to privacy reasons (Moresi-Izoo et al., 2010).

Interestingly, recent literature provides in a much ‘less intense form’ the NPM reforms’ outcomes. As Ward (2011) argues, health professionals were organised through strong networks and trade unions in order to keep their autonomy and interests safe and keep away the strict managerial and rational culture. According to Ward (2011, p.5)

*“The end result of this professional control was that many professions were able to determine their own criteria for membership, police their own ranks and generally control the standards and practices present within their professions. These professions were loosely administered as part of working in a larger bureaucratic organisation but they were not necessarily managed in the manner advocated by NPM”.*

That is in direct contrast to the claims by Fitzgerald and Ferlie (2000) who argue that, in the USA, strict monitoring, especially in terms of financial matters, restricted the autonomy of physicians. A more ambivalent picture emerges in the UK where it has been shown that managers, over time, took control over health professionals despite the initial strong resistance (Harrison et al. 1992, Fitzgerald and Ferlie 2000). However, as Dent (2003b) argues, that does not necessarily mean that doctors have completely resigned to the spirit of managerialism but it does demonstrate that they have been trying to comply with the federal government’s policies.

More recently, researchers began arguing that British doctors have started accepting managerial values and feel more accountable for money and resources being spent (Llewellyn 2001, Dent et al. 2004). One main reason was the creation of internal markets within the NHS. Hospitals were deemed autonomous ‘trusts’ and doctors had to think and act as managers in order to generate productivity and efficiency savings (Pollock 2005). The focus on building doctors’ managerial capacities through undergraduate programmes also contributed to that (Royal College of Physicians, 2005). As Fitzgerald and Ferlie put it (2000 p.726) “it is easier to implement organisational change when those affected have had some chance to influence and comprehend the nature and the need for changes”. Forbes et al. (2004) highlight the fact that, as time went on, more and more doctors wanted to engage with hospital management. Means and Smith (1998) conclude that even though there was strong resistance, doctors fared better under those reforms than under the previous bureaucratic situation. According to Pollock (2005, p.40) “a new business culture was installed in hospital policy making*”.*

For their part, politicians from different countries mention very different reasons, motives, and goals on the same kind of reforms (Pollitt el al., 2007b). For instance, in the majority of OECD countries (20 out of 29), hospital managers have complete autonomy in recruiting medical staff. In contrast, in Canada, France, Greece, Italy, Ireland, Mexico, Norway, Spain, and Turkey, only central or local governments make decisions about medical staff recruitment (Paris et al., 2010). Those variances may explain the various interest policies and ideologies hiding behind NPM (Pollitt, 1990) whose presence, most of the time, depends on the political actors’ vision on and commitment to installing public reforms (Kirkpatrick et al., 2013). Further, they may indicate that there is a particular model of public administration in the aforementioned countries that has proved resilient to the spread of NPM ideology in the public sector. That may hold particularly true of countries in that specific list which share certain characteristics. In particular, researchers probing into Southern European countries such as France, Italy, Spain, Greece, and Portugal have identified some common behavioural partners in terms of state control. According to Sotiropoulos (2004), the states of Southern Europe are more state-centred and attached to bureaucratic procedures in comparison to other countries, although even for those states that is about to change as time goes on. It is clear, that further research is needed in order to identify the convergence or divergence between the other states’ bureaucracies.

**New Public Management as an Ideology**

So far, the literature review has made it apparent that NPM made a strong entrance as practice and ideology in the 1980’s. It was part of the significant political change of that era when market ideology became the dominant issue of discourse, later becoming the platform on which policies for reforming the inefficiency of public service delivery were anchored (Lapsley, 1994). New Public Management has been also strongly associated with a neoliberal ideology (Mackie 2005, Connell et al. 2009, Lorenz 2012) and, according to Harvey (2005, p.2):

*“Neoliberalism is in the first instance a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices”.*

On that note, it should be reiterated that, in a sense, the neoliberal framework fostered by NPM may pertain to free market rules (Lorenz, 2012) and to free consumer choice (Dent, 2006) but, more than that, it wields managerial tools and practices, together with an ideology, as a means of fortifying the public sector through the private paradigm.

The concept of ideology itself purports to have a wide range of interpretations be they negative, positive, or neutral, depending on the context in which it is used. The positive and neutral views of ideology are linked to a list of perceptions and beliefs motivating a social group or a political party (Eagleton, 1991). On the other hand, the negative view is interrelated with the false consciousness of ideological notions (Larrain, 1979), in the sense that this notion may not fit ideologically a specific group but it may constitute the core of an ideology for another. In other words, ideologies have loose borders and can be interpreted in different ways (Hall, 1986). That often brings ideologies into close association with political beliefs (Schmid 1981, Hlouesek and Kopeecek 2010) but also with materialistic practices (Althusser, 1971). In the same sense, Vincent (2009, p.14) argues that “ideologies, are conceptual maps for navigating the political realm; they contain core, adjacent and peripheral conceptual elements”. Through that, it becomes apparent that ideologies can be used in luring and proselytising large groups of people. Haas (2012) also showcases ideologies as tools in the hands of politicians highlighting the values and aims of the paradigm they represent. And even though the international dimension of an ideology is asserted by several authors (Brace et al. 2004, Vincent 2009, [Schwartzmantel 2008](https://www.dawsonera.com/search?sType=ALL&searchForType=2&author=%22John%20Schwartzmantel.%22&searchBy=0)), it is important to stress that ideologies have many domestic themes and variations which may strongly impact on their whole concept (Haas, 2012). However, the core part of an ideology remains unalterable in terms of its central philosophy (Freeden, 1996).

One aspect of the neoliberal philosophy of NPM is managerialism. It is assumed that managerialism and NPM are synonymous since the wealth of articles using both words to describe the same concept is substantial. It is worth mentioning that the two terms were found by some of the literature to be slightly different. Those who believe that public sector reforms should be based on technical devices to achieve greater efficiency normally use the term NPM (Hood 1991, Pollitt 2003), while those using the term “new managerialism” stress the ideological component of the phenomenon. Other researchers, such as Deem and Brehony (2005); and as Clarke and Newman (1997), advocate that managerialism provides more of an ideological concept than a technical competence. As Deem and Brehony (2005, p.218) state “Managerial reforms are ideological in the sense that they are used to serve or promote interest and maintain relations of power and domination”. According to Pollitt (1990), NPM is an ideology, a set of beliefs and values centred on the role that management can play in promoting social progress. Dent (1995, p.875) indicates the “ideological and organisational contradictions between state policy and local practice” and assigns changes to political directions. In turn, Scott (1992) defines NPM as a moral superiority of human cooperation within organisational settings. Yet, Krantz and Gilmore (1990) managerialism is a technocratic ideology of managers’ beliefs that they can make an organisation function efficiently with their means and knowledge*.* Voicing the same concern, Diefenbach (2009b, p.71) asserts that:

*“NPM is ideological and is used ideologically since it covers up the pursuit of egoistic personal and group interests-the interests of many senior and upper middle managers who care much about their own careers, market values and egos than about the organisations they work for or the people for whom they are responsible”.*

Through those readings, it has been determined that NPM represents a neoliberal ideology, emerging at a time when it was promoted as a new world paradigm for greater prosperity and efficiency as corroborated by the Thatcher and Reagan alliance during the 1980’s. That paradigm promotes managerial values taken from the public sector experience and gives managers the power to direct public organisations. However, it emerges from the literature that it would be misleading to think that the NPM project is an optimal solution for public reform. It is obvious that the conquest of organisations by managers does not guarantee those organisations’ success. On the contrary, it triggers fear of change, and leads to negation, juxtapositions, and resistance from employees (Pollock, 2005).

Further, Aucoin (1990, p.127) adds a new point of view to NPM by:

*“seeing politics as present, essentially in the determination of the basic values or missions, and thus the policies, of an organisation. It assumes that the realization of these values through a process of implementation can be achieved without the need for direct intervention by those who have set the basic values; at most, a monitoring role is required to ensure that there have not been departures from basic values”.*

In essence, managerialism is viewed as a gatekeeper of effective policy implementation. It may also be seen as the remedy to irrational spending and misuse of resources. Additionally, it resonates with the ideas of Hood and Jackson (1991, p.179) who claim that “NPM can be seen as a development of the international scientific management movement, with its concern to eliminate waste and measure work outputs as a precondition for effective control”. Yet, it is questionable whether that form of technocratic ideology is beneficial to society, as there are many concerns about NPM allowing only for economic efficiency by brushing aside social cohesion and equity.

It is no secret that the neoliberal ideology lying in wait behind NPM has attracted severe criticism in the past as far as the changes in public sector employment practices are concerned. Brennan (2009) explains that public employees are under strict surveillance for the benefit of the organisation and they strive to comply with its goals and objectives in order to be rewarded for their achievements and contribution. According to Pollock (2005), the UK’s NHS clinical staff grumbled about not having the chance of becoming innovative and about the poor quality of hospitals due to large-scale outsourcing. The same author (2005, p.118) asserts that:

*“Efficiency savings resulted in hundreds of cuts weakening the morale of staff which became increasingly isolated. Patterns of work changed as the hospital was reconfigured along factory lines, with renewed emphasis on shift working and higher productivity”.*

Other critics stress that managers have not only gained power but many other privileges and lucrative perks as well which indisputably link to wider inequalities at work (Connell et al., 2009) This opinion coincides with Harvey’s (2005, p.145) who confirms that “managers were given significant portions of the shares and sometimes received a yearly salary one hundred times that of their average worker”. Another radical critique insists that, under the spectre of the NPM regime, rights became risks, leaving patients with only the power to purchase health services from a handful of competing firms (Lorenz, 2012). Overall, the picture that surfaces is that neoliberalism, together with NPM, represents anti-humanistic paradigms. And, though Harvey (2005) paradoxically believes that neoliberalism “as a viable theoretical guide to ensuring the future of capital accumulation”, is about to end, the quintessential idea is that, under the economic crisis, it has now become politically more powerful (Crouch, 2011): its hidden rhetoric about prevailing powers continues to influence the way public enterprises operate, although such rhetoric, especially in the cases of the UK and the USA, is expressed in a less radical manner than it was in the past (Turner, 2008). The reason is simple enough: At the beginning, the public sustains a shock, followed by reactions, and eventually it reaches a pragmatic state of accepting or simply resigning to the changes.

The adoption of NPM principles in the UK stemmed from the Thatcher’s ideological belief that efficiency in healthcare can be brought about only if managers were to seize the reins of the NHS and trade unions stop exercising control and power. To that purpose, a new Board of Managers was established in the Department of Health; and Roy Griffiths, the director of a large chain of supermarkets in the UK, was appointed by Thatcher to implement managerial practices in the NHS. In 1983, the famous NHS Management Inquiry, better known as the Griffiths Report, on management in the NHS was produced. The report was based on management principles and requested changes in policies and roles (Dent, 1995). However, it would be misleading to assume that the changes proposed concerned structural changes alone: it was far more intense than that. It entailed the ideological embeddedness that interferes with existing working relationships with a view to making them more efficient by implementing managerial rules and restricting professional autonomy in order to oil the wheels of the public sector system.

Some may argue that such an approach only makes the change coercive and barbaric and is no guarantee for success. To illustrate, the study of Parker and Dent depicts the changes and the penetration of managerial ideology within the NHS. More specifically, the researchers assert that (1996, p.335):

*“Managers’ ideas about creating a unified culture were reflective of an attempt to move from medical dominance to a managerialist orientation but this change was the subject of considerable dispute. There was debate about whether management was appropriate to an organisation that had traditionally relied on administration and the consequent medical autonomy that this implied. Conflicts over the proper role of doctors, managers, and the health service itself meant that this culture was best conceptualised as divided, not shared”.*

In the same vein, Handley and Clough (1996) mirror the intense and conflicting relationship between managers and professionals and argue that reforms fell short of their goals. Reactions to that were round the corner with Syrett et al. (1997) highlighting the persisting depth of anti-liberal perceptions. As Davies (2009, p.1) argues “The Royal College of Nursing mounted a campaign to resist general managers”. Equally fierce, was the resistance expressed by the British Medical Association, which represents doctors in the UK, against managerial autonomy and reforms (Gabe et al., 1991).

Many NHS workers perceived the change as a private sector takeover led by external managers who occupied hospitals and began controlling health professionals (Davies 2009). According to Hafferty (1988), the intrusion of market principles in hospitals boosted the competition between medical professionals and broke up their collegiality while McGivern and Ferlie (2007) argue that auditing and appraisal systems enlarged the gap between managers and doctors. Another neoliberal trait of NPM is mirrored in the following quote: “GP fund-holders are building up cash surpluses because of their reluctance to commit their funds to contracts at the beginning of the year” (Lapsley 1994, p.23). It is an opinion also found in Harvey’s strong arguments (2005) that neoliberalism favours the wealth accumulation of the upper class, and in Lane’s views (2000) who supports that contractual agreements under NPM engender corruption.

Overall, the changes were sweeping, and caused not only a political but also a social welfare crisis (Gorsky, 2008). That is why the expansion of that neoliberal ideology was strongly criticised and disputed by nations, such as the UK, Australia, New Zealand and the USA which have undergone changes to a considerable degree. It should be pointed out that certain NPM critics argue that, sooner or later, managerial values will prevail over professionalism (Ackroyd et al. 2007, Bolton et al. 2011). Indeed, some of them are already talking of de-professionalisation (Fitzgerald and Ferlie, 2000) or going to the extreme of discussing the proletarianisation of the medical occupation (McKinlay and Arches 1985, Dent 1995). In that light, it is more than likely that medical professionals may regard NPM as a threatening ideology (Kirkpatrick et al., 2009). Be that as it may, reforms cannot be established in the public sector without the consensus, and participation of the professional body (Fitzgerald and Ferlie, 2000).

In terms of political orientation, NPM has been supported by Conservative as well as by Social Democratic governments as a result of public discontentment with state failures. In the UK, dissatisfaction with the absence of accountability of professions and the shortage of money spent on social welfare services drew the left wing’s severe criticism (Dent et al., 2004). Equally worthy of note is the 2000 launch of the NHS Plan by Tony Blair and the New Labour party. It which was deemed as a remedial action in view of strong disaffection with long waiting lists and low quality of care. The plan was characterised as modernised and consumer-focused (Alvarez-Rosete and Mays, 2014). At the same time, however, Dawson and Dargie (2002) wondered whether New Labour was in favour or against the rise of NPM. The Greek public sector is another interesting example. Both governments, right and left, have implemented policies oriented to NPM. Pollitt (2007, p.112) claims that “NPM is definitely not just a neoliberal political doctrine. Its intellectual roots are more diverse and certainly its adoption has occurred in many countries with centre or centre-left governments, as well as by centre-right and right wing regimes”. In that sense, it may be assumed that public provision is not curbed by private rules but that it is managed in different ways (Lane, 2000).

However, events in Greece and the imposition of market rules by the Troika indicate that Pollitt may have underestimated the power of a widespread belief in market principles. That belief was permeated and embedded gradually in the world as a result of a variety of reasons such as the failure of welfare systems, the expansion of capitalist ideology, the development of organisations and management theory, and the erosion of technical efficiency some years ago. The adoption of NPM elements by different regimes does not imply that NPM is not a neoliberal paradigm. It is, and it brings along with it the prevailing neoliberal, market and managerial ideologies that private sector principles are the best option to strengthen public services by opening them up to management and marketisation. As Sarker and Pathak (2000, p.57) point out “NPM emerged in response to a number of environmental forces which governments everywhere have faced in the last twenty years”. It was thus that NPM rapidly became the dominant paradigm and spread round the world (Levy, 2010), an ideological movement with universalistic trends promoted by managers and policymakers (Groot and Budding, 2008). In a more allegoric interpretation, NPM could be seen as an ingredient that matches every recipe. The result depends on what you want to make and how much of NPM you are going to use.

Adoption of NPM did not occur simultaneously throughout the world: different countries folded it into their systems at different times, with different results, with the ‘core group’ of Anglo-Saxon countries which used NPM earlier now having the opportunity to evaluate and compare results. Even though Osborne (2006) asserts that the NPM era came to an end in 2000 and was replaced by a new paradigm called New Public Governance, other scholars believe that it continues on its trajectory of expansion (Pollitt 2007, Lapsley 2008) which, owing to the financial crisis, has now picked up intensity (Simonet, 2013). To illustrate, it is pertinent to note that NPM ideology is compatible with the principles of international organisations such as the IMF, the World Bank, and the United Nations which play an important role in promoting economic stability and efficiency on a worldwide scale (Lynn 2006, Harvey 2007, Fatemi and Behmanesh 2012) during harsh economic times.

It may then be concluded that NPM brings in a specific ideology for a number of reasons. First of all, it represents the over-arching philosophical and political ideology of neoliberalism. Further, NPM does have a positive and negative meaning and it does have adherents and opponents. Advocates of NPM assert that the diffusion of economic and managerial values does not necessarily mean that the public character of the service is threatened. On the other hand, opponents of NPM are of the opinion that as a specific paradigm it is a loose concept and its elements do not provide efficient solutions (Christensen and Lægreid, 2002). In fact, development of NPM would not have come about, had it not been for something missing or something not functioning well within the societal system of some countries. It brings forth a complete set of practices with a strong impact on the public sector and fosters a series of values such as efficiency and rationalisation. It is actually representative of the faith held by certain groups and by managers in particular that problems within the public sector can be solved. It is also a tool in the hands of politicians who wield it in the name of fierce political discourse. Many researchers do view NPM as a vague or loose concept but most of them never fail to acknowledge its universal applicability and domestic variability. Countries and governments which have not used NPM reforms do exist, but their not doing so is mostly owed to different policies in their institutional framework (Ormord and Loffler, 1998). At the moment, NPM ideology seems to match the Greek case. To that extent, it may prove interesting to discover which NPM practices are actually suitable for the Greek case and how key NHS players are involved with those practices. Better yet, the fascination lies with exploring the narrative and the forceful ideology pushed by the Troika on how change should come about.

**New Public Management in Greece**

Though a considerable part of the volume of research and literature highlights the problems and inefficiencies of the Greek public system (Kufidu et al. 1997, Argyriadis 1998, Makrydimitris 1999, Pelagidis 2005, Sotirakou and Zeppou 2006, Economou 2010, Sissouras 2012, Antonopoulou 2014) very few studies have explored the patterns, the change, the variation over time, and the extent to which New Public Management has been adopted by the Greek healthcare system. According to a meta-analysis study by the COCOPS Project (Coordinating for Cohesion in the Public Sector of the Future), a public management research consortium directed by Pollitt and Dan (2011), only eleven studies in Greece have analysed the impact of NPM-style reforms on public services. To that extent, it may be of value to explore the idea of NPM and how it has grown in legitimacy in Greece.

NPM in the Greek public sector arrived relatively late in the 1990’s (Zampetakis and Moustakis 2007, Spanou 2008). Its belated arrival is owed to a number of factors. First of all, when compared to Anglo-Saxon countries such as the UK and the US where NPM practices were implemented holistically, NPM in Greece seems to have been applied in an ad hoc mode and is still evolving (Philippidou et al., 2004).

As explained before, the strong bipartisanship present in the country proved a stumbling block for implementation of affirmative initiatives (Mouzelis et al. 2005, Dikeos 2011). Most certainly, the state was plagued by rigidity, regularity, and legalism which can be attributed to Napoleonic traditions but some areas, Greece as well as other Southern European states, had taken different paths which did not facilitate the implementation of changes (Spanou, 2008). In Greece, one of those paths entailed the zealous practice followed by political parties of literally and summarily stuffing the public sector with their voters without complying with any procedures and without considering the qualifications of those voters. The phenomena of patronage and clientelism were some of the prevalent features characterising the public service not only in Greece but also in Italy, Spain, and Portugal (Kickert, 2007). To make matters worse, civil servant unions in Greece directed their energy at combating many of the reforms as they felt that their interests were being threatened (Sotiropoulos, 2004). Unlike its UK counterpart, when it came to NPM policies, the Panhellenic Medical Association seemed unwilling to mount its white horse and act as the knight in shining armour in protecting its members and championing their interests. (Gabe et al., 1991)

Admittedly, Greek public authorities had indeed made some concerted efforts to bring reform about in the public sector in the past. One such endeavour took place in 2001. It was the “Politeia” Project, voted as a law by the Greek Parliament with the main objective of implementing changes that focused on citizens and delivered results in the public sector (Law 2880/2001). To that purpose, the project required every public organisation to set goals, establish performance indicators, report accomplishments, and direct itself towards the re-establishment of relations between citizens and Administration by providing its citizens with better public service quality. The Politeia Programme also included main NPM principles such as: efficiency, decentralisation, downsizing, entrepreneurship, and innovative managerial practices (Philippidou et al., 2004).

Following suit, two subsequent and improved versions of the same programme, Politeia 2005-2007 and Politeia 2008-2010, were developed. Despite the numerous innovative interventions of the various Politeia Reform Acts their results were assessed as poor, and the proposed changes did not achieve their goals (Sotirakou and Zeppou 2006, Kastaniotis 2011). Towards the same direction the Greek government introduced more laws: the law for the establishment of an administration system through goals and measurement of performance;[[22]](#footnote-22) the law regulating the employment system and issues of public administration;[[23]](#footnote-23) and the law containing the new code for public employees that regulated personnel management matters, including hiring and compensation regulations[[24]](#footnote-24). More recently, in 2010, a law whose stipulations resembled NPM standards and involved an administrative reform programme called “Kallikratis” was enacted in Greece. It entailed the modernisation and rearrangement of local municipalities (Economou, 2010). Its main purpose was to reduce the number of municipalities in order to facilitate their monitoring and financing. Special emphasis was given to achieving economies of scale, improvements of service, and professional quality. As Hlepas (2011) argues, it was the Greek State’s effort to conform to the Lisbon Treaty principles for fewer public entities. Indeed, the number of municipalities did decrease from 1,034 to 325; the regional governments from 76 to 13; and the municipal companies from 9,000 to 1,500 (Di Mascio and Natalini, 2013). Arguably, the degree of downsizing depicts the levels of waste and inefficiency that had been afflicting the Greek local authority services before the reforms. Regrettably, the Kallikratis programme was hard to implement effectively, owing to the lack of support by the dominant political parties and the presence of administrative incapacities (Di Mascio and Natalini, 2013).

Turning to the public healthcare sector, here too, Greece had attempted several times to rectify its healthcare system in the past. Still, those attempts were fragmented, had a limited scope and, consequently, were not effective in solving the crucial functioning problems of the NHS. The following researchers’ arguments serve in highlighting the desperate need for the establishment of measuring and monitoring tools within the Greek NHS:

*“the main drawback in public administration is the total lack of functional supervising mechanisms independent of government direct control. Despite the widespread and persistent reference to corruption and wasteful behaviour in hospitals for at least 20 years, there are still no reliable computer-assisted financial reporting appliances, pharmaceutical consumption is almost unchecked and the often fraudulent, misuse of medical technology widespread.”*(Liaropoulos et al. 2012, p.56)

With regard to wasteful practices in terms of resources, it is the doctors who bear most of the responsibility. The fact that they are the ones who decide those resources’ final use gives rise to the concept of medical subjectivity. According to Minogiannis (2012, p.72):

*“It is the great knowledge imbalance between management and the physician community in a hospital setting. Whereas it is important to underline the importance of such differences, one cannot avoid examining the question of medical subjectivity. This medical subjectivity leads in turn to an imbalanced services consumption (via physician agency) which on occasion cannot be justified and leads to elevated costs and inefficiencies”.*

It is an issue inherent in the professional power of doctors. The weight as well as the status of the medical occupation gives doctors the autonomy and authority to exercise their own professional judgment when it comes to their patients’ treatment options. It thus stands to reason that some medical professionals may take advantage of their prestige for their own benefit (Economou, 2010). One such example prominently features the steady willingness of Greek doctors to accept extra payment by their patients in order to provide them with extra healthcare (Dent 2003b, Mossialos et al. 2005). Accordingly, Mossialos et al. 2005 and Papanikos (2013) highlight the fact that Greek doctors, especially those working under social insurance funds, boost their income by referring patients to their own private practices (OECD, 2009c); and by being shareholders in private diagnostic laboratories and pharmaceutical companies (Mossialos et al. 2005). It is only inevitable that such a situation would lead to conflicts between doctors and hospital managers, as the latter, in their role as rational gatekeepers seeking to tackle hospital expenses, frown upon shady practices (Parker and Dent, 1996). Granted, the coin does have another side, that of the Greek NHS doctors who are ideologically opposed to illegal and unethical practices. Sadly, their number is paltry and does not suffice in trying to change the rules of the game.

It is also of great significance to mention the lack of evidence-based information emanating from the Greek NHS. According to Minogiannis (2012, p.72):

*“In Greece, however, this is a discussion that has not even begun both due to professional resistance but also due to the lack of both clinical and until recently even financial information which would have allowed such a discussion to take place based on actual data. The medical community at best is indifferent and at worst promotes medical subjectivity and reformist voices within medicine are often overheard”.*

To increase the quality and efficiency of health services and contain healthcare costs, established managerial tools provide evidence for policymakers and managers in order to assist them in making rational decisions. Expanding on this, it seems that such instruments are conspicuously absent from the Greek NHS. As a result, doctors ask for unnecessary examinations and over-prescribe medicines for their own personal benefit. Another reason exacerbating the doctors’ aforementioned questionable behaviour is the low income they earn. Worse, public service doctors work on a fixed salary and not on a pay-per-performance basis (Economou, 2010).

Other major aspects that may explain the unsuccessful attempts at reform have already been mentioned involve a fragmented and deferred public sector, skewed manpower and inefficient use of resources (Tountas et al. 2002, Sissouras 2012) as a cause of lacking the evidence-based information (Economou and Giorno, 2009) and of appraisal tools which could act in an inhibitory manner on the irrational use of system’s resources (Sissouras 2012). Further, many researchers assert that, for years on end, political willingness was insufficient, even though the problems in the public sector were ubiquitous (Papoulias and Tsoukas 1994, Pelagidis 2005, Economou 2010, Sissouras 2012). Measures to achieve decentralisation and management control were only partially fulfilled. The most important change was the establishment of seventeen regional health systems (later reduced to seven) in an attempt to strengthen public health in urban areas. Primary healthcare in particular was deemed as a crucial mechanism of the system that could foster the efficient use of available resources and safeguard the quality of the services offered; however, efforts to organise a primary healthcare sector are still in their infancy (Lionis et al., 2009). Similar mechanisms involved the afternoon and evening shifts established in all public hospitals to ease congestion but also to empower their competitiveness and efficiency against the private sector; and the equal distribution of hospital beds and medical staff between urban and rural areas (Tountas et al., 2002).

More recently, Minister of Health Lykourentzos claimed that the brand new hospital on the island of Santorini, which is still closed due to the state’s financial inability to pay contractors, is to be used for medical tourism through public-private partnerships (PPP’s) (Venizelos, 2012). Similarly, the Greek Health Ministry authorities submitted to the Troika the real estate property belonging to the Greek NHS and proposed plans of its utilisation by the medical tourism industry (Kaitanidi, 2012). Moreover, Member of the European Parliament Chatzimarakis, who represents the German Liberals in the Parliament, stated that “the German Ministry of Health has visited Greece twice and has requested that privatisations in health so that the country becomes more attractive to medical tourism” (Inews Gr, 2011). There is some evidence emerging from the above and, early estimates that during the Troika’s tenure the Greek healthcare sector has been strongly influenced by new managerialism.

Under the Troika’s insistent recommendations, new initiatives are still forced upon the Greek government. An example of such an initiative is the establishment of PPP’s whose promotion by the IMF, European Commission and Central Bank may be characterised as coercive (Kondilis et al., 2008). Notably, there are many other austerity policies and enforcements being pushed by the Troika for the sake of rectifying the Greek NHS under the aegis of a market mentality. To name but a few, those are: reduction in the public sector’s size (layoffs); curtailment of public expenditures; privatisation; infliction of strict controls; useof rationalisation in the allocation of resources; and introduction of competition to the public sector. To illustrate, it is worth mentioning that Evangelismos, the largest state hospital in Athens has very recently advertised on its website that part of its real estate property is available for renting (Evagelismos-Hosp Gr, n.d.).

As a Greek scholar has stated (Sotiris 2012, p.1), “Greece is becoming the test site for an extreme case of neoliberal social engineering”. His statement reveals, somewhat surprisingly, the magnitude of the phenomenon of neoliberalism in Greece, in the sense that the country has been turned into a laboratory experiment in the not-so-tender hands of the Troika. As Kentikelenis et al. (2011, p.1458) pithily argue “In an effort to finance debts, ordinary people are paying the ultimate price: losing access to care and preventive services, facing higher risks of HIV and sexually transmitted diseases and, in the worst cases, losing their lives”.

**Chapter 4: Setting the Analytical Framework:**

**NPM, Principal-Agent Theory,**

**and Critical Realism**

**Introduction**

As part of the social world, healthcare organisations constitute open systems of a multidimensional nature. To meet and research that complexity the present thesis develops an analytical framework comprised of three elements: New Public Management (NPM), Principal-Agent Theory (PAT), and Critical Realism (CR). The framework establishes the basis for understanding social phenomena such as the Greek NHS and public hospitals in particular by combining the knowledge extant in theories relevant to the study and contributing in that way to the development of new knowledge. The main argument for using those concepts is the following: The NPM paradigm generates the changing reforming context of the Greek NHS. The PAT incorporates the interplay and manoeuvres of human actors within that context; and CR offers an interpretation of reality and provides the structural analysis that binds healthcare organisations with human actors. Together, they form a unified analytical framework that entails reforms, actors and organisational structures, in essence, all the parts necessary in grasping the changes in the Greek public medical system.

The framework is integrative in that it combines different constructs and their dimensions within a single analytical approach with the purpose to meet the study’s aim and objectives. It focuses on fathoming whether the NPM paradigm is applied to the Greek NHS so as to lead to firmer conclusions regarding the process of reforms and their sustainability. PAT and CR were not selected at random. The two theoretical approaches are expected to advance the theory of NPM and enriching the international literature as a means of understanding the complexities of national health systems in the process of reforming. Since power is emerging from the literature as a vital element in understanding the relationships between and among key players as well as in gauging their influence on decision-making, Lukes’s theory on the three dimensions of power contributes to addressing that factor theoretically and aids the analysis and discussion of the thesis.

Apart from conceptualising the research, the framework serves other functions as well. First, it steers the researcher towards finding relevant literature and building a coherent concept: how other countries implemented NPM; how actors responded to reforms; and what the structural influences were. In turn, that allows for a comparison with the Greek case. Second, it contributes to reviewing and grouping the literature; identifies research gaps in issues of crucial importance such as the Greek reforms brought about through the Troika’s intervention; and flags themes to be examined such as the influence exerted by the system’s old structures. Methods, key sample, and interview schedule all emerge from the framework. Last, the framework guides the analysis and discussion of the present thesis. One of the issues it tests is how the Principal-Agent relationships and the new Greek NHS structures have been interacting after the intrusion of the neoliberal ideology promoted by NPM within hospitals.

It is also more than likely, that the model may serve as a tool for other countries. Portugal, Ireland, and Spain are three such quite recent examples of countries that summoned the IMF and the Troika to their side so as to fix their deficits and correct their inefficiencies. The benefits the model provides may also be of use to cross-national studies which examine public sector reforms with or without the IMF’s interference, or even to longitudinal studies which could compare a country’s reform progress through their own time frame.

**Why this Particular Analytical Framework?**

The notion of NPM reached Greece in 1994 when an international team of healthcare specialists, headed by Professor of Economics Abel Smith, renowned for his keen interest in health and social welfare, were invited by the Greek state to provide their expertise on health reforms. Their proposals targeted practices such as hospital management and hospital autonomy, decentralization of health, unification of funds, better appraisal systems, improvements in quality of healthcare, and the abolition of the permanent nature of employment in the public sector (Abel-Smith et al. 1994, Mossialos and Allin 2005). Despite the fact that other Greek researchers have demonstrated the use of the NPM paradigm in the country, research on the issue has been considerably limited when compared to research on other countries. In 2004, Philipidou et al. (2004) explored and analysed NPM reforms aiming to improve the efficiency of public services. In the same vein, Spanou (2008) identified the reforms of the Greek state over the last 25 years and compared them with the NPM paradigm. According to the author “Greece was open to NPM ideas, however it has not closely followed the NPM trend” (Spanou 2008, p.153).

The fact that the use of the NPM has been explored to an infinitely lesser extent by the Greek research community in comparison to the international literature on the topic, gave rise to an intriguing field of research. Lapsley (2010, p.3) argues that the “financial crisis points to an intensification of NPM in public services as government, of whichever political hue, seeks to maintain both levels and quality of service with less resources”. What is more, the fact that the arrival of the Troika, which comprised international organisations which champion managerialism and efficiency (Lynn 2006, Harvey 2007, Fatemi and Behmanesh 2012), coincided with an increase in the pace of reform activities in Greece raised questions over whether ongoing changes were being shaped by the NPM paradigm. In other words, there do exist grounds on which to wonder whether those changes are manifestations of a shift towards managerialism; or represent, once more, another archetypal Greek public sector reform overshadowed by an unstable political and economic context; and characterised by a great deal of “steering but not rowing” reform traditions (Day and Klein, 1997).

Christopher Hood was the first to coin the term New Public Management in 1989. He conceptualised and grouped together seven doctrines adopted by political leaders as measures to fight the public sector ills of that era: (1) stress on discipline and parsimony in resource use; (2) disaggregation of public organisations; (3) competition in the public sector; (4) private sector styles of management practice; (5) hands on managers; (6) emphasis on output controls; and (7) measurable standards of performance (Hood 1991; 1995). The doctrines stemmed from the new institutional economics and business managerialism and targeted the traditional bureaucracy and failures of the Keynesian welfare state (Hood, 1991). Needless to say, NPM was enthusiastically accepted and followed by countries in financial disarray, especially Anglo-Saxon countries looking to provide better public sector services. During that timeframe, NPM turned into a mega-trend public reforming paradigm. Indeed, that revolutionary “doctrinal set” (Hood, 1991), flourished as a policy paradigm propelled by the rise of the New Right (given the failures of the welfare state) and the unique period of economic growth that ensued. However, it would be wrong to assume that formula remained consistent for every country. NPM soon became a controversial issue with economic, cultural, social, and political differences replacing the basis of NPM (Lodge and Gill, 2010). That does not necessarily imply that the paradigm had suddenly lost all support; its influence had spread globally but, due to diversification, it had acquired more flexible and ad-hoc uses. Pollitt and Bouckaert (2004), together with a number of other scholars, have criticised NPM for possessing an ill-defined basis and lacking conceptual clarity. The researcher conducting the present study has chosen to follow the path of the many scholars who defer to Hood when essaying to conceptualise the NPM. However, for the purposes of this thesis, the researcher has also chosen to attribute the name ‘dimensions’ to Hood’s seven doctrines so as to show not only that NPM is no longer a dogma but also to point out the flexible and interwoven two-pillar nature of NPM, as practice and ideology, as that strongly emerges from this thesis. To illustrate, Hood’s “hands-on managers” has both ideological (authority, domination) and practical (rewarding system, monitoring resources) dimensions. As stated earlier, practice and ideology fuel each other. Managers cannot survive in a profoundly bureaucratic environment. They need the sustenance of a managerialistic neoliberal climate. Thus, in order to achieve greater responsiveness of improvement implementations in public sector organisations, it is paramount that awareness of developments in the environment be developed. In view of that, it may be intriguing to examine, in terms of practice and ideology, which of those dimensions are being implemented in today’s Greece under the intensification of the crisis and the Troika’s intervention.

The NPM model is relevant when analysing and comparing the development and reforms of the Greek NHS within the framework of neoliberal policies carried in the suitcase of the IMF and the Troika. NPM literature has shown that in some cases managerial tools and practices have the power to combat corruption and enhance accountability and transparency in the public sector (Kirkpatrick et al. 2009, Dan 2015). As Larbi (1999, p.36) resonates:

*“While the new public management approach may not be a panacea for the problems of public sector management in crisis states, a careful and selective adaptation of some elements to selected sectors may be beneficial. Implementation needs to be sensitive to operational reality”.*

Literature has also shown that, in the Greek NHS, there is a tradition of corrupt practices and malfunctions, such as clientelism, which will burden reforms each and every time. According to Dent (2003b, p.145), “such practices may well emerge when the health system is inadequate and/or the state is weak, but they may well be present for other socially and culturally embedded reasons too”. The NPM school of thought actually emphasise the power of historical, cultural, and social traditions and their influence on a country’s working settings and public sector reforms (Putnam, 1995). Similarly, Granovetter (1992) advocates that human behaviour and social relations within organisations affect their further development and, by extension, influence the country’s economic and political conditions. On that issue, interestingly enough, Dent (2003b, p.143) asserts that “these [cultural influences] may be eventually erased and replaced by (or incorporated within) the new practices or they may co-exist with the new arrangements and continue to exert a strong influence”. It is worth investigating and being the first to record the interplay between cultural-historical traditions and the new coming neoliberal forces in Greece. Based on that rhetoric, the framework consists of a strong analytical tool that can trace NPM’s implementation process, provide a first evaluation of the reforms, and ascertain the factors which may enhance or burden their proper functioning. Such an approach ensures that the aim and objectives of the thesis are being addressed.

The thesis explores the Greek reforms and discusses whether they have been influenced and shaped by NPM logic, as it is the first time that their implementation is radically guided by foreigner experts. In doing so, it is necessary to look at reforms in other countries that used the same logic in the past and observe whether they match the practices and ideology being applied to Greece at present. To make analysis more concrete, it has been deemed necessary to refer to the UK’s reforms not only because it was a “first mover” country to implement reforms holistically and one of the best NPM benchmark cases (Barzelay, 2001), but also because of its many similarities to the Greek case. Both countries belong to the EU, both have a NHS of national coverage at no cost to citizens (Dikeos 2011), and they are under a bipartisan (conservative-socialist) political system which plays political football with health. Moreover, although that is no longer valid in the UK case, a belated consensus between parties on health policies and hospital management trends has been reached (Dikeos, 2011). Additionally, a common feature that binds the two countries is a financial disaster which forcefully brought about IMF interventions (in the UK in 1970s) (Larbi, 1999). That had also happened with many other countries in the past, such as Argentina and Turkey in the 1990’s (Onis, 2006); Ireland in 2010 (Robins and Lapsley, 2014); and even more recently the European South (Spain Portugal and Greece) (Ioakimidis et al., 2014).

As Pollitt and Dan (2011) argue, to realise whether it is NPM or not, someone needs to look at the types of reforms first. That implies that to deepen understanding and research on the new reforms in Greece it is important to build a detailed framework on the concept, practices, and ideology of NPM and then test it in the Greek case. To evaluate critically the level of the reforms’ adoption by the Greek NHS, factors such as the country’s level of disengagement from old inefficient bureaucratic mechanisms and the key players’ adjustment to the new conditions need to be analysed. Thereby, the NPM paradigm is enriched by Principal-Agent Theory and Critical Realism conceptual contributions.

The former emphasises that the role of the key actors is pivotal in shaping policies and accepting reforms. As Saltman et al. (2007, p.22) argue, in the health sector:

*“supervision, oversight and persuasion are needed by those mandating the system (the principal) over those who have to implement the system’s daily functions (the agents). This framework focuses attention on different scales and intergovernmental relationships within the decentralized health system, the key role of health system personnel in implementing policy, and the intentional and perverse incentives that any given system structures may produce.”*

PAT illuminates the framework by showing how the main players interweave with the dimensions of NPM and how they interact with the past and the system’s new structures bearing in mind that they all try to fulfil their personal interests. Further, as Granovetter (1992) suggests, the social world informs, intermeshes, and directs the way economy and its institutions operate. At the heart of that approach lies the conceptualisation of the relationships, incentives, and games of power between the Troika (foreign principal), local principals (policymakers and managers), and agents (health professionals). It reflects the power of the Troika to embed the NPM paradigm and the neoliberal ideology into Greek hospitals, the efforts of local principals to secure smoother reforms and benefits for themselves (i.e., political fame), and the efforts of the agents to adapt or react to the new reforms having though to deal with obviously harsh conditions of austerity measures and crisis everywhere. In the next section power is approached theoretically and its emerging role in the thesis is analysed in detail by referring to Lukes’s theory of Power.

Critical Realism assumes that social phenomena and objects exist in reality and shape processes and behaviour (Ackroyd, 2012). That generates an objective nature of the research context denoting in that way that reality can be understood, interpreted, explained, and critically evaluated. NPM is integral to CR and PAT in the sense that NPM provides the basis for contextualising reforms, CR sheds light in the groups of agents and structures that shape these reforms (Archer, 2002), and PAT illuminates them through the interaction of key actors. To illustrate, Pollitt and Boukaert (2011) assert that while socioeconomic forces and political pressures lie behind the spread of management reforms globally, crucially important at the national level are the perceptions of elite decision-makers of what is both desirable and feasible. The latter relates to what is considered possible, given available resources, existing structures, and likely obstacles such as ‘conservative forces which resist change’ (Pollitt and Boukaert 2011, p. 25). It is worth noting that even though NPM reforms were found suitable for developing countries, the lack of available resources (i.e., human resources) usually constrained their further development (Mongkol, 2011). Those associations are examined in the study with the help of the framework upon which the research questions and the theoretical propositions are constructed.

**Power dynamics**

While reflecting on the literature of the Greek NHS and NPM and by studying the relationships between the key players, attention was given to the emergence of power as a factor of influence and control. Before proceeding to the development of the framework, it is worth making a short reference to the theory of power so as to offer some insights on power relations within the Greek NHS that will strengthen the analysis. In doing so, Lukes’s work on the “three faces of power” is reviewed since it has been used by other researchers who examined empirically the power influences in a political and social context (Lorenzi, 2006) and matches the thesis’s contextual background.

According to Lukes (2005), power is the capacity of an actor to influence another actor. Particularly, “A exercises power over B when A affects B in a manner contrary to B’s interests” (Lukes 2005, p.37). A typical situation drawn from the present thesis is the power of the Greek government to enact laws and influence the work of public servants; or the power of political parties to embed themselves through atypical means into the country’s public system. Lukes conceptualises power as having three different dimensions according to what is decided and by whom.

The one-dimensional view characterises power as the concrete and certain decision-making taken by political factors and lobbies. That mainly refers to political power, meaning the government’s power to make decisions on behalf of its citizens (Lukes 2005). It is concerned with the capacity to vote on new laws. In this case, power is legitimised. The main focus is centred on observable behaviours and conflict between actors from which outcomes emerge (i.e., the doctors’ reactions). It should come as no surprise to the reader that it is the most powerful actors who usually win in these conflicts.

The two-dimensional view defines power as including one more dimension than concrete decision-making. That involves certain issues left off the political agenda so as to avoid conflicts. They constitute the less overt applications of power which go beyond the first type by focusing on which decisions are not made; and which issues are kept from arising in the political and social arena. Lukes (2005) argues it is that hidden action which depicts the power of elite people to ignore the demands of the weaker through manipulation of policy decisions. That kind of exclusion serves certain interests that could easily drive to corrupt practices. An example emerging from the present thesis is the phenomenon of clientelism and the doctors’ under-the-table payments. It should be noted that the Greek government has never taken strict measures against those two practices, possibly because Greek politicians had never had any intention of increasing civil sector doctors’ salaries.

The three-dimensional view refers to the ideological dimension of power. Without a doubt, it is the strongest type of power as it has the capacity to change people's beliefs in a manner that negates even their own self-interest (Lukes 2005). It is also known as ‘the power of domination’ (Swartz, 2007) where the entire policy process can become a manifestation of power. It becomes an invisible tool through which new policies are shaped to serve the interests of certain groups. It is the case where international institutions through education, religion, or other means of persuasiveness exercise ideological power and secure the compliance of the weaker. In sum, Lukes’s theory adds to the analysis an illustration of how the key actors are involved with the ideology and practices of NPM and form the system’s structures depending on their delegation of power, relations, incentives, and networks.

**Development of the Integrated Framework**

The NPM dimensions that emerged from the current literature coincide with Hood’s seven NPM dimensions, which summarise the most important aspects of the paradigm (Hood 1991, Van de Walle and Hammerschmid 2011). Further, many scholars refer to Hood when conceptualising the NPM. These dimensions structure the framework of the thesis by means of two main pillars. Ideology is the first pillar of the NPM paradigm, with the other being a set of practices and techniques. Ideology represents a set of beliefs and values interwoven with a particular class or group of people (Eagleton, 1991). NPM has been associated with a range of ideologies anchored on business efficiency in the public sector. An example is the link between the neoliberal ideology that fosters efficiency through private property rights, the market ideology that produces efficiency through free market rules (Lorenz, 2012), and the managerial ideology that generates efficiency through the adoption of private sector managerial techniques (Mackie 2005, Connell et al. 2009, Lorenz, 2012). Practices entail the technical part, in other words, the tools employed by managers to bring about public sector changes. The framework offers an integrated analysis on how each dimension contributes in ideological and practical terms. To illustrate, the use of managerial tools, a basic dimension of NPM, in the public sector is underpinned by a strong managerial ideology which emphasises the application of modern management techniques such as IT practices to all areas of society with the purpose of boosting that society’s productivity. The following table presents the NPM dimensions and their insights on the two, main pillars. It lists the most important ideologies and practices describing each dimension, although additional ones do exist. Further, the table does not intend to provide a comprehensive NPM review. Rather, it aims at focusing on some of the paradigm’s key aspects.

**Table 4: The core of the Analytical Framework:**

**The New Public Management Paradigm**

|  |  |  |
| --- | --- | --- |
| **DIMENSIONS** | ***IDEOLOGY*** | ***PRACTICE*** |
| **Discipline and parsimony in resource use**  **Reductions in public expenditure** | **Neoliberalism** | **Layoffs,**  **Budget cuts**  **Salary cuts**  **Privatization**  **Downsizing (closures and mergers)**  **Cost savings** |
| **Disaggregation and Decentralisation** | **Managerialism** | **Decentralised decision-making**  **Reduction of hierarchy**  **Delegation of power**  **Resource allocation**  **Health Map** |
| **Competition in the Public Sector** | **Marketisation** | **Sale of health services**  **Contracting-out**  **Outsourcing**  **User charges**  **Marketisation and globalisation of health services** |
| **Use of private-sector styles of management** | **Managerialism** | **Efficient use of IT**  **E-procurement aspects**  **Emphasis on quality**  **Improved Accounting System**  **Financial management** |
| **Hands-on managers. Control of public organisations by managers** | **Managerialism** | **Managers in hospitals**  **Monitoring resources**  **Mechanisms of evaluation and promotion(incentives, sanctions)**  **Personnel management** |
| **Control of public organisations according to output measures** | **Marketisation, Managerialism,**  **Neoliberalism** | **DRGS**  **Gatekeeping**  **Electronic monitoring**  **Evidence-based mechanisms**  **Clinical guidelines** |
| **Explicit standards and measures of performance** | **Marketisation,**  **Managerialism,**  **Neoliberalism** | **Performance measurement**  **Pay-per-performance scheme**  **Performance indicators**  **Benchmarking**  **Performance contracts** |

The main NPM reform agenda is the downsizing of the public sector. It carries the influence of neoliberal ideology which advocates that the advancement of a society may be achieved through growth and creation of wealth generated by the shrinkage of the public sector, competition rules, and private property rights (Harvey, 2007). As argued by Onis (2006, p260), “countries facing a heavy debt burden do not enjoy the luxury that the more successful countries possess in terms of avoiding the IMF completely and following an independent path over a long stretch of time”. That may serve in justifying the IMF’s intervention in Greece. In that regard, the ascendancy of the neoliberal spirit is closely associated with the IMF and the NPM paradigm used in reenergising Greece’s cumbersome public sector (Hannigan 1998, Van de Walle and Hammerschmid 2011).

In terms of practices, previous studies have shown that the arrival of the IMF in a country does not simply imply budget reductions in the vulnerable sectors of health and education. It also demands salary cuts and layoffs (Farazmand 2006, Robbins and Lapsley, 2014) without, however, forcing mega corporations and high income earners overall to pay (Ruckert and Labonte, 2012). Another practice widely used in regaining financial stability is privatisation. Public organisations become private so as to generate profitability (Frangakis et al., 2010) and almost all European countries have included privatisation in their reform agendas to smaller or larger extent (Loeffler et al., 2012), despite the fact that privatisation has been severely criticised as an inappropriate tool for reforming the public sector (Bangura, 2000). According to Winfield et al. (2002), the citizen in a privatised system is treated as a customer and “the rights of the customer are really quite minimal compared to those of a citizen” (Christensen and Lægreid 2002, p.23). Hospital closures and mergers might also take place as a result of expenditure’s rationalisation (Hanlon and Rosenberg, 1998). More specifically, Hermann (2009, p.132) explains that there has been:

*“a wave of hospital mergers in Belgium, including mergers between public and private non-profit organisations, more than half of all hospitals have disappeared since 1981. In Germany, 10 per cent of all hospitals have been closed since 1990, eliminating 134,232 hospital beds.”*

Given the changes about to take place inside Greek hospitals, it is worth testing and comparing the levels of reductions in public health expenditures ‘before’ and ‘after’ the Troika’s intervention. Therefore, questions regarding hospital mergers, privatisation budget reductions, layoffs, and salary cuts are compatible with the framework and have been included in the interview schedule. Admittedly, the higher the reductions, the deeper the intrusion of the neoliberal spirit within the Greek NHS and the stronger the power of the foreign principal (Troika) to impose its policies on a disordered NHS.

A coherent concept of NPM includes the disaggregation of public services and organisations. It stems from the managerial ideology which enthrones the shift from public administration to public management so as to make government more business-like, to force it to act responsively to stakeholders and market challenges (Christensen and Laegreid 2002, Osborne and Brown 2005).When provision of public services takes place in a decentralised rather than a top-down hierarchical manner (bureaucratic system), flexibility and allocative efficiency are achieved (Lane, 2000). In the health sector, it involves delegating responsibility and directions to hospital managers and local principals who will then manage the health organisations and their resources as a matter of better local coordination mechanisms (Pollitt and Bouckaert, 2011). However, at this point, it should be stressed that the level of authority diffusion taking place between health systems across the world differs because of the discrete historical and cultural patterns of the countries involved (Tulchinsky and Varavikova, 2009). That holds especially true to countries such as France, Italy, Spain, Greece, and Portugal which are more state-centred and attached to bureaucratic procedures and where decisions are made by central governments (Paris et al., 2010). The relationship reveals the first and second dimensions of power where politicians enact the legislative activity and manipulate the political agenda according to their personal interests and benefits. Undoubtedly, that may change when the Troika seizes the reins and the power is transferred over to the triumvirate, a likely scenario since the Troika wields the strongest power among the principals, i.e., the third-dimension of power. The neoliberal spirit has already shown its effect on the social, economic organisational and political life of Greece. That impact is of absorbing interest and will be investigated further so as to identify the principals who hold the most power and will eventually prevail in the Greek NHS. Will the neoliberal spirit prevail in the public sector? Will Greek politicians and parties lose their power over their country’s NHS? Will agents react against managers and their neoliberal policies as it happened in the UK? Is the transfer of power going to burden the hidden mechanisms that have caused inefficiencies in the Greek NHS so far? Those are some of the questions the thesis will answer.

Another basic dimension of NPM is market competition in the public sector. In its keen pursuit of improved efficiency and containment of costs, NPM relies heavily on competition and the introduction of quantitative performance measures (Hood 1995, Blair 2000). That NPM component is interlinked with free market ideology which sees public services and, in this case, healthcare, empowered and more efficient if exposed to market competition (Terry 1998, Pollitt and Bouckaert 2011). In that type of business environment the laws and forces of [supply and demand](https://en.wikipedia.org/wiki/Supply_and_demand) are not controlled by the State, they emanate from market principles. However, that kind of climate comes with a caveat as the risk of belittling the noble side of public services and degrading citizens’ rights increases a hundredfold. On the issue of the health sector, NPM upholds that, due to the fact that a public monopoly on health is inherently dysfunctional and does not effectively meet the citizens’ demands, more markets should be created so as to compete with each other and provide more options to patients who can then pick and choose between different health providers. In the ‘eyes’ of NPM, market competition ensures the presence of an efficient economy and better service responsiveness to consumers. It is precisely that dynamic presence and potential of the private sector in the health market which has paved the way for partnerships with the public sector. Accordingly, there is a growing number of contracting-out agreements, PPP (public-private partnerships) networks, sales of services (e.g., sales of healthcare services and hospital beds to private insurance companies), and other mechanisms functioning between the two sectors with the purpose of generating quality and cost efficiency (Hermann, 2009).

One more aspect of market ideology is the globalisation of health services. Not only does it encourage the mobility of health professionals, management consultants, and patients across borders but also the expansion of multinationals and public health entities. The UK’s NHS is such a case (BBC News Health, 2012): it targets innovative solutions in international healthcare through the use of new technologies (WHO, 2015).The growth of international finance and health research has the potential to help countries, mostly developing ones, faced with instability in finding solutions. Medical breakthroughs in one country can be made almost instantly available to other countries as well (Wassenaar, 2003). Moreover, the development of international healthcare organisations with a strong influence, such as the WHO, facilitate the collection and sharing of health statistical data (indicators, health standards, country profiles) and raise the global alarm against potential threats to health.

Yet, without a doubt, the coin of globalising health services has a reverse side. The abundance of multinationals and the increase in international trade have weakened the control that governments can exert over their countries’ domestic policies: the financial crisis of 2008 affected the entire world due to the strong cross-borders links that had been developed. Further, as Djelic and Sahlin-Andersson (2006) highlight, in its most extreme form, marketisation is associated with the commodification of all public values which might end up in commodifying nearly all aspects of human life. As Pollock (2005, p.15) asserts that what is occurring “…is an accelerating erosion, and, increasingly, a reversal of what the NHS was created to achieve: making healthcare a right, and no longer something that could be bought or sold”. On the same issue, Hermann (2010, p.136) advocates “healthcare is not an economic activity and should therefore not be subjected to economic rules”. In the case of Greece though, research has shown that Greek public hospitals have been imposing user charges on their patients, throughout the years in order to increase hospital budgets. Be that as it may, that practice directly contradicts the founding law of the Greek NHS which envisages public health as a social good, free to all, and provided by the State. Among other things, the present study’s framework will be exploring exactly that: whether global forces, such as the IMF and the Troika, under the pretext of restoring financial stability in the country and in return for the financial help they have offered, will succeed in spreading managerial rhetoric and proceed to reforms which will cause the marketisation of health services. Crucial here is the contribution of the principal-agent theory which will examine the power of the Greek policymakers and whether the voice of the agents is sufficiently stentorian to withstand the onslaught of foreign power and international reform trends, filtering the best options that could fit their country’s capacities (Pollitt and Boukaert, 2011).

The introduction of managerial administration as borrowed from the private sector consists of another basic dimension of NPM. As Hoggett (1991) supports, bureaucratic practices were ideal in the past when working conditions were standardised under a system of mass production. In today’s world, emphasis is put on institutional economics and the ideology of managerialism. It involves the prioritisation of private sector values such as supervision, performance appraisal, and resource efficiency in the operation of public enterprises, on the assumption that the former is superior to the latter. Usually, it represents the organisational mask of neoliberalism behind which the ultimate goal of accumulating wealth and profit rather than tending to the public interest is concealed. Among the new management practices actively promoted in healthcare is the use of Information Technology (IT). As Simonet (2014, p. 6) puts it in a nutshell:

*“the widespread adoption of information technology such as electronic medical records and accounting systems in the new digital-era will ease the collection of health data, reduce transaction costs, eliminate the information asymmetry that benefits the medical profession, and allow a better planning and monitoring of hospital activity”.*

Another honing element in the NPM toolkit is the modernisation of procurement systems. Through that specific mechanism and the help of e-technology hospitals achieve better control of stock and allocation of resources since effective procurement requires market research that identifies the best supplier in terms of price and contract details such as after sales support (Stoker, 2006). In either case, the main purpose is to safeguard the public sector against wastage and corruption (Pollitt and Bouckaert, 2011).

On the same axis, NPM literature highlights the significance of accounting and auditing systems in all countries in need of having their public services reformed (Gruening 2001, Bolton 2002, Torres 2004, Lapsley 2008). Financial management and modern accounting systems emphatically rationalise public expenditures and aim at enhancing transparency and economic development which are indispensable components of reforms. As Blair (2000, p.520) outlines:

*“Today, because of devolution, states and cities must be ready to use their political power and resources to strengthen and revitalize area economies. When industries begin to weaken, when branch plants reduce the size of their workforce, or when a company looks for a site for a new facility, most state governments must willingly and quickly use their resources to influence the business decision-making process.”*

It is obvious that all of the above are clear-cut traits of NPM reforms and constitute an appropriate tool for tracing the level of influence exerted by the NPM paradigm on Greece. Further, Blair’s quote above denotes the crucial role of the principals’ power to make rational decisions on the ways resources will be used and drive agents to change; and points to the importance that the principal-agent theory has for the NPM framework.

Managerialism, however, should not just be seen as a mere introduction of new practices but also as a new ideology regarding the role of the state and of public employees and policymakers (Clarke and Newman, 1997). In that regard, to improve the performance of public organisations, the state delegates to resourceful managers, at levels differing among countries, the management of its healthcare organisations (Kettl, 1997). Not surprisingly, this new school of thought has caused a host of reactions in the UK between managers who tried to exercise their authority and employees who tried to protect their professional autonomy. Dent (2003b, p.33) explains that managerialism:

*“represents a challenge to the professions. This is especially so in relation to professional regulation, audit and the organisational governance and not least the medical and nursing professions”.*

The Greek state does appoint managers inside the hospitals under its auspices but their freedom to manage is limited indeed. That is attributed mainly to the fact that the Greek NHS is administered by the central government and the political parties whose presence within hospitals takes the form of politicised trade unions. A propos the arrival of the Troika and its sweeping reforms, a landmark in Greece’s history, it is worth investigating whether the intrusion of managerialism will try to change that deeply embedded mechanism. What is more, the issue makes it imperative that managers be asked whether they have started acquiring more freedom in managing hospitals, a mechanism that Critical Realism both fosters and requires.

The literature has shown that increased managerial autonomy and freedom could result in unethical behaviour such as basing employment posts on personal preference relationships and raising issues of accountability, transparency, and corruption (Minoque, 2001). Expanding on that, Christensen and Laegreid argue that (2002, p.290) “a managerial concept of democracy might have weakening effects on civic responsibility, engagement and political equality, and enhance the role of administrators and managers”. What matters here is the level of the managerial autonomy and delegation that each country enacts through a set of laws and regulations. Again, the framework and the principal-agent theory in terms of the level of power that hospital managers will acquire through the new reforms; and how they will use that power when guiding their agents will help determine the level of NPM implementation both as practice and ideology within the Greek hospitals, which is the aim of the thesis.

The sixth dimension of NPM refers to the control public organisations can have by measuring their outputs. It relates to the neoliberal ideology which decrees the ‘virtue’ of parsimony in the use of public resources. Similarly, market ideology mechanisms require rationalisation of resources and efficiency in production so that provision of services may become as competitive as possible (Exworthy and Halford, 1998). Adherence to managerialism will provide the technical expertise and the tools to measure productivity, the implication being that targets, cost, and outputs will be clear. Further, such practices will make failure and inefficiency more transparent and, in certain cases, will even rectify such drawbacks. In the health sector, the DRGS consists of such a measure. As Simonet (2014, p.3) explains:

*“DRGS is a good proxy for the broader concept of NPM, because DRGS draws on two of its basic principles: firstly, a split between financing, primarily from the government, and care provision by hospitals; secondly, incentivisation and competition for patients as care providers’ income is directly related to patient volume”.*

The system of gatekeeping falls under the same concept: a primary healthcare network of General Practitioners acts as a gatekeeper who limits the cost and supply of health services emerging from excessive and repeated visits to doctors. The measure has been adopted by a number of health systems in the world such as France’s, the UK’s, Germany’s, Switzerland’s (Simonet, 2008), and the USA’s (Tulchinsky and Varavikova, 2009) and contributes to savings in health expenditure and to decongestion of hospitals. Another tool is the electronic drug prescription monitoring system that will curb the irrational use of medicines. It is a method that, in the past, has significantly contributed in controlling pharmaceutical expenditures of some countries’ public healthcare sector (Porterfield et al., 2014). Similarly, as Dent argues (2006, p. 450), in many EU states “physicians are now expected to work in line with clinical guidelines or protocols and have their work routinely evaluated according to criteria not necessarily of their own choosing”. Clearly, all mechanisms described above refer to the ideologies of marketisation and managerialism, combining a view of efficiency in public services with more individualistic and business-pattern norms. It is clearer than day that, neoliberalism has been stealthily creeping in bringing in its wake less autonomy for health professionals (Kirkpatrick et al., 2009) and potentially more risks in healthcare received by patients in hospitals, in the name of cost savings and due to budget constrictions. With that framework in mind, a perusal of the reality as it unfolds at present in Greece may prove worthwhile. Will the new mechanisms emerge victorious from their fight against the deeply embedded corruption practices? Will they vie with restricting medical subjectivity (Minogiannis 2012)? Will evidence-based work be applied to and adapted by hospitals? Those are queries which from a critical realist’s perspective will assist with the crucial task of exploring the underpinning generative mechanisms and evaluating their outcomes. The reports by Greek officials (policymakers), hospital managers, and doctors are expected to shed light in that direction and clear the mist shrouding those issues.

Emphasis on performance measurement is another important dimension of NPM. It needs to be thought of as an element of a rational system tied to the ideology of neoliberalism in terms of strict surveillance and controls (Hoggett 1996, Bezes et al. 2012); to the ideology of managerialism in terms of stressing efficiency and productivity (Bangura, 2000); and the ideology of marketisation in terms of economically advantageous performance contracts (Simonet, 2014). One common practice in healthcare is the pay-per performance scheme. Under it, doctors are offered financial incentives to improve health outcomes (Forrest et al., 2006). It has been used by many a public and private health organisation worldwide (Pollitt and Bouckaert, 2011) but it found fertile ground for expansion in the USA and the UK. As Lee (2010, p.6) explains:

“*Physicians know exactly how they compare with their peers, both locally and across the network, on specific pay-for-performance measures. Those with the lowest rankings meet with medical directors to discuss strategies for improvement”.*

However, as Bezes et al. (2012) argue, the encouragement of competition between employees of an organisation may threaten their collegiality and devotion to teamwork which, in turn, may affect their productivity.

Another significant instrument in that toolbox is performance appraisal: a complete set of performance health indicators, ready to monitor the efforts at work in order to ensure quality, efficiency, and accountability of the services offered the public. What is more, performance appraisal foresees the use of discrete indicators for each category of health services. For instance, clinical protocols:

*“intend to evaluate, reassess and improve clinical care not only in terms of outcomes but also in financial terms for the benefit of patient welfare, and of the hospital as an organisation, denoting in that way the significance of evidence-based medicine.”* (Tagarakis et al. 2015, p.1298)

In the UK, the benchmarking evaluation method is merely a way of rating performance of hospitals in terms of services such as waiting lists and death rates and determining use of resources so as to determine a hospital’s financial status. It is also present so as to reward achievers and overachievers by offering more autonomy and financial incentives (Lapsley 2008, Simonet 2008); and to penalise offending hospitals by holding over the head of their management teams the Damoclean sword of dissolving their contracts (Bevan and Hood, 2006). Additionally, hospital managers have specific performance targets to accomplish within a limited period of time as specified by the practice of performance contracts (Dunleavy and Hood, 1994). Even though it has been argued that more public accountability and transparency are possible when performance indicators are established within an organisation, the issue that arises here involves the demand that hospital managers perform within an all-too-short time during the term of their contract (Dopson, 2009).

**How do Principal-Agent Theory and Critical Realism inform the analytical framework?**

Healthcare organisations constitute complex systems which are shaped by social entities that produce social processes and structures. With that in mind and in order to probe into the depth of NPM embeddedness into Greek healthcare organisations, it is necessary to enrich the framework of NPM with other perspectives. The first one, Principal-Agent Theory (PAT), incorporates the manoeuvering of human agents within a changing organisational context by taking into consideration the responsiveness of their individual incentives (Petrie, 2002). It enriches understanding of NPM by assessing the human logic and rationale behind reforms, considering issues such as the manner in which doctors interact with reforms. The second one, Critical Realism (CR), as a philosophy emerging from the combination of transcendental realism and critical naturalism, brings into the present research ontological and epistemological perspectives (Archer et al., 2013). The thesis posits that there are some common grounds between the two approaches. Thereby, ontologically seen, the incentives that trigger thoughts and actions between principals and agents are in the sphere of the real, they exist, regardless of whether they are researched or not. Methodologically, CR offers a three-layered organisational reality which provides the basis for causal explanations which mesh human agents with organisational structures, in other words, those incentives act as the driving force for provoking outcomes such as the formulation of laws. It adds to NPM the importance of the capacity individuals have to interact and form organisational structures (Bhaskar, 1975). Principal-Agent Theory and Critical Realism are interlinked in such a way as to assist a study understanding the motives and tactics of groups of participants at the workplace and the role these might play in producing generative mechanisms and types of outcomes in the formation of organisational structures. Both concepts are examined in detail below.

*Principal-Agent relationships*

The Greek NHS historical development chapter and the NPM literature review highlighted the interconnection between the main NHS actors as an important factor in understanding their role in the system and their contribution to its development. When studying working relationships it is essential to take into account the intentional aspect including that of self-interest. Theoretically, analysis of these relationships within an organisation and especially in public healthcare settings may be approached by means of the principal-agent theory (Smith et al. 1997, Saltman et al. 2007, Ludwig et al. 2010). Although it is not an over-arching theory with a strict set of assumptions or conclusions, researchers do turn to it to elucidate the interactions between important players and the managerial and political issues of central relevance binding those relationships.

In broad terms, the theory explains that, within an institutional setting, there are different groups of players with ambiguous goals and incentives (Broadbent et al. 1996, Fleetwood and Ackroyd 2004, Lane 2005). Principals delegate responsibilities to agents to perform certain tasks for a predefined reward (Jensen and Meckling, 1976). Those relationships are characterised by different goals, benefits, preferences, and information asymmetry (Archer 1995, Lane 2000, Van Slyke 2007, Thompson and McKee 2011). Principal-Agent theory argues that there is usually conflict between principal and agents due to different personal objectives and hidden actions on each part, unless both parts work for altruistic reasons. Public principals hire agents to perform the job efficiently so that themselves, gain power, prestige, and money. Agents on the other hand, are motivated by hefty remuneration packages and the security of their autonomy. It is then that information asymmetries arise. For instance, it is difficult for hospital managers to monitor the doctor’s performance and evaluate cost and efficiency because of the latter’s special expertise. One of the challenges is to try and create greater alignment between the behaviour of the agent and the objectives of the principal by means of various incentive schemes (Petrie, 2002) so as to ensure better cooperation between the two parties.

In the Greek context, principals are the holders of different kinds of power. The Troika, the foreign principal, is assumed as striving to negotiate with the domestic principals (policymakers and hospital managers) in order to force them to bow their heads to austerity measures and managerial reforms, all the while allowing neoliberal ideology to trespass undetected. In return, the Troika is offering managerial support but also financial aid in the form of a loan. The loan does have an interest rate so it would be safe to assume that the Troika is not helping Greece for altruistic purposes. In turn, domestic principals try to negotiate for smoother reforms. They are principals in the sense that they have the power to make a deal with Troika or even decide to leave the negotiations table. They have the power to change the law of the country and implement reforms by mandating agents (doctors) to accept and interact with them effectively. To put it bluntly, Greek doctors are the agents of both domestic and foreign principals, thus serving two masters.

The thesis will focus mainly on the past and present relationships between domestic principals and agents, as those themes clearly and unquestionably emerge from the literature. The agency between the Troika and the Greek doctors makes for an absorbing study but with the Troika in the role of the foreign principal the particular principal-agent problem becomes complex and nebulous. That is due to the nature of the task (only final decisions are publicised, not negotiations); the underlying loan contract (complicated and not in fixed terms); and the mandate and characteristics of the principal (main incentives are not revealed). More than that, qualitative data on the Troika’s perspectives were not made available to the present study’s researcher. The Troika’s power as a foreign principal will be highlighted implicitly in order to help with the analysis and discussion of the thesis.

The fruitful relationship between Principal-Agent Theory and the NPM paradigm lies in the fact that the latter promotes relations of power and domination (e.g., managers and doctors in the UK). NPM promotes the technocratic ideology that managers can mandate agents to work in a more efficient manner in the public sector. In this case, PAT intends to provide a more detailed picture of the NPM reforming context by integrating the past and current manoeuvres and intentions of the Greek and foreign principals and doctors (agents) in a changing institutional setting. It intends to provide an understanding of their new incentives and efforts to secure benefits upon the occurrence of opportunistic behaviour while involved with NPM practices and ideology. In terms of the link between the Principal-Agent Theory and Critical Realism, it is assumed that the study of the stakeholders’ interactions generates mechanisms that CR tends to unravel. For instance, the lack of strong incentives for agents may lead to poor job performance or unethical practices (clientelism) in an organisational setting. Overall, it is implied that in order to understand public sector reforms an elementary understanding of the PAT concept is essential. It integrates stakeholders’ interaction in terms of analysing their role, power, and tactics within the system. Relevant questions are generated in the interview schedule. One such question may investigate the frequency with which hospital managers meet with doctors and to what extent they are serious about solving their concerns. Another one may look into the extent to which policymakers understand and respond to the needs of health organisations. Answers are expected to provide the meanings extant in principal-agent relationships. Together with the interpretation of other data, they contribute to the evaluation of the recent Greek reforms.

*Critical Realism*

Critical realism supports the thesis by offering a coherent exploration and analysis of ontological (what organisations are) and epistemological (how organizations are changing) assumptions (Fleetwood and Ackroyd 2004, Contu and Willmott 2005). It provides a causal-explanatory method for identifying the way the social world is constructed (Archer 1995). According to CR, the world is composed of a stratified reality which provides the mechanisms and the casual power for actual events to happen (Patomaki and Wight 2000). By building on those insights it guides the researcher to look for that form of social reproduction which invokes the power of people (influenced by hidden factors) to affect the organisational progress (Ackroyd, 2012). This research can improve and develop knowledge. Thereby, CR contributes to NPM an in-depth and comprehensive analysis of change in the public sector. It enriches and binds NPM with Principal-Agent Theory as it holds that organisations are structured and reformed by their people who are engaged in different organisational roles and group activities.

The researcher came across other theories that could potentially fit the needs of this study. One of them is New Public Governance (NPG) which, according to a number of authors, is a development of NPM (Osborne 2006, Dunleavy et. al. 2006). Its theory upholds that the state’s reforms are better supported by synchronised means of governance such as citizens’ networks, interrelationships between public organisations, and technological integration (Rhodes, 1997). Nevertheless, although NPG seems a dynamic concept worth employing, it will not do for the Greek context. At present, the country is in a serious crisis and in a phase of disarray. Resources are scarce, citizens see life as a daily struggle, and morale has been sinking to new lows. In that context, networking sounds like an improbable luxury. Further, the external forces that rule the country are trying, together with the Draconian reforms, to also embed in the public sector the neoliberal ideology. As a result, collective efforts to govern Greece are thwarted. Therefore, a framework such as the NPG would fit countries with far more stabilised socioeconomic contexts.

Historical institutionalism is another approach that could have possibly helped the present study. The argument in its favour is that policies and rules that form the structure of a public institution have a persistent influence over its key actors and their behaviour for the remainder of that institution’s existence (Steinmo et al., 1992). As approaches go, it is obviously well-suited to explaining the persistence of policies. Nevertheless, given the focus of the present study, it is less promising as a means of explaining policy and structural changing. Further, as approaches go institutionalism does not explain ideology adequately nor does it focus on practices: It centers more on the intramural politics and existing structures of organisations rather than those organisation’s extramural intricacies such as interest groups and changes in the legal and/or political system which influence the business realities. For instance, it is common knowledge that organisations exist but how do they vary? Change is endemic to social relationships and organisations. As Ackroyd resonates (2012 p.234) “realists see organisations as being embedded in a particular social and sconomic context, which external entities can profoundly affect the activities of organisations”. Pressure groups and stakeholders as well as other external factors such as technological, political, and economic influences need to be analysed properly as part of their changing context.

In that case, CR provides a far more coherent concept for the integration of the conceptual framework. It views organisations as open complex systems with structures reproduced by the participants within them. Still, they have emergent properties binding participants to a particular pattern of relationships. Therefore, the object of each critical realist study is to unearth and reveal the truth and reality hidden behind those discrete sets of relationships; and to analyse the way outcomes may become the consequences of causal processes. CR argues that organisations exist independently of the researcher’s knowledge. It does however accept a form of epistemological methods which can be applied by researchers in order to provide explanations while analysing these phenomena (Fleetwood 2005, Easton 2010). In doing so, it distinguishes three layers of reality which can certainly help the researcher be in a better position to understand and explain the research context. Those layers are: the Real, the Actual, and the Empirical (Bhaskar 1998). The Real includes the mechanisms (or structures) which, because of causal powers, generate events and outcomes. The Actual refers to those events and outcomes caused by the interaction of the real domain. Provided that those powers and mechanisms are activated, it helps in evaluating the result. Last, the domain of the Empirical encompasses how outcomes and events are experienced by the actors of the system (Angus et al. 2006, Bergin et al. 2008, Clark et al. 2008).

By integrating that approach into the analytical framework the study focuses on the hidden factors, such as bureaucracy, that enhance or burden the implementation of reforms and the actual reforming outcomes be they failure or successful implementation. The study is therefore also in a position to identify how the above are experienced by principals or agents. As Reed (2001, p.220) asserts, there also exist “new generative mechanism(s) which has been driven by ideological and policy changes within the wider socio-political context”. Finding out whether the ideological move of NPM brought by the Troika in Greece will provoke new mechanisms and generate more efficient changes certainly makes for an intriguing task.

Central to CR analysis is an acknowledgment of the agency (or human beings) who may have the capacity to mobilise resources and skills to change the structures (Archer 1995). The two, agency and structure, are not ontologically separated but interwoven and mutually influential. Structures are only possible because of human activity. Yet, once they emerge they possess casual powers that affect human actions. Moreover, as Arger (1995) argues, structures have a history which influences their present and future existence. Thus, understanding how historical events have contributed to the formation of Greek healthcare organisations also becomes a focal point within the central scope of the present thesis. Conceptualised as a practice and ideology, NPM looks at structure and agency. For instance, in its manifestation as a reforming paradigm, it takes into consideration the politics of change, ideological values, historical roots, new structures, and the actors (managers versus bureaucrats) who are engaged in that change. Those considerations also incorporate the principal-agent theory in the sense that each part has different incentives to produce structures. As Lane (2005) explains, “efficiency or public ends may not be met because of the power of agents, such as bureaucrats when dealing with politicians”. Needless to say, lying in wait in the background are the reforms of the NPM which seek to address the problem by placing new constraints and competition upon public employees in lieu of what are viewed as inefficient political and bureaucratic structures.

**Framework Applicability in Analysing Clientelism**

To illustrate the applicability and usefulness of the conceptual frame it is necessary to elaborate on the phenomenon of clientelism. The most evident effect of that unethical practice is the abuse or misuse of public power for personal intentions (Ongaro, 2009). That which emerges from the literature is that clientelism has cultural and historical traditions rooted in issues as wide ranging as the Ottoman influences in Greece (Dent, 2003a). In the case of the Greek NHS, clientelistic practices have taken several forms. For instance, in political clientelism, officials offer public posts to appointees to win electoral support. They also employ as hospital managers personnel stripped of all necessary qualifications or eligibility (Liaropoulos et al., 2012). In another form, doctors oversubscribe unneeded medicines to win benefits from pharmaceutical companies (Mossialos et al. 2005, Minogiannis 2012), or receive informal payments from patients by offering the lure of preferential treatment (Dent 2003b, Mossialos et al. 2005). Some doctors also go as far as to refer patients visiting public health organisations to their own lucrative private practices (Mossialos et al. 2005, Papanikos 2013). And if that were not enough, in regional Greece, local governors build new hospitals next to each other so as to keep their local ‘clientele’ happy by providing hospital services right at the voters’ doorstep. Such vote canvassing practices may only imply the undermining of public service efficiency, ethos, and values. Hence, if the nature of clientelism were to be clarified, it must be examined in context.

The framework of NPM contributes to providing part of that context. The review of international literature offers the comparison with other countries and identifies the public failures. It demonstrates that there have been other countries with equally high levels of clientelism and patronage which tried to reform using the NPM paradigm so as to avoid ill practices. It also indicates that certain managerial practices driven by ideological motives (neoliberalism and accumulation of wealth) may worsen clientelism and corruption. Such is the case of managers who abuse their position to their own benefit instead of arriving at the desired reformative result. Literature emphasises that as early as the inception of the Greek NHS, the abusive phenomenon of clientelism has been as acute as it has been severe. It also asserts that measures towards reducing clientelism had been taken before with little or no success. The literature points out that the Troika’s arrival did intensify attempts to reduce clientelism but, at the same time, it directs attention to the fact that Greek culture and history, influenced by 400 years of Ottoman traditions, have played a pivotal role in the diffusion of clientelism. In that way, the literature points at the extreme level of embeddedness clientelism and corruption have had in Greek mentality. A key finding of the present study anchors on whether NPM will help eliminate the phenomenon or whether NPM will permit malfeasance at higher levels than previously possible. It may also be wise for the researcher to consider whether the influence of the paradigm will enhance or undermine other key NHS issues such as bureaucracy and wastage of resources.

Unquestionably, PAT is a theory that will come to the aid of the present study in researching clientelism as it advocates that many are the kinds of personal relationships in the public sector which may drive to clientelism (Lane, 2005). Main causes are the difference in incentives, benefits, and information asymmetry between principal and agents. The thesis explores those areas and identifies the problematic relationships between actors and their negative consequences on the system. One such consequence could be that doctors (agents) establish clientelistic relationships with pharmaceutical companies because principals are unable to monitor the doctors’ work due to the information asymmetry existing between them.

With its structured ontology, critical realism provides a profound understanding of the phenomenon of clientelism. Critical Realism links clientelism to human actors and the established social context. For instance, a chain of events and their interaction with social groups may give rise to processes which, if and when activated, may bring about possible outcomes. Based on that premise, the study tries to discover not only the mechanisms provoking clientelism but also to identify that unethical practice’s outcomes. For instance, Greek doctors may be engaging in clientelism because of their deplorable salaries in the Greek NHS. The interdependence of agency and structure contributes to illustrating that even though clientelism is created by doctors it is so deeply structured within the Greek NHS that it becomes inevitably interwoven with medical practice.

In essence, it can be argued that the entire integrated framework contributes to fathoming the phenomenon of clientelism. Through the use of three discrete concepts, the study examines clientelism in context, clarifies its nature, identifies the mechanisms that generate it, and embraces the role of human actors. The wealth of that knowledge, combined with primary empirical data contributes to discourse and addresses the aim and objectives of the thesis.

**Summary of the Analytical Framework**

In sum, the chapter provided the formation of an analytical framework with a view to comparing and testing it in the Greek case as well as evaluating the intrusion of managerialism as underpinned by the Troika’s intervention.

The core of the framework is the NPM paradigm which develops the research’s broad reforming context. Ideology and practices are the main pillars emphasising each dimension of NPM according to the literature. Ideology describes the prevailing climate, the broader picture of reality, the structure, and the context. It provides explanations of how public services are structured, whether and to what extent they are corrupt and how efficient or not they are. It also shows how government is organized and how it exerts influence on the efficiency or lack thereof of public services. Moreover, it examines other nations’ structures and the ideologies that fuel them. Additionally, ideology looks at the global setting and global institutions such as the ECB and IMF and describes their reigning influences. As to the practices, those give the narrow picture of the public sector, which not only informs on NPMs dimensions and tools of implementation but also facilitates exploring the ways in which different principals and agents are interwoven with the NPM paradigm.

The Principal-Agent Theory integrates the framework with the manoeuvring of key players during reforms. It enriches NPM as it provides valuable information about how the powerful and their followers are involved with NPM ideology, practices, and politics of change in different countries. Lukes’s theory of power furthers understanding of the behaviour of different actors during and in decision-making. As it is a given that human beings form social systems and have the power to change organisations, their attitudes and games of power should not be neglected from this analysis.

The views expressed by Critical Realism bolster the conceptual framework by building a real organisational context and illuminating the main mechanisms and structures that form and evolve in Greek hospitals. CR enriches the NPM paradigm by identifying the structures that bind actors with organisations and by identifying the factors enhancing or burdening the reforming activity.

The international literature on NPM is rich indeed but it is certainly missing one small albeit crucial component: the Greek case, especially now that the Troika is reigning supreme (in emulation perhaps of autocratic Ottoman rule). Seizing at the opportunity to contribute to international literature, the present thesis develops a new, three-concept framework to analyse the case. The three concepts bring together all the elements –reforms, actors and mechanisms– necessary in testing them in the Greek context; and contribute to understanding the development of reforms in the Greek NHS under the Troika’s intervening policies. The framework serves in addressing the key aim and objectives of the thesis, guides the methodological and empirical work, and offers key themes for analysis and discussion.

**Chapter 5: Methodology**

**Introduction**

Chapter 5 outlines the methodological approach towards understanding the implementation of New Public Management as a practice and as ideology in the Greek Hospital Service at a time of financial austerity. That is also the main aim of the thesis. First, the aim and objectives of the study remind the reader of the research focus and purpose. Second, the methodological background offers a broader picture of the research field by presenting similar international studies carried out on the health sector in the past and the methods employed to that purpose. That picture serves in justifying the researcher’s choice of methods which consist of the literature review (historical background and integrated framework); and the interviews with key actors. What is more, the researcher’s stand on making those choices becomes clear.

Then, the chapter introduces these methods and gives information on the pros and cons of each method. The qualitative research furthers insight into the implementation of NPM in the Greek NHS through the collection of (a) secondary data (literature review and framework); and (b) primary data (qualitative interviews). At the beginning, a review of past and present literature on the Greek NHS examines past efforts to rectify the health system and offers an overall estimate of the country’s general context. Next, the chapter turns to the Troika’s tenure as a cause for the intensification of managerial spirit in Greece. For that reason, the study develops a novel theoretical framework which is the main conceptual approach to the realities prevalent in the Greek NHS and its deeply social, political, and human aspects. Thus, the literature review of the NPM paradigm offers theoretical and practical insights into multiple cases -especially that of the UK’s which underwent a path similar to the Greek case’s; and assumes the role of a comparative tool in order to assess whether the NPM paradigm has indeed been implemented in Greece. The framework is intertwined with the Principal-Agent Theory which captures human interactions within organizations; and enriched with Critical Realism by means of a realist social ontology which sheds light on mechanisms, structures, events, and outcomes. As a three-pronged approach, the framework constitutes a strong analytical tool that aids the researcher in his pursuit of the Greek case by identifying the core sample and questions, as well as by providing key themes for investigation. Accordingly, it guides the empirical work of the thesis and contributes to the analysis and discussion of the theme under investigation.

Next, the chapter’s empirical research section describes how the research was conducted, including the documents researched and how they were analysed; who the participants were; how the questions were selected; what the interview process was; and how the data were analysed. The chapter then focuses on the limitations of each method, providing information on the study’s qualities; and the researcher’s training. It concludes with the actions taken to safeguard the ethical conduct of the research.

**Aims of the Research**

Unquestionably, the Greek NHS has been the subject of major change initiatives promoted by the Troika. Especially hospitals are a particular target for implementation of new managerial tools towards cutting costs and increasing efficiency. A review of the past and present literature of the Greek NHS and an examination of the subsequent health reforms over the history provides an integrated picture of the country’s political, economic and social context depicts the impact of crisis in the health sector of Greece and identifies research needs and mechanisms to be investigated. In order to explore the influence and effectiveness of Troika’s neoliberal agenda and to track the progress of reforms as remedy measures, the main aim of the research is to understand the implementation of New Public Management as both practice and ideology into the Greek Public Hospital services, a key element of the Greek NHS, at a time of financial austerity. Further objectives which intend to guide the thesis and contribute to the efforts of solving the puzzle of Greek healthcare after so many efforts at reform include the following:

**a)** Detail the characteristics of the Greek public healthcare system in terms of health policies and working conditions within public hospitals.

**b)** Investigate and critically evaluate the success or failure of the successive reforms in the Greek NHS; and track the formation of a National Health Service and implementation of NPM as a political project.

**c)** Identify those factors which contribute to or impede the adoption of New Public Management in the Greek NHS system.

**d)** Explore the impact of the crisis on the present and future development of the Greek NHS system and look into the opportunities for reform.

**Methodological Background**

Research into public services is usually concerned with the provision and efficient use of resources that contribute to an outcome satisfactory for citizens and, consequently, to an improved quality of life within society (Bowling, 2009). There is also a growing body of research that peruses the impact of reforms on public sector employees (Berg, 2006). The rise of NPM has created new demands and has raised high expectations for performance and outcome indicators. Several methods have been used so far in an attempt to evaluate the daily operations in the public sector and especially in the vulnerable sector of the health services. A brief review of methods used in similar past studies is provided as a foundation for selecting this particular research approach as the basis of the thesis.

Zampetakis and Moustakis (2007) have examined entrepreneurial behaviour in the Greek public sector. The authors investigate the expression of entrepreneurial behaviour within the context of organisational support. They use structured questionnaires which are distributed to public servants in different job categories such as engineers, medical staff, IT staff, and others. Their results reveal that there is a positive correlation between organisational support and employees’ entrepreneurial behaviour. Another study examines the impact of NPM on social work managers from England and Sweden through in-depth interviews (Berg et al., 2008). Its researchers’ aim was to reveal a picture of changes and reactions that the new wave of reforms has created. The findings reveal that social work managers appreciate the autonomy given them, feel comfortable dealing with financial issues, and appreciate the benefits of new knowledge in management.

In the UK, Storey (2011) examines the attitudes of managers and NHS employees regarding the role of the central government in the provision of public health service. To accomplish this, Storey used semi-structured interviews to engage 22 key informants. His approach is rather interesting as he draws interviewees from two different layers of the NHS: the central layer (Ministry of Health); and the peripheral (Strategic Health Authorities) one. Following the interview process, transcripts identify key areas of interest, behaviours, and perceptions between the two levels. Overall, Storey’s research indicates that the central authorities ensure that local administrators are aware of the government’s new policies and reforms. In turn, local authorities ensure that, at the very least, basic standards are being met.

In a similar study, Kirkpatrick et al. (2007) examine and compare the reactions between healthcare professionals, managers, and policymakers arising as a result of NPM reforms in the British, US, Danish, and Dutch healthcare systems. Another aim of that study was to identify efficient mechanisms which could contribute to the productivity of the systems above. To that purpose, the authors use a number of research methods such as seminars, workshops, and interviews. Starting with the study’s interviews, those have the purpose of gleaning the personal stories, ideas, and facts framing organisational realities (Cassell and Symon, 2004). As to the seminars and workshops, they obtain peer opinions and perspectives on the subject investigated. According to Lincoln and Cuba (1985), peer reviews are preferable when discussing the results of a study. Nevertheless, they usually involve a wide range of opinions, making it difficult for a researcher to record different angles at the same time. That type of method adds value to the quality of the research only in tandem with other methods (Flick, 2008). Yet, the study by Kirkpatrick et al. (2007, p.9) does reveal a vital fact: “there are some places where productive relationships have been forged and managers and doctors are working together –where the two perspectives have been a catalyst for service development.” Likewise, the pivotal role of policymakers is denoted in terms of encouraging the co-existence of management and medicine as well as delegating authority and empowering initiatives at both the clinical and local level.

Another study chooses a survey method in order to assess occupational profile, level of performance, and on-the-job training needs of nursing staff, employed in all public primary healthcare centres on the island of Crete (Markaki et al., 2009). For the purposes and facilitation of the authors’ research, the Training Needs Assessment (TNA) questionnaire was translated, culturally adapted, and validated.

Another intriguing approach investigates the performance assessment of health centres in Portugal using the EUROPEP instrument in order to analyse effectiveness regarding patient satisfaction and quality of services (Amado and Santos, 2009). The EUROPEP instrument encompasses 23 outcome questions grouped into five major dimensions: (1) patient–doctor interaction; (2) medical care; (3) information and support; (4) continuity and cooperation; and (5) organisation of services. Each question uses a 5-point Likert scale, ranging from ‘very poor’ to ‘excellent’. The EUROPEP instrument also considers a global satisfaction indicator, resulting from the clustering of those dimensions, which varies between 0 and 100 (Grol and Wensing, 2000). In another study of managed competition in the health reforms of Southern European countries, it was parliamentary discussions and similar documents which contributed to the research (Cabiedes and Guillen, 2001).

One of the few studies to use mixed methods in the health sector of Greece is by Merkouris et al., (2004) on nursing care quality. The study uses a quantitative and qualitative study on patient satisfaction and consists of 200 randomly selected in-patients from two, large, Greek metropolitan hospitals. The blend of qualitative and quantitative methodology makes for a complete description which facilitates understanding of the phenomenon and confirms the reported merits of triangulation (Coyle and Williams, 2000).

In an attempt to evaluate the move from the Greek Traditional to New Public Management, Philippidou et al. (2004) use interviews conducted with 15 expert officials. An initial investigation was based on documented and published reports (articles, official statements etc.). The authors showed a preference for interviews rather than structured questionnaires when it came to obtaining a deeper insight into the driving forces facilitating that passage. On the one hand, semi-structured interviews enable researchers to open directed conversations with officials and, on the other, officials feel relatively freer when expressing their perceptions.

In their longitudinal study on culture in a U.S. governmental environment, Zamanou and Glacer (1994) collected different types of data in order to examine various aspects of organisational reality. By using the mixed methods of survey, interview, and observational data, they were able to combine the specificity and accuracy of quantitative data with the ability to interpret idiosyncrasies and complex perceptions provided by qualitative analysis. Ratings on the 190 questionnaires are combined with data from the interviews, 76 of which were conducted before and 94 after the introduction of a communication intervention programme designed to change the organisational culture under investigation. Zamanou and Glacer suggest that the triangulated approach enables the collection of different types of data relating to different organisational elements, from values to material artefacts.

**Introducing Critical Realism Methodologically**

Based on the above research background, it is necessary to introduce briefly how the critical realism paradigm with its realist social ontology and epistemological grounds has enlightened the methodological approach of the research. A more thorough analysis where the contribution of the integrated framework is investigated follows later in the chapter. As the Greek NHS and especially hospitals are in the process of changing, Critical Realism provides a set of principles which guide the research and probe into the changing and complicated nature of organisations. According to that paradigm, the world is composed not only of events, states of affairs, experiences, impressions, and discourses but also of underlying structures, powers, and tendencies that exist or are known through experience. That underlying reality sets the conditions of the possibility for actual events and perceived or experienced phenomena to happen (Patomaki and Wight, 2000) thereby prompting the researchers’ analysis. The Greek healthcare is a system comprising a great deal of institutions with structures reproduced by the participants in them. In turn, participants have emergent properties which bind them to one another under a particular pattern of relationships. Therefore, the object of a critical realist study is to excavate the organisational structures and mechanisms which have historically comprised the organisation and reveal the reality that is concealed so as to be in a position to analyse the different sets of relationships which are still being reproduced and the way in which outcomes are the consequences of causal processes (Fleetwood and Ackroyd, 2004).

Critical Realism is highly pluralist in the types of methods that it uses to arrive at the ‘truth’. Its range of various methods focuses on alternative aspects of reality. Therefore, it stands to reason, that Critical Realism will provide more than one method to interpret the complexity of the Greek NHS and subsequently meet the thesis’s aim and objectives. The qualitative techniques employed are true to the nature of their subjects. As a first step, the literature review builds a solid foundation on which to base understanding of the Greek NHS. It sets the organisation’s historical development, reveals the characteristics and peculiarities of the system, and sheds light on how the Greek public health service is structured and what the needs for reform are. NHS literature also links to NPM literature as, at this point, Greece is just closing in on other countries where the paradigm has already been implemented together with similar ideologies and practices. NPM contributes to building an integrated framework that will be tested in the Greek case to explore the extent of the intrusion of the neoliberal paradigm as a means to reforms. Moreover NPM ties in with CR as its practices and ideology depend on the structures and hidden mechanisms that the CR guides the rearcher to focus. It also binds with the principal-agent theory as it takes into serious account the actors engaged in the reforms.

A significant number of themes in want of investigation come from the framework. Next, the interviewing method places the key themes under scrutiny leading to frontline vistas of the hidden mechanisms. It also identifies the changes as those have manifested themselves and have been steered through the system by three closely involved groups: policymakers, managers, and doctors. Using three different perspectives was deemed necessary for the purposes of the study as the groups’ discrete nature makes for varied and strong arguments on the complex reality of the Greek NHS. In other words, the thesis uses a deductive qualitative analysis through which the researcher essays to understand a phenomenon that is new to Greece by using concepts and theory which are already established (Elo and Kyngas, 2008). In that type of analysis, questions derive from theoretical patterns and frameworks which also contribute to the formation of categories and themes used in creating new senses of meaning but also in guiding the discussion on findings (Patton, 2002).

In sum, Critical Realism informs the thesis, its research approach as well as discussion. It shows that organisations are entities with real social structures and outcomes which have to be evaluated before their further development is understood. Accordingly, it enriches with its insights an integrated framework which serves as a tool that is being tested in the Greek healthcare case and contributes to its analysis. It also strengthens the research design as it identifies key questions and advocates that the only way to understand the truth is through declarations and lived experiences of the key sample. Last, as part of an analytical framework, it contributes to the emergence of key findings and to their discussion.

**Research Methods**

The study proposes the use of qualitative research since the main research goal is to examine the implementation of NPM in the Greek healthcare system and identify the changes that an economic crisis would imply. The argument in favour of using that approach is that, while quantitative research focuses on numeric data and deduction of generalisations via experiments and statistics, qualitative research seeks to scrutinise and explain social phenomena by interviewing or observing key actors (Winter and Munn-Giddings, 2001).

*Qualitative Research*

This type of research tends to view social life in organisations in terms of processes. As Pettigrew (1997) explains, process is a sequence of events, actions, and activities unfolding over time in context. It includes understanding how the past history of an organisation shapes present reality, how the interchange between agents and contexts occurs over time and examines them in a cumulative way. It is considered a flexible type of research method:

*“…because of its ability to represent the views and perspectives of the participants in a study. Capturing their perspectives may be a major purpose of a qualitative study. Thus, the events and ideas emerging from qualitative research can represent the meanings given to real-life events by the people who live them, not the values, preconceptions, or meanings held by researchers”* (Yin 2010, p.8).

Yin’s interpretation echoes the aims of the present thesis which are to grasp the realities, experiences, and views of health professionals, managers, and policymakers on the Greek NHS and on the changes that reforms trigger. That is also illustrated by the Critical Realism paradigm which is well suited to qualitative research and is used in the thesis as a guide for identifying the nature of the phenomena investigated.

In terms of research disciplines, qualitative research focuses on identifying patterns of attitudes and behaviours in a real, occurring context, such as the one of healthcare (Pope and Mays, 2006). On that, Al-Busaidi (2008, p.5) advocates that “using qualitative methods in health-related research has resulted in more insight into health professionals’ perceptions of lay participation in care and identification of barriers to changing healthcare practice”. Since the Greek NHS at the moment is the focus of major change initiatives promoted by the Troika, qualitative research seems to be the most fitting way for making a record of such developments. In the view of Denzin and Lincoln (2005), there is a variety of methods in qualitative research which can be applied such as narratives, documents, discourse, observation, and archival analysis. The purpose in doing so is to provide valuable historical information and describe routine situations, controversies, and meanings in the individuals’ lives and organisations.

As social research is a mixed bag of goods, it is customary for researchers to use mixed methods whose combined efforts help cope with the complexity of studied phenomena such as underlying exegetic mechanisms which may go undetected if using one and only one research approach. Therefore, when analysing an open social system such as a public organisation there are a number of mechanisms that can cause events and outcomes to occur. The researcher’s main goal is to identify them and provide explanations and meanings for those events. As those mechanisms are many and varied, the analysis should identify the key ones, in other words, those which carry the strongest explanatory power and are related to the empirical evidence-the causal structure that best explains the events observed (Sayer, 1992). Any mechanism proposed should be treated as a possible explanation. Moreover, data collections and the feedback by respondents constitute the validation techniques (Bygstad and Munkvold, 2011).

Mixed methods make for a more creative (Patton, 2002) and accurate insight of reality (Polit and Hungler, 1999). They are also recommended by Bowling (2009) as an effective means of investigating the multidisciplinary nature of health research. In the present thesis, the method of the literature review is combined with the interviewing one. At the beginning, the relevant documentation (books, articles in periodicals and newspapers, laws, etc.) provides a foundation for the research by tracing the historical development of the Greek NHS. It conveys a strong sense of how change affects processes and a sense of flow. It intends to show how events, patterns, structures, and system mechanisms have unfolded over time by focusing and contextualising not only the relevant discourses, reform issues, laws, and policy changes but also austerity measures regulating the economic crisis and those measures’ implications. That type of analysis also discloses the key players’ role and following their process of acting, reacting, or remaining apathetic. Further, it tracks the ways in which they have transformed their respective health organisations down the passage of time. The approach’s next step is the examination of the New Public Management literature as found in books and articles. Investigating the NPM parameter through the literature is instrumental in building a broader picture of how health public services have been structured in other countries as well as in Greece; and whether those services have been influenced and to what extent by the NPM paradigm. That is an indispensable step because NPM practices and ideology are fundamental parts of the identity of NPM. Observing their influences denotes observing NPM embeddedness and its impact over time. That also helps in building a threefold framework comprised of the NPM key dimensions in terms of practices and ideology, the principal-agent theory, and the critical realism paradigm. In turn, all generate the interview schedule and lead to findings on whether, under the guidance of the Troika and the Greek government, the NPM paradigm has indeed been embedded in the Greek public sector.

*Literature Review as a Method*

Reviewing the literature is a research activity all in itself. It is not unusual to see in journals mostly published reviews of literature that prove valuable resources for those wanting to gain an overview of a particular field’s existing studies. Literature review undertaken as part of the present thesis has invariably focused on the researched topic, analysed all the information available, and gained invaluable insights into floodlighting the complexities and challenges of the Greek NHS (Machi and McEvoy, 2009). On such insight is extracted from the course of the historical context and development of the Greek NHS using the literature review method. The process facilitates investigating how events have unfolded over the years (Boote and Beile, 2005). In doing so, the literature review identified gaps in the existing literature and moved towards filling them by offering a new building block to the edifice of knowledge. During its review, the present study earlier indicated that the Greek case and the Greek health sector in particular were topics somewhat neglected by the international literature relating to health sector reforms. Moreover, the review helped in identifying the research methods used by similar investigations and facilitated the researcher’s task of selecting and justifying that methodological approach which best fit his study (see section of methodological background) (Boote and Beile, 2005). The literature review also revealed that the present research project is innovative and unreplicated as it encompasses the influential –conceptual or empirical – studies in the field of health reforms and bridges the information gaps in the issue (Cronin et al. 2008, Onwuegbuzie et al. 2012).

The method in question does far more than simply describe perspectives of other authors since it proffers a critical evaluation of those studies. As Creswell (2013, p.48) states, a solid literature review should be able to:

*“present results of similar studies, to relate the present study to the on-going dialogue in the literature, and to provide a framework for comparing the results of a study with other studies.”*

Literature reviews are also important because they seek to summarise the theory that is written on a specific topic and identify relationships between theory/concepts and practice (Onwuegbuzie et al., 2012). Indeed, in the case of the present study, a literature review of the NPM helped in gathering and grouping together all that had been written on theory and outcomes. It then contributed to building an integrative analytical framework by grouping the theoretical knowledge into core themes and providing its main pillars: ideology and practice. In sum, the literature review gave the present thesis a novel synthesis of existing work. In turn, that composition led to new ways of looking at certain subjects such as building a multidimensional framework and identifying and filling gaps in the existing literature.

*Building a Novel Framework as an Analytical Tool*

As it was necessary to calibrate the study’s objectives and analysis with some precision; and make the nature of the work clear, the researcher structured a new framework from existing theory. In turn, the framework endowed the study with a wealth of attributes.

*Grouping the literature*

First, it provided the analytical lens that influenced nearly every aspect of the empirical work. In that sense, it served as a tool of grouping the literature by setting a narrower context of the most important parts of the theory. Subsequently, it helped the researcher in avoiding the confusion that exists in the international literature on the topic; and in concentrating only on the theoretical material that was most relevant. That focus contributed to addressing the aims and objectives of the research. As Anfara and Mertz (2006 p. xxiv) advocate:

*“Without at least some rudimentary theoretical framework there would be no way to make reasoned decisions about what data to gather or to determine what is important from among the wealth of data and possibilities of approaches to analysis that exist.”*

It was precisely that framework that came to the aid of the researcher, enabling him to grasp research complexities and guiding him to the ‘safe waters’ of a set of already established concepts and dimensions. The researcher was thus able to identify gaps in the existing literature and attempt to fill them by means of the study’s findings. Hopefully, that increases the study’s validity, giving readers the chance to follow step by step the entire process and decide whether study results are reliable. Were we to extend on the subject, the study’s novel framework also sets directions for future research (Croom et al., 2000), and bolsters the existing conceptual theory’s framework by enriching it with further data on the Greek case.

*Approaching the multidimensional nature of the study*

As outlined, the framework was developed in the current study so as to approach that multi-faceted and complicated field of research. Selecting the concepts relevant to the study relied heavily on how useful they may prove when shedding light on the past, delineating the present, and predicting the future of the Greek health sector (Eisner, 1997). Central in the ambit of the thesis’ analytical framework lies the NPM paradigm. The international, heated debate on the ideology, principles, and logic governing NPM were paralleled with the changing conditions in Greece under the Troika’s supervision so as to probe into the embeddedness of managerialism in the Greek NHS. The theory allowed the researcher to develop specific questions for each dimension individually and examine the level of NPM applicability. More than that, the NPM dimensions present facilitated not only in putting the data in order after the interviews’ transcription but also in that data’s interpretation and explanatory analysis in the discussion chapter (Anfara and Mertz, 2006). While building the framework, one of the main challenges encountered hinged on how to address the human factor and its influence on mechanisms and the development of reforms. The Principal-Agent Theory in that case complemented the framework by describing the relations and games of power between the Greek health system’s change agents. Further, the PAT has the added advantage of fitting in with NPM as the latter promotes relations of power and domination and, more specifically, the technocratic ideological notion that managers are the ones who make a public organisation work efficiently. Indeed, the PAT theory will be providing a more detailed account on the role health personnel has played and still plays in implementing new reforms and policies. Integration also came about via Critical Realism whose social ontology enables the empirical exploration of the hidden impediments and facilitators affecting organisational realities. One of the researcher’s goals is to make more critical evaluations. In order to accomplish that, the study linked Critical Realism to the NPM paradigm and the PAT theory, since both NPM reform implementations and interaction of key players, greatly depend on the interplay of those historical, political, economic, and social mechanisms and structures that CR can detect.

*Reaching the aim and objectives of the study*

As the nucleus of the conceptual basis, NPM (tools and ideology) illuminates the reforming process and tests whether and to what extent Greece has been complying with the traditional neoliberal paradigm in the IMF’s and the Troika’s portfolio. The more it is complied, the stricter will be the implementation of the managerial agenda. Through the PAT, the framework becomes richer as it can then address the study’s core aim by revealing how principals and agents are involved with the practices and ideology of NPM: If the data show that both groups appear to accept the incoming ideology and practices as a means to recovery, then, the influence of NPM paradigm is evidently strong. In a similar manner, CR turns its limelight onto the existing structures and mechanisms, reveals the historical and political context of Greece; and builds the foundation on which reforms will be erected: the more receptive the base, the easier the growth of reforms and the implementation of NPM in Greece. In that way, the integrated framework is enabled to proceed to further analysis and offer credible answers to the study’s research objectives. For instance, when the framework guides the researcher to focus on present and past structures-mechanisms of the Greek NHS, it brings into the surface the characteristics and peculiarities of the system which consists of one of the study’s objectives.

Change is in the very heart of the willingness of a country or organisation to reform in order to extricate itself from the claws of recession. The role principal and agents have elucidated their involvement with organisational structures and their ability to change steadily and consistently. In that sense, the key NHS players’ role, relationships, and ability, together with structures and mechanisms, act either as major contributors or grave impediments to the implementation of reforms (research objective) and assist in the evaluation of the current and future reforms’ development and sustainability (research objective).

*Informing the methodological approach*

Vital information added to the methodological design is yet another strength of the framework. As selection of the right sample for the study implies credibility and reliability, the framework, complementing the work of the literature review on the Greek NHS identifies the sample of key players best suited to the research’s goals. For instance, when examining the involvement of other countries with the NPM paradigm, it was shown that there existed tension between managers and health professionals in their working relationships (Handley and Clough 1996, Day and Klein 1997, Exworthy and Halford 1998, Lapsley 2009). The crucial role of policymakers and their depth of commitment to the implementation process were also showcased by the framework (Kirkpatrick et al., 2013). Further, according to Critical Realism, the only way to arrive at and uncover the hidden mechanisms, structures and events occurring within hospitals is to ask key personnel such as doctors and managers. Investigation of interactions between principals (the Troika, Greek government, ministry of health, policymakers, hospital managers) and agents (health professionals) was also facilitated by the use of the Principal-Agent Theory which helped it explore those key actors’ involvement with the new reforms. Suffice it to say, were it feasible for the interviews to include Troika executives as well, the study would make for an interesting reading. Be that as it may, it stands to reason that such an opportunity was next to impossible: stealth practitioners that they are, the Troika’s executive echelons work in absolute secrecy, under strict secure measures, and have never been known to grant interviews.

With the appropriate sample selected, the researcher turned again to the framework for assistance in deciding on the suitable methodology. The development of public services in Greece and the rest of the countries could only be traced in the international and Greek literature. Thus, the next logical step was to seek for existing knowledge and theories in journals, books, and other documentation. The secondary data gleaned from the existing literature on the contextual background of the research enabled the researcher to pinpoint his study’s dynamics and links, such as evidence on how public services had been organised in the past, and the key theories of the framework. It additionally identified gaps and areas to be explored, expressly generating questions needed in order to test and expand knowledge on the Greek case at the international level. Those queries were then grouped under certain themes as those emerged from the framework (i.e., NPM ideology, dimensions, practices, and so on) the interview schedules were carried out using the selected method of interviewing (primary data), and the respondents provided answers to the issues researched.

Equally significant was the contribution of the integrated framework in assisting the researcher of sorting the data analysis that had derived from it into categories. Once data were classified, interpretation of the findings became facile and seamless, steering the discussion. It also guided the researcher who was then able to address more precisely the study’s main aim and objectives: which conditions contribute to the applicability and sustainability of public sector reforms in Greece. In sum, the thesis’s analytical framework incorporated a broad range of relevant concepts which directed the empirical work.

*Interview as a Method*

Interviews were chosen as an appropriate research tool because they offered the opportunity of gathering and grasping the participants’ perceptions and experiences on the issues of special interest (Cassell and Symon, 2004). In the thesis, interview accounts were combined with documentary analysis, both serving as interpretive methods of the social phenomena taking place inside health organisations. Interviewing allowed respondents express their beliefs freely; talk about their daily realities as experienced within their organisations; and complain about dysfunctionalities. The emergent insights were genuine, strikingly clarifying institutional history and point to mechanisms which would have been extremely difficult to detect otherwise (Gubrium and Holstein, 2001). The validity and value of the research were further heightened by the fact that the anonymity of interviewees was fully protected, making them feel safe when complaining or revealing rich information.

The semi-structured interviews were deemed as the most appropriate interview method to fulfil the purpose of the present research. While a [structured interview involves](http://en.wikipedia.org/wiki/Structured_interview) a standardised form with a limited set of questions, a semi-structured one is loose with open-ended questions. It appeared to be the ideal type of questioning to address the multidimensional nature of the Greek NHS and generate a considerable volume of data. The sample encompassed hospital managers, policymakers, and health professionals whose comments, issues, personal experiences, and projections on the future were documented. The selected interviewing method gave the researcher more flexibility on the themes under investigation; and encouraged him to assume an active role and guide the process accordingly (Pope and Mays, 2006). Moreover, it allowed for freedom of movement while talking to the respondents as its structure permitted touching on general issues at first and then narrowing down to specialised topics. Last, the flexible nature of the semi-structured format made it easier to handle both the complexity of the subject matter and the interviewees’ varied background. It gave the researcher broader license to probe. The result was a wealth of in-depth information on the study’s specific area of interest (Mack et al., 2005).

As participants came from different levels of the Greek NHS their diversity helped in capturing different tactics and realities as illustrated by the principal-agent and critical realism contributions to the novel framework. In view of the above, interview schedules for each of the three categories of participants differed slightly. The schedules comprised interview questions drawn from the integrated framework’s literature review; and the theoretical background of the Greek NHS. In that way, they helped in responding more closely to the aim and objectives of the thesis and bridge the international literature’s gaps. For instance, participants were asked about the new tools and practices imposed on their routine jobs and what their outcomes have been thus far. They were also called upon to reflect on the Troika’s policies, and speak on NPM ideology and its adaptation to Greek standards. This enabled the researcher to interlink the aim and objectives of the thesis with the respondent’s evaluations about the structural reforms so as to draw conclusions.

**Empirical Research**

*Literature Review and Document Analysis*

The identification of Greek NHS literature as well as the NPM, PAT and CR were searched in journal articles and pertinent books. The initial search was carried out using the University of Stirling’s database system and the following key words: New Public Management (NPM), managerialism, public health management, NHS reforms, public sector reforms, Principal-Agent Theory, and Critical Realism. The database’s sorting system indicated all articles free to access on the university’s subscription scheme. To increase the relevance of studies available and the quality of literature, attention was centred on certain journals which seemed to concentrate more on issues salient to public management and health system reforms. Those were: Public Administration, Public Management Review, Health Policy, The International Journal of Public Sector Management, Journal of Sociology, International Journal of Health Services, Journal of European Social Policy, and Journal of Nursing Studies. Books on the material the researcher was interested in proved an equally abundant source of information. In total, out of the 280 relevant documents gathered by the search, there were 154 journal articles and 103 books in the literature written in English; and 10 journal articles and 13 books in the literature written in Greek. They all contained theoretical knowledge on NPM either in the international or the Greek context or both. It should be reminded that the gap in the Greek literature on NPM was so striking that it raised high expectations that the present thesis may indeed contribute and be of some value to future researchers.

The volume of relevant documentation such as international journals, conference proceedings, government gazettes, books, newspapers, newsletters, and press releases led to a significant amount of information regarding the Greek healthcare system and its historical development: out of 126 documents there were 36 articles and 36 books found in Greek; and 45 journal articles and 9 books in English. The ensuing data were used in combination with other primary data collected from interviews to support findings (Saunders et al., 2008). Evidence of the impact of the economic crisis on the health sector originated in documentary analysis from newspapers, blogs, and official reports for health professionals. Moreover, the information on pieces of legislation formally and systematically collected became a useful source of policy and reform development in the Greek NHS as well as of the particular structure of Greek public services.

The documentary analysis of the sources above was thorough and strategically ordered so as to extract exhaustive descriptions as identified by the literature review and the conceptual framework. The process involved skimming, reading, and interpreting (Brown, 2014). It was incremental in pace: as the researcher read on and delved deeper into the subject, the areas to be explored and the data to be gathered increased. Most of the time, it was impossible to use the pieces of the newly-found information simultaneously. For reasons of more efficient organisation, the data gathered was subjected to thematic analysis and broken down into theme categories of themes. To illustrate, one main theme of the thesis concentrated on the past failures of the Greek NHS derived through Critical Realism so as to unravel structures, outcomes, and hidden mechanisms. The task entailed documents of different categories such as NHS Laws, NHS Reforms, Hospitals, Greek NPM, Health Crisis, Corruption, Troika, and so on. Memos and notes were also used during the analysis to isolate the kind of information that could potentially fit into more than one theme.

As stated, the literature review was systematically ordered. The researcher’s first readings were books on the development of health science with a specific focus on public health. They led to a more realistic picture of how present-day science had progressed and developed. For instance, they corroborated the doctors’ prestigious professional power by providing data on the equally lofty status medical professionals enjoyed in ancient times. Next, legislation, articles in journals, books, and mainly in newspapers and newsletters, provided the research context along which the research was carried out. Those clarified issues on policies, laws, events, structures, mechanisms, outcomes, political and social insights. In doing so, they helped the researcher and the subsequent readers to track the historical roots and the development of the ingrained mentalities of the Greek NHS as elucidated by the Critical Realism paradigm. They also showcased the key NHS players’ role, power, and motives which generated interview questions such as what key players believe about the past failures in the Greek NHS.

Then, the literature review analysis of mainly international journals and books provided a comprehensive integrated framework, the core of the novel thesis analytical tool. Again, categories did emerge; except, this time, the process was far easier due to the classification of the three conceptual contributors. Some categories of this review analysis included: the NPM in UK, NPM in other countries, NPM tools and ideology, NPM in Greece, criticisms of NPM, Principal-Agent Theory, Critical realism etc. Classifying literature in that matter helped generate questions in the interview schedule such as: “Do you believe that the introduction of management tools borrowed by the private sector can provide solutions related to efficiency and quality of care within Greek hospitals?” The role, power and incentives of key NHS emerging from the PAT generated interview questions such as: *“Is there an adequate performance assessment system for personnel in hospitals?”* The entire process was characterised by one noteworthy element: the reciprocity or, back-and-forth interplay, between the literature content, the novel framework, and the findings (i.e. comparison of the literature using findings to check interrelations). It allowed the researcher to set the connections, anticipate the sequence, and demonstrate objectivity and coherence of the research process. By extension, it enabled readers to draw their own conclusions regarding the interrelationship of the three and the findings’ trustworthiness (Elo et al., 2014).

*Development of the Interview Schedule*

All categories that emerged from the literature analysis and the new framework were put together, interrelated, linked, and sorted into six main themes. By means of those themes questions were classified into categories and three interview schedules were developed. Those last differed slightly from one another but they still evolved round common themes: Crisis Situation, NHS Reforms, Hospitals and Health Professionals Relations, Past Failures, Attitudes towards New Public Management and Sustainability; Future Predictions. Each one of the three, discrete interview schedules corresponded to one of the three participant categories. Key questions remained the same for all respondents so as to ensure coherent data analysis and discussion. Questions which differed from category to category dealt mostly with the relationships between Greek NHS key players with the purpose to explore more the games of power, motives and responsibilities between the interest groups as promulgated by the Principal-Agent Theory. Regarding the schedule’s questions, those were placed in a logical and psychological order going by the following rationale: at the beginning of the interview respondents would feel more inclined to talk more guardedly about innocuous issues such as the current situation, the repercussions of the crisis, and describe reforms in detail. In the middle, they could have let their guard down and begin complaining and unravelling the mechanisms causing failures of the Greek NHS (as promoted by Critical Realism). At the end, respondents would be given the opportunity to make overall justifications about the NPM paradigm and future projections. It is a rounded way of closing the interview and, in a sense, validates and corroborates the respondents’ statements during the interview.

*Sampling and Interview Processes*

Prior to the collection of the primary data, the researcher conducted a pilot interview with a doctor. The main purpose was to assess how long each interview would last and detect any potential misunderstandings that could ensue from the questionnaire’s wording. Questions were firstly developed in English and later translated into Greek. The pilot application showed that the interview was within its time limits (30m-1hr). Nevertheless it did reveal that, for the interviews to flow smoothly, wording and sequence of some questions had to be slightly adjusted.

The research sample comprised 40 Greek individuals who represented the three main types of Greek NHS key stakeholders interviewed: 20 doctors; 10 hospital managers; and 10 policymakers. The fieldwork was carried out during spring and summer 2013. The first step of the fieldwork necessitated a visit by, the researcher to the Greek Ministry of Health. There, he tried to make some much-needed contacts but also to communicate to the Minister the research’s purposes even though that proved infeasible. The researched filled out an application form requesting that his study be communicated to the Minister and other high-echelon health officials. For a period of three weeks there was radio silence from the Ministry where upon the researcher paid the Ministry of Health another visit, followed the same procedure, and was faced with the same outcome as before: no response. It was at that point the researcher made the logical decision to attribute the Ministry’s unresponsiveness on the chaos that usually follows a financial crisis and proceeded to carry on with his research without relying on that organisation for any support whatsoever.

Consequently, the researcher turned his attention to other healthcare organisations and experts in order to find potential study participants. Contact was made with the National School of Public Health, public hospitals, health peripheries, health centres, university health schools, professors, doctors, politicians, policymakers, book authors, and journal article writers. This time, the researcher’s effort met with unqualified success since he identified a number of people interested in participating in his study. He selected those individuals whose expert knowledge and experience qualified them as eligible for an interview.

It may well be argued that the study was based on snowball sampling. However, the researcher did try to mitigate that factor for a number of reasons. As of the outset of the research, it had been deemed necessary, given the strong political interference prevalent in the healthcare sector, for study participants to hold different political beliefs so as to avoid an insular, one-sided point of view. To that purpose, the researcher contacted politicians and policymakers of different political orientations as well as hospital managers who were new at their jobs and were political appointees of the new government as evidenced by the literature. Interviews were also held with hospital managers who had been at their posts for some time but whose tenure had not ended. When it came to interviewing medical doctors, the political factor was not deemed to be of crucial importance. However, the researcher thought it methodologically correct to select doctors from different hospitals in order to gain access to more realities. There were only two cases of two doctors working for the same healthcare organisation. Some of the doctors in the study were also trade unionists. In order to explore healthcare conditions outside urban Athens, the study also included participants from the Greek regions such as small towns, remote areas, and popular or isolated islands.

No interview lasted longer than 25 minutes with the exception of one that ran for 1 hour and 42 minutes. The majority of interviews were performed face-to-face either in the interviewees’ actual working environments or at a neutral meeting point. Especially in the case of participants from regional Greece, some of the interviews were conducted over the telephone or via Skype. All participants received full information on the research before their interviews. Some of the participants, once they had read the information statement provided by the researcher showed a tendency to start discussing the topic informally and wanted to know more about the researcher/interviewer’s background purely as a matter of curiosity. The researcher politely shared information on a need-to-know basis without going into great detail and declared to the interviewees ready to continue with the formal interviewing process. With that in mind, he informed all on the issue of protecting their anonymity and asked permission to record the interview. The announcement on protection and recording, together with the initial informal discussion built rapport and trust between participants and interviewer. Two of the participants withheld their consent and the researcher proceeded to keep notes instead of recording.

In their most part, interviews felt more like a casual conversation and there was two-way communication. The interviewer felt close to the participants and sympathised with them by indicating he understood the difficult organisational context his interviewees had been experiencing during the recession. Most of the time, the flow of giving and receiving information was maintained. That actually allowed both interviewer and interviewee the flexibility to probe and expand respectively in order to become more specific. In turn, that led to collection of in-depth information which unveiled hidden aspects of the topic under discussion. People shared their experiences at work, including reflections on past inefficiencies and present changes. The level of complaints ranged from mild to grave. At times, when the researcher felt that participants were faltering when called upon to reveal ‘extreme’ incidents, he spurred them on by reminding them that their anonymity was protected at all costs.

Interestingly, many were the participants who showed a keen interest in and appreciation of the research. Some told the researcher that no one had ever asked for their opinions regarding conditions in Greek healthcare. In particular, they expressed the desire that the researcher conduct an across-the-board study which would include all Greek hospitals and submit the study’s findings to the Minister of Health. To the mind of the researcher, that was hard evidence of the doctors’ discontent and the lack of research and development processes in Greek healthcare organisations. In some cases, the interview had to be interrupted because of a telephone call or case of emergency an interviewee had to answer. In three cases, the process was picked up later on, either at the same location or on the telephone on another day. The researcher tried to contain those delays: were participants to lose their train of thought, the quality of data would suffer. In all three cases of delay, the researcher went on to reintroduce the pertinent topics and helped interviewees recall and keep pace with the subject under investigation.

*Interview Transcript Analysis*

All interviews were fully transcribed into Greek, saved in electronic format, and produced in hard copy: the three, discrete batches of interview transcripts respectively corresponding to doctors, managers, and policymakers were repeatedly read by the researcher who wished to become fully conversant with the material. Next, the researcher kept notes of first impressions, thoughts, and strong statements as well as emphatic words. It was a process necessary in composing and memorising the profiles of those reactions by the participants which were vehement so as to classify such responses under the findings section. Existing conceptual theories of and literature on the Greek NHS helped the researcher along the way to form categories, code, and analyse interview transcripts. That is a well-known part of deductive analysis where analytical categories emerge from theory or a framework approach (Pope and Mays, 2006).

Therefore, as the questions were sorted into main themes (i.e. Crisis Situation, NHS Reforms, Hospitals and Health Professionals’ Relations, Past Failures, Towards New Public Management Attitudes and Sustainability-Future Predictions) and transcripts were separated according to the three types of respondents (doctors, managers and policymakers) –the researcher coded the transcripts manually. The process involved thorough re-reading of all transcripts so that researcher may perceive which quotes fit the given themes and obtain the bigger picture. Hence, large amounts of text from interview transcripts was sorted into smaller categories (Weber 1990, Pope and Mays 2006) which identified the overarching themes as drawn from the literature’s analysis and the novel framework. Comments and memos were also attached to the coding to help the researcher highlight those vehement statements and/or quotes which could go under more than one theme. One such case was the quotes regarding the inertia of policymakers which perfectly fit two themes: past failures and relations between professionals. As finding hidden but common grounds more easily between the three types of interview transcripts was indispensable, all batches were merged in one electronic document. Using the FIND keyboard shortcut (CTRL+F/F3) and key words, common points between the three, different NHS players were distinguished. For each one of the themes, the researcher tried to include in his analysis accounts from all three types of NHS stakeholders so as to show and compare how the narrators converged or diverged in their positions. Collection and establishment of all key themes enabled the researcher to fathom the data and categorise them under three, main findings chapters before carrying on with their analysis.

**Research Ethics**

Due to the fact that qualitative research focuses mainly on studying people’s attitudes and feelings, a conscientious researcher is required to behave ethically towards participants. To that purpose, the thesis complies with the Stirling University’s Code of Practice on Ethical Standards and was approved by the Management School’s Research Ethics Committee. Each participant was given an information form before deciding to participate in the research. The form contained information on the study’s aim and objectives and on the university; and gave brief biographical data and contact details on the researcher and his supervisors. Participants who consented to an interview had to sign the Participant Consent Form before the interview process. In that fashion, their anonymity and confidentiality in the storage and use of data were ensured. Interviewees also had to sign a form indicate their willingness to be voice-recorded.

Another ethical dimension of the research concerns the fact that hospitals and other healthcare organisations are vulnerable working places with emotional aspects. In that regard, the researcher was thoroughly discreet, quite careful, and extremely sensitive to the interviewees and their institutional environments. Thus, participants did not feel constrained or restricted when answering questions. One way or another, they had been told at the outset that they were free to leave the process at any given time. Indeed, few were the respondents who preferred to leave one or more questions unanswered. Since no participants abandoned the interviewing process as a sign of unwillingness to participate, the researcher believes that his interview schedule followed the appropriate ethical path.

**Methodological Limitations**

*Qualitative Research Limitations*

Qualitative research comes with a number of remarks which should be taken into consideration. Most of them have to do with qualitative research being too impressionistic and subjective and tending to generalise the attitudes of a small sample. That is due to the fact that findings rely on a researcher’s unsystematic views about what is significant and also upon the personal relationships between researcher and population studied.

In the present case, that factor did not come into play as interviewees were completely strangers to the researcher. Some of them did know each other but they were meeting with the researcher for the first time. As far as the issues of generalisation are concerned, it should be stressed that the thesis aims more at addressing particularities, rather than provide common accounts. Another critique levelled is that the process of qualitative data analysis is frequently unclear because it is difficult for the researcher to express what has actually happened and how the study’s conclusions were reached (Bryman and Burgess, 1994). The main challenge is that there is no clear and accepted set of conventions for analysis corresponding to those observed with quantitative data (Robson, 1993). However, the study’s purpose is to try and capture organisational insights and hidden realities such as only profound interviews rather than quantitative data can provide.

At this point, it is important to address the fact that numerical illustration of the impact of NPM reforms would not have been feasible through the use of quantitative analysis: the situation in Greece is still far from normal and reforms are still in progress. Therefore, the objectivity of results encapsulated by a quantitative approach (Winter and Munn-Giddings, 2001) would not be valid. After all, the focus of the present research is on investigating the past, present, and future organisational reality and not on measuring the effectiveness of reforms by using numeric data.

*Literature Review Limitations*

As helpful and useful a literature review may be for every researcher, it can prove a tricky method to use. First of all, review as a method is time consuming and the researcher needs to spend a great amount of time in finding the latest literature that is relevant to the conducting theme (Yin, 2010). It also has to do with organising the considerable volume of material collected. That includes first reading, then analysing and sorting through data, and, last, classifying that data into different files according to their common dimensions (Seuring and Muller, 2008). It is thus apparent that the researcher must have the expertise and capability to synthesise and put all the pieces of the ‘jigsaw puzzle’ together so as to describe in the best way possible the whole picture to the ‘virgin reader, pointing out what parts of the picture are clear, what parts are fuzzy, and what parts are missing and in need of further investigation. It is also worth noting that the quality of a great part of the literature varies as there are no standard evaluation criteria governing journals, books, and other written material (Boote and Beile, 2005). Still, systematic efforts have been made in recent years to establish such criteria. As Hek and Langton (2000) posit, the quality of an article depends on the journal, the peer review, the author, and the arguments that are made.

The quality factor aside, certain types of documents conceal biases. Newspapers, blogs, and press releases are such types of documentation since they may adopt a specific political stance or serve other vested interests (Yin, 2010). In a case such as this, the researcher must be in a position to filter contents and perceive the hidden biases. Either way, the present thesis did not make an extensive use of that kind of literature data. Another risk involves literature that is outdated with articles in journals being more up to date than books (Cronin et al., 2008).However, the study had little use of such material since most of its theoretical background stems from articles in journals which have been peer-reviewed and thus ensure reliable quality literature. An exception was made in the case of literature review in Greek, as the international sources were fairly limited. To meet that shortage, the researcher derived the knowledge he needed from sources written in Greek such as books, journal articles, legislation, and executive briefings for health professionals.

*Analytical Framework Limitations*

The use of frameworks also comes with caveats which must be taken into account. Due to the multidimensional nature of social phenomena, no single theory or framework provides a perfect explanation of what is being studied. That is the reason why the present study has made use of three, distinctive, key theoretical models. In this way, more research fields are explored and better in-depth understanding of the research area is provided. However, that type of approach runs the risk of becoming complicated, hindering the process of analysis and the provision of explanations. In order to overcome that obstacle, the researcher has delineated in detail the research purpose of each conceptual model (e.g., what will be achieved by using the principal-agent theory) and how, together, all three interrelate and are integrated in one single framework. More than that, the intention was to show the connection between each framework and the findings so as to demonstrate that each framework did contribute its mite to the study. Arguably this representation may serve in convincing that the research is credible and that the researcher did not pick random theories which could generate irrelevant data.

Another limitation of the analytical integrated framework is that it restricts the broader analysis of the research in context: the researcher can only talk of data coming out of the framework. Indeed, when reducing the horizon of a study to one conceptual tool, it might constrain the creation of rich knowledge later on. Logically speaking, since it is the framework that guides the research, the ensuing findings cannot come out different than those of the framework. It is akin to carrying a NPM torch which spotlights NPM tracks only. That coincides with the general limitation of qualitative research as being subjective. In such cases, researchers need to demonstrate quick reflexes and qualities that will help them think ‘out of the box’. Hence, the three different frameworks as an integrated analytical tool endow the study with flexibility. NPM has much to offer in terms of portraying a set of practices but also an ideology and shows how they have both been applied in other countries, something that makes it an adequate comparison tool. Case in point, the supervision of Greece by the IMF intensifies the use of the NPM’s neoliberal agenda and convinces that NPM forms a compatible analytical framework. The Principal-Agent Theory adds to the framework in terms of depicting power games, interactions, politics and beliefs about NPM reforms and public reforms in general. Last, Critical Realism underpins the framework by informing that the investigated phenomena of the crisis, in hospitals, and through doctors are all real and, therefore, qualify for critical examination and evaluation.

While NPM has become an almost universal paradigm in public sector reforming, it carries a number of critical remarks lodged within it. For one thing, it has been criticised as being an ill-defined and slippery concept (Pollitt and Bouckaert, 2004). It appears that the results of implementation programmes adhering to NPM have not been clearly defined, and therefore there are almost no systematic comparative and quantitative research studies that measure in numbers (i.e. money savings, output increases, quality improvements) the NPM’s impact (Van de Walle and Hammerschmid 2011). Another NPM flaw concerns the global appeal of NPM and the lack of focus on domestic circumstances. As Larbi (1999, p.36) explains:

*“NPM-type reforms in crisis states seem to be based on a common framework with those in developed countries and seem to follow a blueprint rather than a process or contingent approach. Yet countries differ widely in terms of their institutional conditions and their capacity to implement public sector management reforms based on NPM principles and practices. There is a need to give attention to questions of how to implement rather than just what to implement”.*

Indeed, not all countries need public sector reforming, nor do all of them have the same deficiencies or structural compositions. Especially countries under a financial crisis may lack the necessary resources and infrastructure that could secure the successful implementation and sustainability of reforms (Caiden and Sundaram, 2004). Enter the novel framework with its insightful analysis and contribution to the thesis in the form of two more concepts to fill the gaps and add value to the research: First, CR was employed to focus on the past and present established mechanisms and structures of the Greek NHS which brings to surface the country’s peculiarities and expresses the needs for reforming, enabling the comparison with other countries and explaining whether NPM reforms may fit the Greek case. Second the PAT was used so as to stress the self-interest of all stakeholders and explore whether they have the power and the capabilities to distinguish and adapt reforms to Greece’s social, cultural, economic, and political peculiarities.

Even though the researcher identifies the methodological flaws of NPM, the paradigm serves as an analytical tool for the thesis and lies at the heart of the integrated framework. The literature of NPM provides a starting point for explaining similarities and differences in Greek reforms across international cases, assuming in that way the form of an international comparison tool. In that role, NPM provides a more coherent approach as it carries a set of practices and an ideology agenda which serve in describing, comparing, and analysing reforms in public organisation. As NPM is intertwined with the Troika and its neoliberal agenda and, at present, it is the Troika which rules the country, it contributes to understanding the current Greek situation. It is the historical intersection at which the first evaluations must be made in terms of pushing forward for change and reforms for the first time in the Greek history under the guidance of a neoliberal international organisation. More than that, as a framework, NPM allows the researcher to look at the whole forest instead of concentrating merely on the trees. The following are some of the attributes of NPM in the case of Greece: First, it provides insightful understandings into the inner workings of the country such as the nature of the crisis, the challenges that Greece has been facing, the role of the government, and the key players. It also probes into the global setting, such as global institutions (ECB, EU, IMF) and their influence, public sector reforms in foreign countries, the role of international stakeholders, and the outcomes of reforms. Once the overall setting has been explored with the contribution of the three conceptual approaches, the researcher will be able to compare and evaluate how public services in Greece are structured, influenced, and whether they have become efficient or not under the Troika’s tutelage.

*Interview Limitations*

As a qualitative method interviews also have specific limitations which the researcher tried to control so as not to affect the quality of his research and its outcomes. First of all, when it comes to a qualitative study, the representative sample should be investigated (Cohen et al., 2007). Due to the fact that healthcare organisations constitute vulnerable and crowded places-especially during a crisis period, gaining access to hospitals and finding an appropriate representative sample was a challenging task.

Snowball sampling in this case helped in speeding up the process of finding available participants with common characteristics. Those were located through colleagues of theirs who referred the researcher to them (Hancock et al. 2009, Yin 2010). Snowball sampling is often used when the population under study is hard to reach as is the case with the current settings. Still, that type of sampling may raise some bias against selecting interviewees who are too well connected; or against excluding isolated people (Elder 2009). In such cases, the researcher tried to find a representative sample from the cities and the periphery of Greece. Since, some of the potential interviewees the researcher was referred to had very similar traits (same specialty in the same hospital), it was decided to seek interviewees of varying characteristics who belonged to different specialties or worked in different health organisations but were always within the acceptable research frame (i.e., public servants). Another problem that has arisen is the difference of experience among the referrals (Biernaki and Waldord, 1981). That is, junior doctors might propose other junior doctors due to empathy and collegiality and this might affect the data of the sample. However, as mentioned earlier, the sample contained a wide range of participants with different levels of experience and different specialties and there were only two cases of two doctors working for the same healthcare organisation.

Sample size is also of vital importance. In qualitative research, an adequate size should be investigated so as to ensure that the number of participants suffices to provide meaningful and adequate information (Cohen et al., 2007). There is no concrete answer in the literature on the question ‘what is the optimum number of participants in a qualitative study?’ Some researchers argue that the size of interviewing is adequate until the data saturation occurs where nothing new is being said (Miles and Huberman 1994, Morse 1994). Some others suggest that the number of size depends on many other factors such as research purposes, methodological and practical issues (whether there are any subgroups within the sample), available resources, and more (Baker and Edwards, 2012). There is even the case of some researchers who propose an exact number of interviews but the range proposed is very different, i.e. 20-30 (Bryman, 2012) versus 60-150 (Gerson and Horowitz, 2002).

It is true that the current study uses a relatively small sample of 40 interviewees; however, that sample represents three different groups of key NHS actors from urban areas but also from the periphery of Greece. What is more, it comprises twenty doctors, ten hospital managers, and ten policymakers. It can thus be argued that the main aims of the study which explore how key NHS stakeholders have been experiencing the consequences of the crisis and the development of reforms are being met succcessfully. Coming again to the defence of the present study, it should be noted that in qualitative research, sample size does not necessarily need to be large. As Richie et al. (2013, p.144) put it “it is impossible to do justice to the richness of the data yielded if the sample is large-scale”. Notably, qualitative, in-depth interviews trawl for hidden realities and reveal peculiarities in an organisational context which quantitative methods could not have otherwise achieved. In the present case, quantitative evidence could have support the analysis of the thesis. Still, the galloping changes in the public sector made it impossible to focus on numerical data and make generalisations.

Similarly, the type of the study’s core sample of the study gives reasons for some concern. As mentioned earlier, the sample represented three main categories of NHS players. Arguably, a more complete picture could have been shaped if two additional types of NHS actors such as nurses and patients had participated in the sample. They are equally important players of the health system as the ones selected. However, that was not felt to be a significant limitation as the thesis concentrates more on the managerial aspects of reforms and doctors’ professional background rather than patient aspects and the background of nurses. Had the researcher proceeded further, there would have been far too many interviews which would have required extended analysis and led to exceeding the word limit of the thesis. One way or another, the doctors interviewed give an analytical description in their accounts on how the crisis has affected the patients as well.

Another limitation is concerned with the bias that interviews carry. The rationale is that people respond differently depending on the psychological state they are in during the interview process or on the pressure they encounter at work. As explained, the workload in Greek hospitals has dramatically increased because of the financial crisis. Moreover, many are the things in the process of changing because of the reforms in progress. Therefore, the answers are highly dependent on whether respondents had had a good or bad business day or whether a new policy that has arrived has given them cause for anxiety. In fact, similar incidents such as the examples given, did occur during the interviews. In an interview with a hospital manager, a fax arrived at his office from the Ministry of Health asking for more reductions in his hospital’s budget. Following that, the manager became stressed beyond control and began shouting that the hospital cannot operate any longer. Needless to say, the interview continued under a very intense climate. In a similar context, interview data created some ambiguity as they were confusing and complex at times. However, it is worth reminding that the aim of the research is not to produce generalisable outcomes but to identify and present realities and particularities. So, unexpected events are worth mentioning and analysing as they reveal the hidden reality that the critical realist tries to bring forth.

In the current context, it was thought form the beginning that interviewees might be biased by having the preconceived notion that the researcher intervened in their job routine asking them to reveal hidden realities (Cohen et al., 2007). In fact, respondents may become even more biased on hearing a mention to the NPM concept which obviously depicts the neoliberal ideology. When a system is in crisis and about to collapse, talking about neoliberalism may be perceived as provocative. The researcher overcame that limitation by interviewing participants of different political ideologies. However some respondents seemed to be overly reserved and tried to use ‘safer’ words or even started to say something, stopped in mid-sentence, and carried on with a different answer. In such cases, the interviewer realised that the respondents involved were holding back and was also able to understand the reason why. Yet, that missing information that was never uttered was the key element that the researcher wanted to record. In order to extract that type of information the interviewer reminded respondents politely that their anonymity was protected and encouraged them to complete their actual thoughts. Overall, since the interview was semi-structured and felt more like a casual conversation, most of the respondents assumed that they were free to talk and express their ‘for’ or ‘against’ attitudes on NPM reforms.

When it comes to bias, it should be stresses that researchers may also be subject to prejudice. In essence, the subjective nature of a qualitative study derives from the researcher’s view of what should be included in the analysis as significant. As Yin (2010, p.123) argues:

*“Being the prime research instrument requires fieldworkers to be aware of the instrument’s (i.e., your) potential biases and idiosyncrasies. These include conditions arising from your personal background, your motives for doing the research, and your categories or filters that might influence your understanding of field events and actions”.*

Having been educated in the field of business and management, the researcher is no stranger to the managerial and technocratic ideology. However, he has also specialized in Organisational Psychology and Healthcare Management at the postgraduate level and, therefore, his managerial archetype is counterbalanced by his personal interest in the wellbeing of workers and equity in social welfare and health. That minimises any biases of the researcher’s holding a strong managerial stance throughout the thesis. Besides, the additional methodological sources included in the thesis such as the literature review on the development of the Greek NHS build an objective research context which enhances the critical realist’s view and fully inform readers, allowing them to form their own judgements and interpretations. Further, the researcher’s training as part of his doctoral studies armed him with qualities and competencies which enabled him to use a critical and objective approach. In that regard, the researcher firmly believes that he was neither in favour nor against NPM, but, as a member of that system himself, he felt closer to those who questioned the performance of the Greek NHS. Overall, the main trigger for the present research inquiry was the Troika’s arrival in Greece and the researcher’s interest in paving the way to solving the puzzle of the Greek NHS. His principal intention throughout the study has been his fervent wish to contribute to an effective health system detached from corruption and ingrained, faltering mentalities; and place the focus on protecting health as a public good.

Another limitation was the health professionals’ schedule which can be unpredictable at times. Although all of them, doctors, managers, and policymakers, were free to choose the day of their interview, some unforeseen incidents did occur. They mostly had to do with emergency calls or personal phone calls, so the interview had to be interrupted and resume later. Such limitations may have had a negative effect on the research as the respondents seemed to be overwhelmed and lose focus of the interview’s background. In such cases, the interviewer courteously tried to remind respondents what their interview was about and bring them back to the point where the conversation had ended.

Telephone interviews were yet another concern during the present study. The interviewer knew all too well that the lack of personal contact that telephone calls necessarily imply could affect the trust of interviewees in the researcher and in the process’s confidentiality. Further, it was the interviewer’s belief that a disembodied voice cannot compensate for the absence of body language. In either case, once extracted, data did not seem to suffer in quality. To ensure that, the researcher kept the number of telephone interviews to a bare minimum. Moreover, whenever viable, he opted for interview contact via Skype, especially in the case of respondents located in remote places, so as to obtain as much face-to-face contact between interviewer and interviewees as possible.

Time constraints also became a matter of concern during the study. According to Robson (2007), interviews lasting less than half an hour are not usually of any value and those that last more than an hour might exhaust interviewees and make them lose interest. Most of the interviews were kept within the proscribed time limits. However, semi-structured interviews produce complex data. Indeed, some participants, especially policymakers, strayed somewhat from the point under discussion and started talking about irrelevant issues (irrelevant past experiences, political plots and intrigues, promotion of their book). They were politely but firmly interrupted and guided back to the interview schedule. Those allowed to exceed the time limit had intriguing information to share so the interviewer encouraged them to go on by asking more questions so as to probe further into the issues on the table.

The large volume of data from literature documents and interview transcripts and the way the written text is understood and transferred into the study also posed certain problems (Robson, 1993). Suggestions made by Lindolf (1995) and Morse (1994) provide some useful guidance on how to face problems when analysing qualitative data. According to them, the first step is to familiarise one’s self with the data and assess their value for the study. That requires setting in place procedures and systems to manage data effectively such as cognitive mapping as a method of analysis used in structuring, analysing, and making sense of written or verbal accounts of problems. A further step involves arranging data in an orderly fashion by using data reduction. It is a form of analysis that sharpens, sorts, focuses, discards, and reorganises data so as to reach easily drawn and verified final conclusions (Miles and Huberman, 1994). The present thesis used both cognitive mapping and data ordering to deal with the bibliography’s large volume. For instance, all literature on Greek hospitals (documents, articles, newspapers, health reports) was kept in one file and all Greek legislation on public health went under a separate file.

An additional problem involved the language barriers that the researcher faced during the data analysis. Participant accounts had to be translated from the Greek language into English. The stumbling blocks were the differences between the two languages in verbal and idiomatic structure. The researcher was able to overcome those obstacles by slightly altering syntax or idiomatic use without affecting the meaning of the oral narrative.

Overall, it became necessary at some point to design a strategic research plan to deal with all of the issues that arose during the qualitative research process. With that in mind, the researcher had to prioritise between the two methods he had used. An exploratory survey of the literature proved a satisfactory way of introduction and guidance to the study by identifying key areas such as inefficient practices, constraints, malfunctions, and difficulties in reforming the Greek NHS. Then the literature of the integrated framework helped in identifying core themes for exploration, and generated the interview schedules and the type of the sample. The key stakeholders selected were then interviewed at length on their experiences, thoughts, reflections and reactions about the past, present, and future of Greek healthcare.

**Research Training**

Mason (2002) has observed that a qualitative researcher must be critically reflexive so that his decisions and judgments give form and meaning to the data gathered. In that context, the researcher needs:

*“to develop active skills which include identifying the key issues, working out how they might be resolved, and understanding the intellectual, practical, moral and political implications of different ways of resolving them”* (Mason, 2002 p 4).

While carrying out the tasks involved in his Ph.D. studies, the researcher enrolled in a research methodology course in Business and Management. The seminars helped him develop competencies across the spectrum of Research Methodology for a doctoral study and included modules of Research Methods, Research Philosophy, Advanced Quantitative Methods, and Advanced Qualitative Methods.

After that rigorous training, the researcher felt far more prepared to undertake the project he had designed. For example, he was able to demonstrate awareness of the philosophical dimensions of research and the expertise to apply those in practice. Part of his learning was that the management and organisational context is guided by a set of ontological (what it is) and epistemological assumptions (how we know what it is) which all have to be analysed accordingly. As mentioned earlier, the applicability of Critical Realism to organisation and management studies demonstrates that organisations, developed by humankind, are social structures where real events take place. The object of each critical realist study is to probe and reveal the truth and reality hidden behind different sets of relationships; and analyse the way outcomes are the consequences of causal processes (Fleetwood and Ackroyd, 2004).

In terms of research methods, the course familiarised the researcher with the range of advanced research techniques and with their advantages as well as disadvantages. It also showed him that combining methods can result in rich data and greater validity and reliability of the study far more efficiently than a single-method approach which may be fraught with potential biases and sterility (Barbour 1999, Coyle and Williams 2000). In the present study, the use of a literature review (secondary data) helped the researcher identify the main areas that needed to be explored, the type of the sample and generate the framework and the questions of the interview schedule. The use of semi-structured interviews (primary data) offered answers to the themes that had arisen. The course further prepared the researcher by teaching him that an interviewer should be more responsive and prepared during a semi-structured interview than during a structured one, to answer questions, proffer explanations, express opinions, and keep discussion within the appropriate topic and time limits. Moreover, it became clear to him that he should be ready to ask for more information when a key matter arises through probing by encouraging the respondent to talk more so as to extract that valuable piece of information. Last but not least, the programme focused on ethical guidelines and on how to conduct ethical research. As a responsible researcher he complied with all University’s ethical requirements, receiving consent from all interviewees, respecting their willingness to not have the interview recorded, protecting their anonymity, and maintaining the ensuing data’s confidential nature.

An overview and part of the study have already been presented at two international conferences. The first one ‘The Small Societies, Small Business, Small Cities and Villages’ was hosted by the Athens Institute for Education and Research (ATINER) in Athens. The researcher’s presentation was ‘The Greek NHS and the Implementation of New Public Management Ideology and Practices’. It included data and analysis from regional Greece. The second presentation took place during the International Labour Process Conference jointly held by Stirling University and ATINER in Athens, Greece. The presentation’s title was ‘Selective Resistance: Doctors, NPM, and the Greek NHS hospital service’. Participants at both conferences found the research interesting and pioneering and the researcher received quite positive comments. As one professor said, from there on, he would have new and very interesting stories to tell his students at the university. Both conferences helped the researcher develop his study further by proposing new literature in public management; and recommending use of other frameworks apart from the NPM one as well as more sample types such as samples of nurses and/or patients.

**Conclusion**

Chapter 5 analysed the methodology followed in order to capture the characteristics and complexities of the Greek NHS and the issue of recent organisational and managerial changes in Greek hospitals as observed through the critical examination of the NPM paradigm. To accomplish that, the researcher carried out qualitative research of secondary (literature review, integrated framework) and primary data such as semi-structured, in-depth interviews with doctors, hospital managers, and policymakers. The literature review regarded the history and development of the Greek NHS; and a novel framework comprising three conceptual theories interrelated to one another. The core of the framework was the NPM paradigm which resonates with the Troika’s operations in Greece and carries a complete set of practices and ideology already tried out in other countries. Critical Realism guides the methodology by determining the realistic angle at which social phenomena are investigated by the researcher. The Principal-Agent Theory provided the study with more focus by identifying the relationships and games of power between and among NHS stakeholders. The integrated framework contributed to informing the research process (identifying core sample and questions) and served as a comparison tool employed to test the Greek case so that the researcher may deduce the level of NPM implementation. The overall outcome revealed valuable realities of the Greek hospitals. The present chapter also provided a detailed picture of the research process, the methodological issues which arose, the ethical dimensions of the research and how those were handled, and the writer’s research and training qualifications. The next, three chapters discuss the findings of the thesis and present the respondents’ views and experiences on emerged themes regarding past failures of the NHS and the current changes jointly imposed by the Troika and the Greek government.

**Chapter 6: The Bigger Picture:**

**Past Inefficiencies as the Culprit**

**for the Current Slowdown**

**Introduction**

Since the onset of the Greek crisis there has been an increase in concerns about the implications for the healthcare sector and the ability of the Greek NHS to provide adequate and effective services to its citizens. Negotiations and cooperation between the Troika and the Greek government are still going on and aim at regulating the country’s deplorable budgetary conditions by implementing strict austerity measures and managerial tools in the public services. The present chapter and the two following it comprise the data chapters of the thesis. They contain rich data gathered by interviewing 40 key actors who are directly or indirectly involved in the Greek NHS; and provide valuable insights into corrupt practices, improvements made, efficient and inefficient tools, policy failures and successes. All portray the complex picture of the introduction of NPM into the Greek public sector which has a long and complicated history and a strongly embedded culture.

This first chapter provides an overview of the Greek health sector and investigates how it has been affected by the economic downturn. It particularly targets the causes that brought the Greek NHS to its knees and to provide some insights into the immediate changes that have taken place under the guidance of the Troika. It also highlights the way historical processes affect the implementation of a new working paradigm as proposed by NPM.

To examine the above issues, Chapter 6 has been organised through grouping the key findings that emerged from the empirical data. It is interesting to examine and analyse the experiences of three key players in the Greek NHS: doctors, hospital managers, and policymakers. Together, they offer a realistic view of the key issues in the health sector. First, the accumulated inefficiencies associated with the chequered history of the Greek NHS are discussed and set in relation to its current situation. Next, the features of the Greek economic downturn and its impact on public health are provided and linked to the interviewees’ experiences. Last, a number of changes implemented under the guidance of the Troika are explained and reviewed by the study participants.

**Inefficiencies of the Greek NHS**

*Bureaucracy and Inertia*

As Chapter 2 discusses, bureaucracy is one of the historical reasons impeding the implementation of the potential reforms in the Greek NHS. This element is inherent in the entire Greek public sector. Not only has it blocked previous opportunities for innovation and modernisation of the system, but it has also been the main source of other dysfunctionalities such as corruption, inefficiencies, political clientelism, and more as discussed later. A representative picture of a bureaucratic working environment is given by a hospital manager:

*A peculiarity of the Greek administration is that all problems that arrive at the office also reach the Central Government and, finally, the Minister. However, they should not reach the Minister, the local governor or the manager. They must be solved by the secretary, by the doctor, whoever it is who’s at the frontline […] we haven't reached the point of predicting the various malfunctions and making policies for all things. Sometimes you have to go yourself to the frontline and help your colleague doing it, whether you do it with the carrot or the whip (manager1).*

The above portrays the centralised administrative system that has been entrenched inside hospitals. It shows that hospital staff (administrative and doctors) are used to working in this way. They usually do not endeavour to solve the problems themselves but prefer to pass them on to their superiors. In this way, managers encounter difficulties in administering public organisations and bringing about change and reforms (Zilidis, 2005). Similar opinions are expressed by a doctor and a policymaker who support that:

*The impression that is given me is that sometimes you might find a good nurse, a good officer, or any one other specialty but these are just a few people. And in such a system these people are lost, or they try to do things that are over their responsibilities. They get exhausted, they are getting more stressed and in the end, they can't always find a solution because this is the way the system operates (doctor14).*

*The truth is that only some of the good doctors are shouldering the burden. Definitely, there are doctors who do not work. There are doctors who operate three times per month and there are others who operate 500 times per month. This shouldn’t happen. I can advise a good doctor to operate more but the whole system should change in order to maintain a certain balance (policymaker10).*

According to the doctor above, the Greek NHS is basically stagnant and is only supported by the heroic efforts of some dutiful people. Indeed, a bureaucratic system demotivates personal commitment (Philippidou et al., 2004) and does not leave any space for progress. Furthermore, many of the interviewees claim that the permanent nature of the public sector prevents the system from functioning properly. They denote that the lack of incentives (Kufidu et al., 1997) and disincentives affects the performance of employees. In this case managers do not have the complete freedom to manage an organisation; therefore, good performance is difficult to achieve (Cleveland, 2000). As a manager and a policymaker reflect:

*The problem here in Greece is the permanency of the permanents. For instance, you cannot fire someone; you cannot control your staff with incentives or disincentives. These are people who have been chosen by the Supreme Council for Civil Personnel Selection (ASEP). ASEP is working properly regarding the validation of their qualifications, but the final result is that they become permanent in the public sector and the manager does not have many incentives and disincentives, to manage them. This is a mess for the public system; it does not help at all. Don’t get me wrong, there are exceptional public servants in the system but there is a big part which isn’t. If we find these people we should fire them. Public servants in other countries can be instantly fired. Have you not achieved your goals? Have you not given the right consultation? Have you failed? We change you. We should not be afraid of doing this (manager10).*

*The inelastic labour relations remain a problem. I am not in favour of having the right to lay off people, but let's see the opposite side: A manager of a public hospital today does not have the means to reward a good employee. I'm not talking about penalties, because I don't believe in negative incentives, as much as I believe in the positive ones. Now a manager doesn’t have the opportunity to give something extra, a bonus or something (policymaker2).*

On the other hand, a doctor believes that permanent employment protects the public sector from private and partisan interests. Otherwise the public sector would be in the jurisdiction of each party who, each time, could employ their appointees and fire their enemies. As a doctor observes:

*I am against removing permanency in the public sector. […] Nepotism is in their DNA. The partisan and the loser will enter into the public sector and the other one will stay outside (doctor1).*

It emerges that the nature of permanent employment in the Greek public sector does not coincide with the flexibility and adaptability that a modern public organisation is said to require (Durst and Newell, 1999). On the one hand, the lack of incentives and performance measures due to permanency restrict managers from reviewing and invigorating individual performances (Kostagiolas et al., 2008). On the other, it reduces hospital employees’ interest and commitment for work especially nowadays when their salaries and benefits have been cut by the Troika’s arrangements. All of the above leave no space for initiatives and managerial autonomy which would be more suitable in a market with the entrepreneurial spirit of NPM (Ward, 2011).

The issue of bureaucratic procedures on the European Public Procurement of goods and services has been addressed by a couple of the interviewees. It refers to the resources from the European Investment Fund for the provisions of each country’s public sector (ESPA). In return the procurement of the supplies has to comply with EU rules. For instance, if the procurement [e.g. of an X-ray scanner] of a public organisation (i.e. hospital) is estimated at a high cost then the organisation is obliged to set a European or international provisions’ competition to obtain tenders not only from domestic firms but from companies abroad as well. In this regard, two of the regional managers complain about the delay of the European public competition. A policymaker blames the slow European mechanisms as far as the competitions of provisions are concerned:

*We are the second hospital to apply an extensive program of ESPA, (NSRF) which provides €1.5 million in medical technology, with a new CT scanner. The competition is still in the phase of completion. Due to the government and the bureaucracy in ESPA, we raise our hands. It is moving at a snail's pace. And this thing does not depend on us. And of course, there are big interests. Once in a while the competition stops with interim measures, with courts and so on (manager3).*

*This hospital has a computerised system but the electronic health records have not been integrated yet. These should have been installed in 2006 via a competition that was organised by a European programme for six regional hospitals but the competition has been stuck for seven years. The government is in litigation with the contractors because the project was submitted unfinished. The result is that six hospitals still have not electronically integrated their services (manager4).*

*There are delays because of the bureaucratic and time-consuming procedures, and is not only the Greek state responsible but also Brussels. ESPA procedures should be accelerated (policymaker2).*

Other inefficiencies caused by bureaucracy are concerned with the shortage of information as a means of controlling, monitoring and evaluating the system. A manager denotes the lack of substantial information systems from Greek hospitals. A policymaker depicts the lack of medical protocols. They claim that:

*There were hospitals which did not have a double entry general accounting system. I will not say that they did not even have a single-entry book keeping. Anyway we didn't have a picture of their financial situation. So, if the economic information is not available, imagine that it was a luxury to have the clinical information. In other words, if we don't have the clinical or the financial information, I do not know what we can manage. Basically it was a bureaucratic procedure, either in a hospital or at regional level, also at the level of social security funds, with papers spread out at right and left. […] for example, if a product cost €100, I could easily buy it for €1,000. I only had to follow the right procedures. It was the institutional framework in priority and not the price. So a manager operates within the limitations of what the legislator requires. This was never discussed (manager1).*

*I was talking yesterday with a colleague who has worked for many years in the UK. He told me that in order to take a decision in Greece you need to collate 25 laws with their paragraphs in front of the Board of Directors. In the UK they can take a decision by only attaching five protocols. For instance, they declare that according to the protocol of hernia, patients should stay in the clinic three days. If it is to remain three days more, I should hire one more nurse. And it’s done (policymaker4).*

Both interviewees, apart from the absence of important information, refer to the attachment of the system to formalism and legalism which diffuse bureaucratic procedures and burden the new reforms (Sotiropoulos, 2004). As far as the accounting methods are concerned, until recently, the Greek NHS was not in possession of an updated accounting system or an integrated information system in most of its hospitals (Sissouras, 2012), hence, this hindered its growth. The literature of NPM makes a specific reference to managerial techniques which include synchronised accounting methods (Le Grand and Bartlett, 1993) that monitor the resources in a better way and provide financial efficiency in the public sector (Bolton, 2002).

The issue of Regional Health Administrations (DYPEs) and their lightweight role has been addressed by policymakers. As they discuss:

*The role of each DYPE is to monitor the developments in Public Health, in the hospital’s network, and in the regional Health Centres. The system is decentralised but the competences have not been authorised yet. Therefore the system remains ministry-centred (policymaker1).*

*The role of DYPEs is quite undermined. I believe they should definitely be more strengthened otherwise there is no reason to exist. They constitute one more grinding wheel of bureaucracy (policymaker2).*

*Each health periphery has specific responsibilities which are determined by the institutional framework. Of course, we still have not reached the degree of the system decentralisation that could satisfy us. At the moment the regional health peripheries represent the intermediary between the Ministry and the hospitals (policymaker3).*

It follows from the narratives that the efficient decentralisation of the Greek NHS has not yet been achieved. The paradox is that it has been attempted since the inception of the NHS 30 years ago. It can then be assumed that the government’s mechanisms are inefficient, cumbersome and ministry-centred. Even though the Regional Health Peripheries have been built and staffed, their role is not that of critical infrastructure. As a policymaker argues, initiatives have not been given to local authorities due to poor planning. This is in direct contradiction with the managerial spirit of NPM reforms, which suggests more decentralised and flexible structures with cross-boundary collaboration (Diefenbach, 2009a). It is worth noting that Spain has made successful efforts in developing a regional health service at an autonomous level (Sunol, 2006) and Italy has created a health regional network to support local needs (Del Torso et al., 1997). However, let it be said that there are countries which developed health reforms in a more centralised way than others (Groot and Budding, 2008).

*Political Distortion*

Another issue that might explain the failures of the Greek NHS in implementing management reforms is political distortion. Empirical material shows that almost all interviewees indicate insufficient political will and personal political interests as the main causes of reform failure in the health sector (Davaki and Mossialos, 2005). The power of political parties and trade unions burdened the health policy implementation (Polyzos et al., 2008) due to the conflicting interests and reactions from lobbies and unions. As a result, political willingness was not strong enough to bring about drastic changes (Pelagidis, 2005). Key actors of the NHS discuss:

*There is lack of political will. And because the system is distorted, many people take advantage of it. These are the people who react to changes. For instance a very good NHS does not include the private sector to a large degree. The one part does not want the other (doctor1).*

*I believe that policymakers receive refuted information from different persons with different interests. The project that you are doing now, if it could include a very big sample of doctors, and a very big sample of interviews, it could reach the ears of some people in charge. I don’t think this project ever happened before […] I believe that the consultants of the occasional Ministers and Secretary-Generals have certain types of personalities who care only about making good public relations. They are the most unreliable people and the least working employees within hospitals (doctor10).*

*In Greece, public hospitals have the worker unions and the doctors’ unions. In this sense, the political parties’ infiltration predominates. This means that the limits are not set because of the mission, the vision and the goals of the hospital but because of political interests of small teams. On the one hand you have the financial interests of the lobby groups such as doctors, nurses, physiotherapists and pharmacists, and on the other you have the political interests (a grab bag). Then, I* [as a hospital manager] *am called upon to manage all of these and to succeed in my goals for the first time after 2009. Until 2009, we didn’t care, we were not affected, and we were pleasant to all. We did not have a problem to solve. We were saying ″ What do you want? This? Take it and take this as well”. On top of that we were also given a bonus. That was the way things were working; but with borrowed money (manager1).*

*There is no political will. If there is one, everything moves. Without it, even if we break the eggs we will not make an omelette. In Greece there is inactivity for many years. Because they did not want to change the system. We are the only state, where health is centralised. We are like a Soviet state (manager7).*

Political instability constitutes another factor that has affected reform progress. The political environment has been characterised by strong battles between the two main parties, especially in the first ten years since the creation of the Greek NHS (Mouzelis et al. 2005, Sissouras 2012). A doctor explains that this battle faded away as time passed so that both parties could gain mutual benefits. A policymaker describes that the short tenure of Ministers and their administrations has impaired the efforts to reform (Theodrou 2002, OECD 2009a). In this regard, there is wastage of effort and resources because politicians abandon their plans after a short period of time. As a result citizens express their misconception and mistrust.

*I think reforms are difficult to be implemented, very difficult because there is no institutional memory. There is no continuation in administrations. Managers are changing, political leadership is changing and everything beneficial that was created by the previous one, it is changing by the next one. The right thing would be that the next one maintains the previous work and adds something new. Ministers stay on average 1.5 years and Secretary-Generals for 2.5 years. This should change tomorrow morning for Secretary-Generals. Troika proposed to change it to four years and everyone agreed (policymaker6).*

Political patronage and favouritism is widespread within the Greek public sector. Empirical data offer some valuable insights that reflect the degree to which this immoral practice has been embedded in the public services of the Greek state. Interestingly, a doctor combines political patronage with the power of the state. He argues:

*The partisans controlled the public sector with inconspicuous participation. They made lots of things, thanks to their party. They lived from their party. Someone who did not have a political connection he had to work. He could not avoid working. Okay, doctors are working now, they do not sit anymore. But there have been other disgraceful people. These were the parties. They were the wound of Greece and they will continue to be as long as the State continues to have such a big share. That is why the State should disappear. I do not mean to completely disappear, but not to be that powerful. Not to be a monopoly. State is not necessary to sell its companies. If they are profitable and good, why should they be sold? I do not have liberal ideologies. I just see what pays off. Public health must exist anyway. However, I believe that PASOK created a big monopoly on health. You couldn’t make a career inside a public hospital if you were not connected with PASOK (doctor1).*

Not surprisingly, patronage and favouritism is inherent in hospitals’ daily operations. It also seems that the social and economic crisis precipitate such phenomena (Spanou, 2008) as the need for public services has grown. Doctors and a policymaker provide some anecdotal stories.

*Our hospital is a distinct hospital because it is well organised. The problem is that each bitter politician was employed like a manager here, regardless of his qualifications. And the political parties still interfere. This is the problem of Greece. This is the cancer of Greece. Once, I received a call from the Health Minister’s Office in order to make a mammogram to a specific patient and to put her in surgery. People are stupid. They go and beg an MP in order to put them in hospital. Instead they should beat him up because they don’t have the opportunity to be hospitalised. I know people are used to this mentality. But it is not always like this. Go cuff him in the head and ask him ‘Why my friend, am I not served? I voted you to serve me. Not to beg you (doctor1).*

*Problems will continue to increase because the bribery governs. They call me from the administration and they tell me “this is my man, take care of him”. As if the other patients have peed in the well* [Gr. idiom: they don’t deserve my attention]*. These people are not willing to solve problems. They want to disdain the Greek NHS (doctor17).*

*The consultant called the manager and told him that Mr X will be hospitalised during August so his son could go for vacations. In another case, Mr X was hospitalised so his son could go and harvest the olives. Now you know why regional hospitals are over-crowded during the olives harvest season (policymaker4).*

Political clientelism is characterised as a common Southern European phenomenon attributed to similar historical traditions (Sotiropoulos, 2004). It is also responsible for illegal recruitment because politicians offer jobs in the public sector as rewards to political appointees. Obviously that practice does not foster productivity and efficiency in the public sector. In that light, managers and doctors discuss the extent to which public employment in hospitals has been affected by clientelism.

*Obviously I don't want to have a large number of employees and particularly specialties and subspecialties that we do not need. Why? Because not only hospitals but the whole public sector in general had become a melting pot of political parties. Every good-for-nothing was seeing a light in the public sector by being recruited through the political parties to work there (manager1).*

*In our hospital there are no stretcher-bearers. And you know why? Because these people had contacts in New Democracy and PASOK and they were reassigned as administration officers, and now they sit all day. Not only here; everywhere in Greece (doctor17).*

*If you search the CVs of the 300 administrative employees, you will see that many of them were nursing personnel. And the greatest desire of a nurse is to sit in an office (doctor11).*

*The General Hospital of Athens has three doors and 36 doorkeepers. It is unreasonable. When I was a Registrar Doctor, I was using the hospital's bus service because I did not have a driving licence. It was PASOK’s tenure, so innumerable appointees of the party have been settled down in the hospital. When I was using the bus it was like I was travelling from Agios Nikolaos to Ierapetra* [towns in Crete]*. You could only hear the Cretan dialect. Well, someone has to control this huge open door. [..]The thing is that the mergers of the hospital will succeed, but the drones as well as the trade unionists will be in the hospital again. They take a sick leave because they have access to all doctors as they come from the a, b or c party and they are all known to each other, so they come to the hospital only when we have elections in the union. All the other days they disappear. And we urge to fill their positions with training programmes for the unemployed people organised by the National Organisation for Employment in Greece (OAED) or with students from the Institute of Vocational Training who want to do their internship. They do all the work of the other employees, who are being paid normally but they come only when the Trade Union has elections (doctor15).*

The entrenchment of nepotism occurs in the higher echelons of public administration as well. Surprisingly, some managers admit in their narratives that they have gained their current posts because of their political contacts. A manager denotes that managers in Greek hospitals do not have the power to take initiatives. Another manager asserts that he obtained his job through his contacts although he does not belong to a political party.

*According to my opinion, the choice of managers in Greece is not merit-based. And I will make a criticism for myself. I have not studied hospital administration. I believe that a person who could have made these studies could offer more. Of course only if there are opportunities to apply policies. If you are limited, whatever you have studied, you can’t make anything. All the policies arrive from the Ministry and the DYPE. Generally, I believe the qualifications of managers and their deputies should include special studies at postgraduate level. However, I doubt if these are taken into serious consideration when they are assessed. Usually, and this includes my case as well, they first look at the political criteria and then all the rest (manager5).*

*Before coming to this hospital I was a general manager in private companies of the health sector in Greece and abroad. This is my work. I did not get the job of the hospital manager only because of my CV. I took it because I knew 5-10 persons and that was the key. I do not belong to a political party though. And I dare say that we are few who are not written down in the catalogues of a political party, very few. It should be completely the opposite. They should recruit people who know the job and if they happen to belong to a party that’s okay. There is some progress to change this but at a very minor level (manager1).*

In the same vein several doctors comment upon the managers’ non-merit and qualification-based process but also on their short tenure in the hospitals.

*As far as I remember many new appointments were taking place each time the governments were changing. All the hospital managers were changing as well. And then it depended on the manager on how good he was and on his willingness to deal with our problems. In other words, there was no constant policy entered into force for all hospitals and it depended on the manager and on what he wanted to implement each time (doctor6).*

*First of all, our manager does not have any idea about the problems that a hospital might have. Actually they don't care. No one there has specialised studies. Our manager is a retired doctor and α deputy candidate of a party who was not elected. Her wage is the only thing that she cares for (doctor7).*

The above strongly depict the lightweight role of managers within hospitals. Indeed, the overall picture that is given by doctors is that managers did not bring any significant change within hospitals and this is justified by the fact that most of them are political appointees without the appropriate educational and professional background. Notably, this also depicts some tension between managers and doctors. A doctor makes humorous confession by arguing that their hospital manager was a presenter on the local TV before his post in the hospital. Because of his previous experience he was visiting the wards and was singing local songs with the patients. The narratives also show that because managers are political appointees they change every time the Minister of Health changes. According to OECD (2009a) over the last 25 years the average tenure of the Greek Minister of Health is 18 months.

Policymakers, on their side, express more positive attitudes about the management in hospitals as an institution, although they do not neglect the political factors. Two of them argue:

*We will have an efficient system of administration when we will have professional managers who are selected with objective criteria based on merit. At the moment there are good managers in the system, but when the whole mechanism works with political criteria, someone cannot demand more. Hospital management is dominated to a large degree by political criteria and not by criteria of performance appraisal but by economic and managerial ones (policymaker9).*

*Managers brought many changes within hospitals, even though they were political appointees. We would prefer a permanent manager. It is not efficient to change the majority of managers each time a different government is formed (policymaker1).*

A reason that might explain the above is that policymakers do not have a real picture of the hospitals’ daily operations. According to doctors’ narratives, policymakers, like managers, follow the short tenure of health ministers and, as a result, there is no policy continuity. There is no institutional memory, as a policymaker, above, argues.

Empirical material suggests that public healthcare has been a political project between different parties. There are revelations of democratic illegitimacy attributed to political distortion expressed through unethical practices. It may be argued that these practices have negatively affected the proper functioning of the Greek NHS and hospitals. By taking it further, if we are to understand the phenomenon of political clientelism, it is important to look at the prevailing mentalities as well the past history of the nation. These dimensions will be discussed in the following section.

*Culture and Mentality*

Interview data reveal that the factors of culture and mentality have been embedded in the organisational culture of the Greek public entities and have negatively affected their efficiency. It is indicated that public employees are used to working in a specific manner having shaped their own ideologies be they right or wrong. It is to be expected that, when a new paradigm interferes in their working lives, changing will be difficult. At first, it is important to examine some of the key actors’ opinions concerning the prevailing mentality in the public sector.

*If we had changed our health policy 10-15 years ago and there was rationality and a different culture we could have managed many things now. Because it is a matter of culture: In order to control an organisation, you must control the people that work within it. There should be a particular culture of economy and anyway a culture against the waste. This is the crux of the matter; i.e., the rational use of materials and medicines, which we never had in the national healthcare system before (manager 6).*

*Changes in the immediate and short-term horizon have already started, but there are also changes that proceed slowly because, at the same time, we need to change the mentality of a nation. It is not only the hospital’s employees. We need to change the mentality of “who cares?”, or “leave it for tomorrow” or “we always blame the State”. We should understand that it is obligatory to offer our service in order to get paid the €1,000. I can’t just sit down and be paid against other people. […]Imagine that I am having difficulties to move an employee from one office to another or from one department to another within the same building. “No, I am 20 years here and I do not want to change.” “Okay, but I need you there” “No I am not moving”. It is a mentality that I can’t understand (manager4).*

*Tragedy. It is tragedy when they cannot relocate someone 3 km far away. They will continue giving you food. And the most probable is that you will not work as you were not working in your previous post (doctor11).*

*The organisational climate that has been developed is not productive. Someone can realise this when he is abroad and comes here or when he leaves here and goes abroad. There are many distortions and wrong approaches and opinions about the way the public sector should function. I don’t want to generalise this but there are regressive and non-productive mentalities (policymaker8).*

*If we do not change our mentality, no matter the number of crises and the number of memorandums, nothing will change. We need to change the mentality of spending incessantly for things we don’t really need. We only buy them because of someone’s personal interest. We need to stop grafts as well as the scandals in the supplies. We have been in the crisis for three years and we still hear about scandals. These people are not punished or they are punished much later on (doctor6).*

The above allegations denote the inefficient use of resources and the inflexible systems in the public sector (Tountas et al., 2002). It is interesting to mention that all key actors converge with similar ideas but, apart from that, they express their resentment of how things had been functioning so far in the public sector. That shows the magnitude of the ingrained practices and depicts the need for new reforms and the change of mentality.

Empirical data also provide evidence that doctors have evolved and become the professional elite of the Greek NHS (at least before the years of the crisis) and that has burdened the successful implementation of reforms (Kaitelidou and Kouli, 2012). A policymaker highlights that in the dialogue for new health policies, other stakeholders apart from politicians and doctors at higher echelons are not included; and a manager talks about the superego of doctors. However, as examined in the next section and suggested by a policymaker, the new methods and tools that adhere to NPM restrain doctors’ autocracy because now there is visible evidence, which restricts their irrational decision-making.

*Medical professionalism has features of extremity. Governments as well as the political system discuss health matters only with the medical elite. And from these discussions, doctors, nurses, other health professionals and mainly consumers are absent (policymaker7).*

*I had the chance to work in a private hospital as well, and, there, whoever was not harmonised with the organisational culture was automatically fired. Here, each day I spend most of the time trying to solve problems of personnel in order to balance situations. [...] It is also the doctors’ superego. Doctors in the private sector didn’t have any superego. Most of them in the name of Alkisti,* [the medical science] *that behind this science are hidden many other things, create their own captaincy. What should I do? Will I declare a war against the whole system? If I do this I have failed. I need to show exceptional persistence in order to implement reforms. I have to sweeten them a bit (manager5).*

*Doctors constituted a team of increased power and influence. We cannot ignore this. Through trade-unions they could succeed with ease whatever they wanted. However, now, in a more objective system of evaluation, and having the Health Map, I also have the evidence to confront a doctor. Therefore, now I can limit his power a little or at least I can give him answers back. Previously, he could stick me in the wall and I couldn’t give any answers back to him (policymaker4).*

The narratives reveal the intrusion of NPM tools and practices within hospitals. It is important to note that despite the power and superego of doctors, it will be shown in the next chapter that only some negativism as well as scepticism is expressed while reforms are progressing. This resonates with Fitzgerald and Ferlie (2000) who comment that management in the US controls health professionals’ autonomy and is a strong argument for NPM acting as a powerful ideology. Most probably, NPM reforms are seen as the only lifesaving raft from a sinking series of malfunctions in the public sector (Stoker 2006, Harvey 2007, Diefenbach 2009a). Doctors seem to have realised that if they react negatively the Greek NHS will collapse.

Some interviewees highlight the power of some doctors and combine it with personal individual interests and corrupt behaviour caused by their beneficial relationships with the pharmaceutical companies. Empirical data reveal that doctors talk openly about these relationships. The magnitude of the phenomenon is highlighted by a doctor.

*One of the very sinful practices in the NHS was arthroplasty. It was very costly for a number of reasons. First, this was because the pricing of materials was double, triple, and five times higher in comparison with abroad. Secondly, during operations, two or three implants were destroyed because they didn’t fit the patients, something that usually happens in Greece because the orthopaedist has beneficial relations with the private company that supplies the implants. The result was to double and triple charge the insurer whilst using only one implant. Now we have moved to the other extreme. We will not destroy the implant, because the patient does not have money to spend. […] The cost of the operation is more rational now but the operation never happens. That patient has to suffer from pain while it’s being decided to operate on him (doctor11).*

Doctors’ corrupt behaviour in Greece is also expressed with informal bribes given by the patients. These ‘under-the-table’ payments (aka *fakelaki* in Greek) are not taxed and they make up for a substantial extra income for doctors (Dent 2003b). However, through that unethical practice, inequity is strengthened against poor people who cannot pay money to receive better treatment (Liaropoulos et al., 2008). The accounts below highlight that the phenomenon of informal payments is attributed to the doctors’ low wages. It is also evident that politicians have no intention of resolving the problem. Their reluctance to do so clearly alludes to the second dimension of political power which decrees that certain thorny issues be left out of the political agenda. Interestingly, a doctor denotes the need for appraisal and competition between doctors and clinics for a more efficient system. A policymaker illustrates that because of the crisis, patients cannot pay ‘under the table’. Key actors discuss:

*Here in Greece we have had the fakelaki for many years now and this might never stop simply because no politician has ever dealt with it in the right way. When a new government is created the classic thing that happens is the new Minister gives an interview on TV and says “we will fight the fakelaki”. It is the biggest hypocrisy in the world. It is like he says to doctors “Keep taking it”. For this simple reason: in order to fight it, you have to control the patient that gives the fakelaki and the doctor that accepts it. Punish the doctor but first give him good rewards. We forget the basic thing. It is not possible to deal with human lives with so many responsibilities and get the same wage with an office employee if we exclude on-call times during which, however, you are absent from the house, which is priceless. Consequently, if you really want to stop the fakelaki, you have to give salaries according to what they pay abroad. That is to say, three to five times the wage that the medium civil servant gets. In Italy for example junior doctors do not get the €900 that they get here (doctor11).*

*They cannot stop the fakelaki. They are fooling people about it. Everyone knows the fakelaki. Without it the system could not work. I am 62 years old and I get €1,600. How could my family live if my wife wouldn’t work? With only €1,600 and by being a doctor? (doctor1).*

*The director of my clinic has been permanent since 1987. Since then, he has never been evaluated again. He doesn’t want to have good assistants because they will steal his clientele. You see how nice the system works? There is private practice behind, black money, everything. All right? Therefore the system cannot work like this. If profit, and especially personal profit won’t be eliminated and if there is no open competition i.e. what is the performance of your clinic?, How much does it spend? What complications does it have? Then you can’t appraise the system (doctor1).*

*It is well known that the salaries of doctors are not the best. And this has functioned as an alibi and as an excuse for the fakelaki. Right or wrong that’s another discussion. […] The problem, that has been created now… however I do not have data to prove it, just from what I hear and see, is that the current curtailments, the general and the salary ones, have reduced doctors’ wages, and this works as a motive for the continuation of the phenomenon, particularly in a harsh moment. However, the patients have also difficulties and they cannot respond to the requirements of certain doctors for extra wages, for the fakelaki. In this case there is a cost shifting to the patient (policymaker9).*

Some of the interviewees refer to the history of Greece in order to explain the inefficiencies of the present. Indeed, a nation’s history shapes deeply rooted mentalities and cultural dynamics that radically impact on its development and are quite difficult to change (Ongaro 2008; 2009). Greece has been strongly affected by the 400 year Ottoman rule where clientelistic practices and corruption were part of everyday life (Dent, 2003a). A policymaker reflects on the context of ingrained mentalities. Other doctors point out the Turkish influence and link it to Greek history. They provide some evidence that the Greek mentality did not change even when there have been opportunities to do so in the past.

*There are difficulties of establishing reforms and changes within the Greek NHS and the public sector because there are traditional and profound conditions that are difficult to change (policymaker1).*

*I believe it is a matter of culture the idea that the governed and the governors have about the State. I think the governed have not changed the philosophy they had towards the Ottoman conqueror. For instance administration is something that we will take advantage of, we will worship it, we will blackmail it, we will bribe it. We still use Turkish words like “baksheesh”* [tip, extra money for service]*, and “haraç”* [forced tax] *left over from the Ottoman époque. Simultaneously, the Greek managers and administrators consider that the political party is always the State in Greece. Even nowadays, the ability of an employee is not of great importance. What really matters is the party that he or she is voting for (doctor3).*

*At the slightest occasion we will think of how to bypass any legal obstacles in our work. We have transformed ourselves to Orientals. We will seek the “baksheesh” that we have adopted from the Turkish people (manager5).*

*The problem of mentality is long-lasting. When* [Governor] *Kapodistrias came to Greece he was a reformer. When* [King] *Otto came, he was a reformer as well. Both of them got into trouble. Kapodistrias was killed by the small landowners and then they brought Otto together with the army. Otto had the Bavarians on his side, the most developed area in Europe. He wanted to rationalise things in Greece but he could not achieve it because there were many interests. He wanted to allocate the government-owned ground fields but he couldn’t, they were saying to him “make me general officer because I was in the war and this is the certificate”, and all this stuff. But if we look at it from his side we can anticipate a rational way of thinking, a Troika that was working quite efficiently. And if you read the history of '52 in Greece, you will shudder. Instead of the Troika we had the Americans who were talking about corrupt personnel, about the Greek rich people who did not pay taxes and they plundered the country. By now we should have a better tax system, but nothing happened. History repeats itself to such a great level that you say “go to hell people, you are spoilt”. This means that mentality needs many years to change (doctor1).*

A manager raises another aspect relevant to the Greek mentality. He discusses the public nature of health in Greece and believes that the social character of the Greek people will not let the private paradigm embed into the system.

*I believe that Greek people will support the system of health because they are deeply social people. Greece is a deeply social state –misunderstood these last years because there have been uncontrollable social benefits such as pensions in fake-blind people etc. But I believe that the Greek as an individual has a deeply social character and this has reflections in the politicians. So, as far as the health sector is concerned they will anticipate the real problems they will cope with them and they will support the system. I do not think that the Greek politicians will easily throw health in the private sector, as it happened with the system of America, where the public hospitals do not count at all but only the private ones (manager8).*

*Irrational use of Resources Drives to Resource Constraints*

So far, empirical material has shown that the public health environment is surrounded by corruption, indifference, bureaucracy as well as anachronistic perceptions of the past. In such an environment the final result could not be different than money and resource wastefulness. In the current section, NHS actors discuss the level of excessive spending that has occurred so far. A manager admits that there was significant cost reduction in his hospital during the previous years without this affecting the health service. A doctor also states that her salary, as well as the salary of other public employees, was extremely high some years ago. Another doctor comments about the irrational spending habits of some hospital colleagues. Her narrative portrays a positive attitude towards the existence of a private company that could avoid these behaviours. In the same vein, another physician explains that doctors are the final decision makers on the use of resources. So far, they had been spending them irrationally, denoting in that way the medical subjectivity[[25]](#footnote-25) that exists in the Greek NHS (Minogiannis, 2012).

*Our hospital, spent €60 million in 2009. In 2011 and 2012 we spent less than 40 million despite the fact that there was a 15% rise of patients. The average cost of hospitalisation per patient decreased by 42-43%. In absolute numbers, 33% lower costs. This shows that there was extra fat because as a hospital we did not lack resources. However, you will see that in other hospitals there are many deficiencies because of the crisis (manager1).*

*Some years ago our wages were exorbitant. Even ourselves we were wondering where do they find and give us that much money. Our salaries were extravagant, I mean scandalously high for civil servants. However, some people say that there were civil servants who were gaining much more than us. In any case, I believe that if you do not work in the primary production and you are only in services, it is not possible to receive a salary of five and six thousands per month as a public servant. The truth must be told. We had reached very high standards (doctor10).*

*There was waste of resources but this does not mean we should end up in horizontal reductions. I believe that if we had a private management company, everything would be much better. I mean, it is not possible for a colleague of mine to use two bottles of antiseptic because he has an obsession with it. If that money was taken from his salary it would be much better. Nor is it possible for another junior doctor to use sterile gauzes in order to dry her hands because she cannot find other tissues. These are our own errors (doctor16).*

*Doctors are the ones who manage, better say “waste”, hospital’s resources. How they are spending them? By asking for examinations, by deciding if someone will be hospitalised or not, and by undertaking operations. If the doctor could work with rules then he would know, “How much money do I have to spend? That much. Perfect”. And as a result I could work with better criteria and I could decide If the examined patient needs to have a hepatitis test or not. Because you know, we are used to taking a paper and saying “You need to do 100 examinations” We don’t care who pays. Did anyone come to check me? Did anyone come to tell me “Hey, why do you ask this from that patient?” I mean you put a patient in a hospital for acute tonsillitis, why do you ask him to do this examination? Do you base it somewhere? Or it just came into your mind? Because if it just came into your mind, and you did it, you are not a good doctor. If you base it on something valid then do it (doctor5).*

In the discussion above, the high level of waste behaviour is attributed to the lack of monitoring and control mechanisms. Even though a manager informs that cost reduction has not caused any deficiencies to his hospital, his narrative indicates that this practice might not be an optimal solution for other hospitals. Troika’s changes will be explored in more depth in the next chapter.

The unnecessary spending is attributed to personal interests of the system’s stakeholders. Doctors argue that these practices burden the hospital operations. A manager contends that the uncontrollable prescription by doctors (for their own benefit) increased enormously the pharmaceutical consumption and expenditure in Greece (Liaropoulos et al., 2012) and a doctor provides anecdotal evidence related to the extremely high number of antibiotics that the Greek population consumes.

*What actually should happen is the reduction of wastage. Definitely, there are lots of expenses because it is not right to offer inferior services to patients but there is another type of waste. This has to do with the system of supplies in hospitals. It has always been a perforated system. There was never sufficient control from the hospital administration nor from the ministry directly either. The latter made things worse because urgently needed supplies were delayed. Also these people had the means to buy unnecessary things for hospitals and served their own interests. Unfortunately the phenomena of corruption and graft created the problem in the past and now. If these phenomena were restricted then I believe that the hospital expenditure is not excessive (doctor6).*

*There was an incredible waste in public health, and as everyone says “a party has been organised by pharmaceutical companies, by administrators, by doctors, by everyone who was joining this party”. Now the thing is that there are many shortages, caused by reductions we shouldn’t have made; that is to say, the need for reduction of expenses swept out everything without absolute rationalisation (doctor10).*

*Actually, I don’t remember how many more antibiotics we take, compared with the proportion of the British population. I think it is eight times more. This means that either our doctors are not good enough, which I don’t believe it, or there are other financial interests hidden behind it (doctor3).*

Unnecessary spending was also caused by other malfunctions of the health system such as the lack of primary healthcare. The first level of care was never well organised in the Greek NHS (Lionis et al., 2009) so hospitals were always overcrowded as there were no gatekeepers. Unnecessary examinations and labour’s overtime have added costs to the existing grave financial situation. Evidence from other European countries has shown that the organisation of primary care benefited the national health systems (Saltman et al. 2002, Sunol 2006, Simonet 2008). The absence of primary care in Greece and its drawbacks are discussed by the interviewees.

*We were wasting lots of money and no one had cared so far. For instance people are going to hospitals even for a hangnail and they block the whole system. Security funds are paying unnecessary medical examinations and X-rays, and serious cases such as heart attacks are delayed because patients cannot reach a general doctor, a regional health centre as there are no personnel. And the whole system is blocked. Then we spend lots of money for useless things. We have many machines for kidneys’ haemodialysis and for ultrasounds but we do not have personnel. In the hospital of Thiva* [a town near Athens]*, as well as in many other hospitals they have machines for which they spend lots of money to buy but they do not have personnel to operate them. And they come to hospitals of Athens or Chalkida* [a town near Athens] *to give birth because there is no gynaecologist* [in Thiva hospitals] *but there is a unit of nurslings (doctor14).*

*It is not possible to visit a hospital because you are fat and your diabetes has increased a little bit. It does not happen anywhere in the world. If we change this, we will have the possibility of releasing resources that will be used in the primary care of public health (policymaker7).*

*People often come to the hospital but obviously they shouldn’t be here. However, someone has to explain it to them. This usually happens in outpatient care. That’s the way the system works here in Greece and people visit the hospital at the slightest pretext […] However, some patients come here determined that they must be hospitalised. And if the doctor has a different opinion, a conflict or disagreement starts between the two (doctor5).*

The above factors as discussed, together with the current abysmal financial crisis in the country, have caused a large number of shortages in Greek hospitals. Two doctors point out the reduction of beds in healthcare organisations and the lack of hospital supplies. Another doctor provides an anecdotal story about the delay in getting paid their salaries.

*I am advising all my acquaintances in Athens not to get sick at the moment because apart from the enormous shortages in hospital resources, there are also shortages of hospital beds as many wards have been closed. There are approximately minus 200 beds in Athens. This is a big number (doctor16).*

*Definitely there are needs of medical equipment in my hospital; in my specialty too. First, the machines that stop working cannot be replaced. One week ago the c-arm machine which is used by the orthopaedists and neurosurgeons broke down so we could not make operations in patients’ spines, and our hospital is a big regional University Hospital. This is important because it covers a big part of the population, more than one million individuals. Hospital supplies are also limited and sometimes our own health can be at risk. For instance, we do not have gloves; we do not have needle holders so we are forced to sew by hand. We do not have sterile gauzes. We open a packet of sterile gauzes and we share it between two patients which is not the best hygiene option. Five years ago I was not anticipating such a big problem. As time passes the problem becomes bigger (doctor2).*

*Some months ago we were demanding the money of our on-call times. We also wanted to know the exact percentage of reduction we had. They told us that they don’t have any information and that they don’t know the actual amount. Then, they told us that there was no paper in Central State so as to print the salary slips (doctor14).*

As far as the adequacy of medical equipment is concerned, many of the narratives coincide with the fact that even though there is no shortage of medical equipment (heavy machines) in hospitals, the equipment that does exist is not functioning efficiently. The machines are either old-fashioned or they have broken down and the hospital does not have the money to pay the private companies for the machinery’s maintenance. Notably, narratives also focus on the shortage of consumables such as gloves, needles, gauzes, etc.

*I think the main problem has to do with the non-working of equipment rather than the shortage of it. Because when machines break down, technicians of the private companies do not come to fix them as we cannot completely pay the companies. As a result there are machines with very little damage and they remain inactive because we don’t have the money to appoint a technician to fix them (doctor3).*

*As far as the equipment is concerned we are in good standards. However, if there is not going to be a replacement of medical equipment in the next two years we will be in trouble. We will be out of the market in the sense that we will be using outdated methods. And you know you need to invest in medicine and new technologies in order to have a good result (manager 6).*

*There is a problem with hospital budgets. We need more money in order to cover the needs for consumables (manager8).*

Further narratives highlight the lack of personnel in hospitals. Indeed, the problem of staffing has always existed in the Greek NHS especially as far as the shortages in nurses are concerned. However, more problems arise due to unfavourable conditions that the crisis has caused in the working environment such as salary cuts, lay-offs, and hiring freezes (Kalafati, 2012). A policymaker outlines the staff shortages and, with regard to the staff allocation in rural areas, focuses his narrative on poor planning. A doctor talks about the lack of administrative staff and complains about the hiring freezes which prevent young doctors from getting jobs in public hospitals. Another policymaker reveals the shortage of staff with managerial skills and another doctor provides evidence of the scarcity of nurses in Greece.

*We have lots of vacant places that we cannot cover because we cannot recruit people. Also there are personnel who leave from the public sector. I believe that it is not only a matter of quantity but also a matter of human resources management. We have so many scattered hospitals in Greece, at a distance of 20km one from each other, which do not operate with modern models of administration, and they do not evaluate the health profile of their local area, so they do not know their staff needs in terms of numbers and specialties. Therefore, even if we had thousands of personnel we could not cover the actual needs because we are not organised (policymaker8).*

*There is no administrative staff, so there is no administrative support in the clinics and, as a result, the quality of care is degraded. People are retiring, and no one cares about the administrative staff. I mean, at the moment, we do not have a complete archive. That is a significant loss. At the moment, we have one secretary and we share her between five departments. Okay, we will have nurses now with the mergers, and doctors as well. However, there are no young doctors. They do not recruit any. The Greek NHS will end in five years. It will collapse. If my generation leaves hospitals there will be no one inside. We did not train anyone to take our places. It’s over (doctor1).*

*The Greek NHS did not develop executives with managerial capacity who could be capable of charring out and actualising the reforms. These executives were incorporated with bureaucracy and were distorted. As a result there is a problem in resource management and reductions of expenditure (policymaker1).*

*We need more nurses because I realise that they cannot take all their days-off. Sometimes the clinic works with one or two individuals in the morning shift. Of course, the two of them cannot cope with 25 patients. It is a very demanding clinic (doctor2).*

*Lack of Performance Appraisal and Measurement*

The available evidence suggests that in the Greek NHS there is no satisfactory performance appraisal system in human resources (Civil Service Union 1996, OECD 2009c). A doctor admits that patronage has been embedded in this sector as well. In the same vein, another doctor feels very suspicious about the objectivity of the evaluation methods and, interestingly, suggests new applications of international standards. On the other hand, a different doctor believes that his colleagues –and especially the oldest ones–do not easily accept appraisal as they do not feel very competitive in relation with the younger ones.

*No way, there is no performance appraisal. I do not know if there is one for the nurses. Due to the fact that nurses were very rare, they were recruiting them all. There is nowhere in the world with a more partisan system than this one. I don’t know if you have seen abroad, they say that Yale has a relevant high percentage of employment. Here there is the sector of Pasok and the sector of New Democracy. They have defeated Yale, Cambridge and Harvard in percentages. Since the directors of clinics are not appraised to such a degree that it could be possible to get fired, nothing can be corrected (doctor1).*

*No. I definitely believe there is no objective performance appraisal system. It is like a year allowance. It is like an increase in your salary every time you complete three years in the public service. The same thing happens with promotion. It is a bureaucratic process. It has no value. Even if evaluation was successful I wouldn’t believe in it because I consider that there are thousands of undercurrents. I would like it to be more objective. And in order to be more objective there should be examinations according to job grade and years of service. Αnd these examinations should be regularly held by international organisations (doctor15).*

*I believe that there are doctors who do not want to be appraised. This process wouldn’t be in their interests because, you know, in Greece there has been an established system which indicates that “the oldest is the best, the most capable, and the one that will have the best places”. And all this because an evaluation never took place. I believe that if old doctors were to be evaluated with objective criteria, under the form of written exams or in any other form of medical subjects, they would have failed. This would also happen for many of the new doctors. However, everyone should be evaluated but not always with the final result being to fire someone or make him suffer; at the beginning just simply to improve his knowledge (doctor5).*

It appears that the entrenched customs and practices do not contribute to the efficiency of the system. Therefore, the majority of Greek doctors express favourable attitudes towards evaluation methods. This context is in contrast with UK health professionals who expressed their resentment with appraisal and auditing instruments imposed by the agents of managerial values at the beginning of the NPM era in the UK (McGivern and Ferlie 2007, Mannion et. al 2007). One reason that might explain the tolerance of Greek doctors is the intrusion of nepotism within the system that has obviously exceeded the limits so the consequences of the crisis surfaced. Furthermore, doctors anticipate that the absence of evaluation burdens their jobs in hospitals. As expected, there is no adequate evaluation system of the hospital services as well. This is inherent in the interviewees’ narratives.

*The appraisal system needs lots of improvements. No, I would not say that the system that evaluates and promotes the public servants is the best possible. It needs special regulations. There are so many different departments inside hospitals. It is not possible to appraise with the same criteria the Psychiatric Clinic, the Unit of Intensive Care, the Cardiac Surgery Clinic and the Pathology Department. There is room for improvements (policymaker4).*

*No, I do not think there is an evaluation of services within hospitals. This definitely causes problems. There are waiting lists of five and six months for a health problem that, if not treated within two to three months, will get worse. This forces the patient to go to the private doctor, and sell his small field in the village so he can pay for his treatment in order to feel better (doctor3).*

*Recently there was a need to accredit laboratories and clinics and we have started the process; however, because it is time-consuming, arduous and it really requires lots of work, it has not advanced as it should. We have accredited this laboratory after too many efforts and after two years of very systematic work. Because the hospital did not provide us with the money for the work to be done by a committee outside hospital, we did the work ourselves and the National System of Accreditation came and set its quality regulations. This has happened for all the laboratories of our hospital and is underway at the moment in Evangelismos* [main Athens state hospital] *and in two other big hospitals. We are still a long way from implementing it to all health organisations (doctor10).*

Apparently, the accreditation of hospital services is based on the employees’ initiatives and it is not included on the main aims of the hospital. That could downgrade the quality of care as the proper coordination of resources is difficult to achieve and, as a result, the patients’ health and financial situation worsen (Sissouras, 2012). Even though there was an effort to increase quality within hospitals through the establishment of the ‘Quality Office’, narratives suggest that this institution has waned. As a policymaker notes:

*There is one office in each hospital that is called “Quality Office” but there is no systematic quality assurance. And the word systematic is of high importance. Some hospitals certify some of their units with the ISO. For instance they say the microbiological unit is certified in terms of quality. But there is no systematic system that monitors quality. The quality control has certain methods. These are the quality assurance methods. There are certain rules. You measure the medical errors, for instance. What we have now is not a coordinated and fully operational system (policymaker1).*

Ample evidence has been provided up to this point to indicate the lack of performance and measuring mechanisms in the Greek NHS. Those two represent managerial tools of the NPM paradigm (Diefenbach 2009a) but it can be deduced that they have not been a priority in the Greek reform agenda so far. A manager and a policymaker also discuss the lack of controlling and monitoring methods

*As far as I know, the European Statistical Office indicated that the Greek economic growth of 25-30% was credited to the health sector between the years 2005 and 2010. These growth rates had to do with the healthcare system. But what kind of healthcare did we have? We had a health system which actually did not control, did not measure, and was not managed. Basically, the Greek NHS on the one hand contributed a lot to create such a big financial gap in the country, and on the other, the public health system is what we need in times of crisis in order to support society. Otherwise, it has no reason to exist. This is a very difficult equation, firstly because things were highly uncontrolled. In 2009 the number of expenses and the way we spent them were not in accordance with the Greek demographic data (manager 1).*

He continues,

*I believe that we were all equally expedited not to lose clinical efficacy, but the matter of fact is that we do not count it. And we do not count it because we don't have the culture or the tools to do it (manager 1).*

*The Greek NHS did not develop a mechanism of documenting and evaluating its progress in order to be able to intervene. That is to say, you evaluate the work of a clinic and then you intervene. This was never made as we never created evidence and documentation so we never evaluated the work and the progress. Therefore, all these accumulated and they did not leave space for any reform to succeed whenever it was attempted. Someone could blame the economic factors. Because, obviously, a reform costs. But here the paradox is that we did not carry out reforms even when we could financially support them. A good example is primary healthcare. We proved that it could cost less because it will decongest hospitals from the patients’ influx, but they did not want to understand it. They wanted to leave it as it is because of all these interests. They did not want us to create networks that would include private doctors or anything else (policymaker1).*

In that context it may be argued that no mentality of cost efficiency and of evaluation exists in the Greek public sector; therefore, it is impossible to avoid unnecessary spending. According to a manager, exorbitant amounts of money were invested in the health sector without, however, being managed effectively. A policymaker points out the hidden interests that did not leave any space for the development of primary healthcare (Gr. PFY) which could have contributed in saving costs and efficiency. Empirical evidence also suggests that the absence of strategic planning did not contribute to the efficiency of the system. As interviewees point out:

*I won’t say that we have good or bad planning; I will say that we have no planning because we lack the available data. And we do not have planning because it is not included in someone’s best interest. Because, if we start planning we will not have the opportunity to recruit our brother-in-law as a director (policymaker4).*

*Even if we put the best managers in hospitals from the biggest to the smallest nothing will change because the hospital structure and composition remains the same. I mean, we have all hospitals concentrated in the centre of Athens, 50% of hospital beds in the country are based in the centre of Athens. We have half the hospitals in the periphery of Greece. That is to say they have few clinics, few doctors, and no nurses. There is also the phenomenon of four hospitals in the same Prefecture with a distance of twenty kilometres from each other. We have 200 health centres in the country, a very dense network of PFY services that actually doesn’t work. It is a matter of not having established the right managerial and organisational measures in order to make it work (policymaker5).*

It is made clear that there is no sufficient strategic thinking in the NHS (Sotiropoulos 1996, Pelagidis 2005, OECD 2009c). The fact that there were no measurement and monitoring systems already established did not help the authorities in obtaining the available evidence in order to strategically allocate the resources. As a result, hospitals in Athens are overcrowded and health centres in regional Greece understaffed (Telloglou 2011, Kalafati 2012). In that respect, developing NPM reforms in Greece was a Herculean labour (Philippidou et al., 2004).

All the past inefficiencies described were brought about by the harsh economic situation in the country. In fact, the state was not sufficiently “armed” against the crisis’s challenges. As a matter of fact, in Greece and, indeed, the rest of the world, the profound intensification of the financial crisis and the failure of the State to take preventive measures caused a domino of reactions with the most important ones affecting the mental and physical health of citizens. In the next section an overall picture of the crisis consequences in the public health of Greece will be given.

**Economic Downturn and Public Health**

*Health Level of the Population*

One of the main consequences of the economic crisis in Greece was the deterioration of the population’s health indexes. Empirical material provides evidence of the above. As two policymakers discuss:

*During the last two years, the Greek population’s health has worsened. First of all there is an increase of psychiatric cases, i.e., depression and suicides. There is also the appearance and spread of certain contagious diseases which came from the past such as tuberculosis and other infectious diseases. These of course are not only attributed to the economic crisis, but also to the massive influx of illegal immigrants in the country. One example is the reappearance of malaria. There is also the radical increase of HIV cases and of drug users which is quite worrisome. Regarding the level of immunisation and vaccinations, we have taken special measures so there will be no unvaccinated children towards common diseases. We have also taken measures, in order for the uninsured patients whose number has dramatically increased because of the long-lasting unemployment, to have access to healthcare (policymaker5).*

*There have been certain studies published in the international journals which show that some health indicators have deteriorated, and the demand for health services has increased as it usually happens during an economic crisis. Overall, the attendance of patients within the Greek NHS has increased by 20% and 30%. This is the result of two main tendencies: One is that people leave from the private sector and seek services in public hospitals. The other one is that lots of stress occurs during the crisis. Therefore, suicides increased also. The number of HIV cases has increased as well (policymaker8).*

As illustrated, many are the aspects which have changed in the health level of the Greek population due to the harsh economic conditions. Previous research has also shown that the IMF’s policies in a country negatively affect the citizens’ health conditions (Stuckler and Basu, 2009). It should be noted that, according to the accounts above, the state tries to provide free access to health services for unemployed people but only subject to eligibility standards.

*Hospitals*

As far as hospitals are concerned almost all participants of the study argue that their quality has diminished due to cuts in spending and understaffing. Key actors of the NHS observe:

*The current financial crisis has increased the imports in hospitals and the measurements so far have shown that the pressure in the hospital sector has increased by 30% in outpatient care and hospitalisations. We understand, therefore, that one more problem is added with the 30% increase and this has to do with disease management. Patients are not going to private clinics anymore and we do not have primary healthcare, so everyone runs to the hospital (policymaker1).*

*At the moment hospitals undergo a violent budgetary and financial adaptation. Definitely there was financial grease attributed to the system’s pathogenies. An effort has begun two to three years after 2009 and has substantially reduced the costs. However, at the moment we function at the borderline. And the forecasts are ominous, as far as compliance with the budget imposed by the ministry is concerned. The other major problem is about the sufficiency of human resources. Many people have retired and they have not been replaced (manager5).*

*There is shortage of supplies. I have not seen the Tuberculin Skin Test Mantoux inside the hospital for one month now. That is one example. Everyday something is missing. For a long time we did not have cups for medical tests. In terms of antibiotics you never find the ones you want. We have also seen differences in the effectiveness of antibiotics because they give generic antibiotics in hospitals. Okay, there are some cheap ones that are good enough but the majority of them are not. We have anticipated that infections are dragging on. This might be attributed to antibiotics. Oncotherapies might not be as effective as the previous ones because the chemotherapeutics are also generic. It is also impossible to find the ones we want. For instance we might want to do platinum-based chemotherapy today and the hospital might not have it. So we postpone it. These all are terrible costs to the patients (doctor17).*

As observed above, apart from the increased demand for public hospital services, there are other disturbing problems that burden hospital operations because of the economic turmoil in the country. A manager asserts that big cuts in the hospitals’ expenditure were achieved as part of reforms; however, the operation of his hospital is at risk because of underfunding and understaffing (Telloglou 2011, Kalafati 2012). Similarly, a doctor admits that her hospital has huge shortages in medicines and supplies of vital importance something which could jeopardise the patients’ safety and life.

One interesting element is that, according to the narratives, the situation in regional hospitals is better in comparison to that in city hospitals, simply because regional hospitals do not attract many patients because of understaffing.

*I do not think that the situation is worse in regional hospitals than it is in central ones for the simple reason that regional hospitals are poorly functioning so patients are forced to visit more central ones (doctor3).*

*The problem is concentrated in Athens. Second comes Thessalonica and then the six or seven big university hospitals as they accept all the patients and workload from the remaining regions. I believe we should reduce the number of hospitals in Athens and in Thessalonica and merge the small hospitals with the big regional ones (policymaker6).*

*There are shortages of all specialties in regional hospitals. There is the problem with staff’s unequal distribution. Actually, there is no system structure based on real needs. I mean, we have not examined a Region or a Prefecture in terms of its population and its age distribution in order to have an idea about the epidemiological profile of the local population (policymaker5).*

*Patients*

Every day, those interviewed experience the adverse effects of the recession on the population and on users of the Greek NHS in particular. In fact, a doctor bemoans the reduced quality of hospitals because of the increased demand for hospital services. A manager talks of the social welfare and state’s efforts to cover the healthcare needs of unemployed people. Last, a policymaker reveals the efforts to tackle pharmaceutical expenditure by transferring the cost to patients through an increase in their pharmaceutical contributions.

*The cost is mainly transferred to the patient. Apart from seeing much more stressed patients in the hospital we also realise that they spend a bigger percentage for their medicines compared with the past. More than that, their discomfort has increased extremely because they are all forced to visit the outpatient care of hospitals as it is cheaper compared with the private practices. Also the quality of care has deteriorated because the number of patients has increased. And the hospitals so far could not cope and achieve good quality with the personnel they had. This becomes worse as time passes (doctor12).*

*Many patients are uninsured. It is a tragic story. The ministry announced an institution with vouchers. In particular, society tries by itself to respond to challenges. Have you heard about the social clinics? We, as a hospital, have taken the decision to contribute to all these initiatives as long as there is no cost of materials. That is to say, we have given permission to some hospital doctors to participate in the social clinic of our region (manager5).*

*One measure that has been imposed by the Troika is the increase in patients’ contribution to the cost of medicines. Definitely there is an escalation that protects the pensioners, the low income earners and the special medicines of chronic diseases. They have other percentages… but generally speaking, there is a tendency towards increases. For instance, in rheumatoid arthritis the co-payment has reached 27%. Yesterday, the Minister announced that uninsured patients will get their medicines for free from the pharmacies of EOPYY (policymaker1).*

Cost cutting policies as remedies to the crisis in the health sector worsen patients’ lives as they lower the quality of health services and increase medicine contributions (Kentikelenis et al., 2011). Behind the narratives, there are signs of the neoliberal spirit that urges cost cutting but to the detriment of patients. However, to be fare the state has indeed built up some welfare policies in order to preserve the basic health services and protect the poor and unemployed. Some of these policies include free access by the unemployed and the uninsured to health organisations and private practices under contract to EOPYY; and reduced co-payments to medicines for vulnerable social groups.

*Doctors*

The economic downturn has affected the doctors’ work and personal lives. For one thing, the stress their occupation involves and, for another, the unfavourable working conditions due to the crisis have decreased their morale. As doctors discuss:

*Employees have lots of complaints about the hospital administration as they don’t see them working for the benefit of the hospital but as the ministry’s lever of pressure for cutting down on expenses. Moreover, patients are not totally satisfied because they cannot enjoy the quality of health they are expecting (doctor2).*

*The medical profession is influenced by many factors such as the severe economic conditions, the patients’ dramatic increase and patients’ requirements. Also, doctors’ psychology has worsened because of the financial pressure. We work extra hours without sufficient staff and we are getting paid much less than before. However I don’t believe that our work performance has been affected. When you want to work you will work. Okay, this sometimes depends on the doctor’s personality. But when you are in an emergency unit or in the surgery you will do what you must do. The question is how you go back home when you leave the hospital. It is a matter of psychology (doctor4).*

*Our salary has been reduced by 60%. Some lost their appetite for work. Most work with these conditions because medicine is a passion. However I realise that they are unhappy. I see them murmuring all the time. They work more than before because patients’ attendance has been increased; however, they feel disappointed. And there is no way out (doctor1).*

*I believe that doctors are trying to do the best for their patients because their job is not a simple job, it has to do with peoples’ lives and we have to do the best for them, even if we are not paid well. But the fatigue, the excessive hours and emotional factors might influence the output of doctors. We can’t rule out this possibility (doctor6).*

It would not be unreasonable to deduce that, after the salary cuts doctors felt unappreciated (Karamanoli, 2011). As it happened with doctors in the UK when NPM arrived (Pollock, 2005), their morale decreased. However, Greek doctors are forced to work longer and harder as demand for health services increases but hospital personnel decreases because of the hiring freezes. Based on their narratives, doctors let it be shown that the changes have affected their job performance; however, they do their best to continue offering their services. One doctor has explained that it is a matter of each individual’s character. Another doctor expressed his resentment against hospital administration which acts as the State’s agent of change (Diefenbach, 2009b). That approach seems to point at signs of conflict between doctors, managers, and the State (Exworthy and Halford 1998, Lapsley 2009).

**Conclusion**

The present chapter has discussed the past inefficiencies of the Greek NHS alongside with the ramifications of the economic downturn in the health sector. The literature on NPM and its trajectories from other countries has suggested that there are ‘leader’ countries which have adopted a more holistic approach of NPM reforms and ‘laggard’ countries which are slower in that regard (Hood, 1995). According to the accounts as narrated by the key actors of the Greek NHS there were no strong signs of such a business-like paradigm used in the Greek system’s operations and services so far (Zampetakis and Moustakis 2007, Spanou 2008). It may then be argued that Greece has been a ‘laggard’ as far as NPM reforms are concerned.

Ample evidence also explains the reasons that the Greek state did not respond to the major challenges of the health sector by initiating reforms. To begin with, the very nature of the public sector in all its bureaucratic glory was a major obstacle in itself to reforms which, inevitably, did not flourish. Second, the permanent tenure of public employees and the lack of an organised appraisal system dispensing motives and disincentives acted in a manner inhibitory to job efficacy. Third, the strongly centralised health system and the lightweight role of Regional Health Peripheries did not provide a sound planning situation which could ensure the efficient use of resources. Fourth, the competition between regional hospitals was never strengthened as it happened in other European countries (Himmel et al. 2000, Sunol 2006) Moreover, the lack of new managerial methods in the NHS such as a cutting edge accounting system and the provision of scientific information (i.e., therapeutic protocols) did not promote efficiency so far. Last, the worshipful adherence to legalism and formalism –a characteristic of Southern European countries –led to the inability to offer initiatives, adopt innovation, and foster growth (Sotiropoulos, 2004).

Inherent in formalism and legalism is the political power which, according to the narratives, holds sway in Greece and seems to control each and every aspect of the system. In particular, there is strong evidence of the second dimension of power: politicians acting as puppet masters of the political agenda by intentionally choosing to omit crucial issues so as to either avoid the political cost or to promote their own personal interests (Lukes, 2005). The political passing of the proverbial buck between Greece’s two main parties; and the disastrously short tenure of Health Ministers were also highlighted in interviewee accounts as reasons behind the prevention of successful policy implementation (Theodorou 2002, OECD 2009c). This also proves that public healthcare has been a political project with much steering but not rowing. Lest we forget, political nepotism is so deeply entrenched in the Greek NHS that not only are hospital employees kowtowing to politicians so that they can get promoted to better posts, but patients as well ask for favours relating to their medical treatment and hospitalisation. Were we to consider that the founding law of the NHS stipulates and ensures that access to it is free and equal for all, then we may safely be talking of a severe malfunction of the Greek health system (Kyriopoulos and Niakas 1993, Theodorou et al. 2001).

All the above factors contributed to excessive spending and wastage of resources in the NHS. Together with the fiscal constraints, they brought the health sector of the country to its knees. In that respect, the health indices of the country plummeted as many people remained unemployed and without social security benefits. The hospitals’ conditions worsened not only due to the considerable shortages in supplies but also because of an increased demand for public health services and an ever-decreasing number in hospital personnel.

Quite a few of the narratives make it clear that some doctors took advantage of their professional status to create beneficial relationships with the pharmaceutical companies. As a result, they evolved into professional elite which protected their interests by prescribing unnecessary medicines and examinations. Consequently, pharmaceutical expenditure became exorbitant due to the lack in managerial applications which could otherwise control it (Liaropoulos et al., 2012). Equally lamentable, are the accounts talking of the doctors’ informal payments from patients known as ‘fakelaki’, an element blatantly denoting the unorthodox practices that exist in the Greek NHS. The paradox is that the majority of the interviewees and the majority of doctors believe that there is no such thing as an objective evaluation system and that they are in favour of establishing appraisal mechanisms within hospitals. In contrast, doctors in the UK did not welcome auditing and evaluation practices of NPM because they felt that their dominance was threatened (McGivern and Ferlie, 2007). As far as the Greek case is concerned, it may be argued that Greek doctors are fully aware that lack of monitoring systems and their colleagues’ corrupt behaviour lead to undesirable conditions for all, such as hiring freezes, excessive hours of work, salary reductions, increased stress, and more. In that sense, they would prefer to see the situation reversed.

In conclusion, the Greek health sector could not turn to its unethical past as fertile ground for reforms. However, some minor improvements in that area did take place, such as the introduction of managers in hospitals; and the establishment of the regional health authorities, even though both institutions were given a limited scope for initiatives.

**Chapter 7: Managing Changes and the Perspectives of Key Actors**

**Introduction**

Chapter 7 is the second chapter on findings and investigates how the Greek government, together with the Troika, have responded to the country’s economic crisis. In particular, it analyses the most important reforms, which relegate to the neoliberal spirit of NPM and seem to have intruded into the public sector of Greece during the recuperation period. It also evaluates the effectiveness of the changes based on how the key health sector players have experienced them. Last, the chapter looks at the respondents’ views on NPM ideology and practices and reveals how that managerial approach new to Greece affects their everyday work.

**Perspectives of Participants on the Troika and Changes**

In framing the overall climate prevalent in Greece after the arrival of the Troika (IMF, EC, ECB), it can be asserted that, at the fiscal level, significant progress has been made. Stringent austerity measures such as pension and salary cuts, special taxes, public sector lay-offs, and a lowering of budget deficits were demanded by the Troika in the name of stabilising the country’s economy (Vasilopoulou et al., 2014). Two policymakers discuss:

*Whatever was emanating from the Memorandum and the Troika, it was focusing 90% and above on budgetary and fiscal policy measures. Government had to impose the measures because Troika was coming back each six months to check if we achieved the objectives of reducing the expenses. However, the government* [centre-left] *and more specifically the Secretariat of the Ministry of Health, had applied mechanisms and tools* [before the Troika’s arrival]*, which helped in the rationalisation of the expenses. This is the crux of the matter (policymaker1).*

*The measures that were proposed over the last two and a half years can be characterised as a stopgap. They were not measures of reconstructing the health sector and of radical reforms. They were measures aiming to decrease the pharmaceutical expenditure which was raised a lot by 2009. Measures in order to decrease the operating expenses and the supplies of various consumables in order that the system could start functioning. Measures concerned with horizontal curtailments in employees’ wages such as those of doctors and of other health professionals. We had very few measures that were aiming at a reform horizon of the health sector. And these measures were incomplete or they were done in a hurry. They were taken under conditions of tremendous pressure and they did not bring the expected results (policymaker5).*

In fact, many of the participants in the study feel that the Troika’s efforts focus mainly on the economic aspect. As a policymaker argues, the measures do not have any structural nature that could strengthen the way the public sector operates. Another policymaker asserts that many initiatives and measures were proactively taken by the centre-left government prior to the Troika’s tenure and contributed to the efforts of overcoming the country’s serious financial constraints. His narrative, on the one side, mirrors his political favouritism towards the left-centre government and especially the Secretariat of the Ministry of Health and, on the other, it confirms that the left-wing government rationalises expenses with managerial tools and mechanisms.

Many of the interviewees express their positive attitudes towards the Troika. As a matter of fact, a policymaker explains in his narrative that there was an agreement between the Troika and Greek authorities not to expand the notion to the public that all changes are imposed by the Troika, so as not to induce fear and provoke reactions. They hoped that by that tactic they could avoid a hostile climate. In that light, a hospital manager puts his trust in the Troika because of their know-how and disputes the Health Ministry’s consultants. Another manager agrees with Troika’s proposals but worries about the implementation of the reforms by the Greek authorities. Last, a policymaker explains that the Troika is a necessary evil, implying that Greece really needs someone with expertise to handle its economy in a better way. They point out that:

*We should stop taking suggestions from the Ministry’s consultants, because they don’t know. Since there is Troika and Task force they are more specialised and they can better judge who is good and who is not, because they have experiences from abroad and from other successful healthcare systems (manager10).*

*Certainly the reforms proposed by the Troika have solved or will solve some of the problems in the health sector. First of all, everything it has imposed is correct in principle. The problem lies now on how the Ministry and the hospitals’ administration will implement them properly and not apply them fragmentarily without examining what the main goal is (manager5).*

*Unreservedly, Troika contributed to the improvement of the situation in the country. Because of the Troika, lots of things were achieved which had failed before. There are many people, like myself, who support that if the Troika wasn’t coming we had to bring it into the country, implying that we could not manage to change ourselves therefore someone was needed to put the knife to our necks (policymaker8).*

The above claims clearly suggest that it is mainly policymakers and managers who positively portray the Troika and NPM ideology it preaches. However, there are some key actors, mostly doctors, who are sceptical regarding the contribution of the Troika, possibly because it’s mostly their work routine which is directly affected by those changes. A policymaker and two doctors assert:

*What bothers me now about the Troika, is that it insists on the reduction of expenses, much more strictly now, and still we have not evaluated up to which point, what the lowest is or, let’s say, the “red line” of cutting expenses. And that’s bad because it interferes in the quality of health which we offer (policymaker1).*

*No, I do not believe that they have solved the problems in the health sector. I believe that the changes were solely focused on the economic part. The saving of resources was achieved, but problems were not solved, on the contrary, they have become bigger because of the lack of financial resources in public hospitals (doctor2).*

*We reduced our expenses to a large degree, of more than 25-30%, without interfering with the patient. But there was a potential. Now it starts becoming a problem. […] Some problems in the NHS will be solved. For instance the e-prescription: Rationalisation should have been done many years ago. These are proof of the politicians’ impotence. But otherwise, there are measures aimed solely at ensuring the availability of resources, to pay back the borrowed money. They go beyond the limits of rationalisation. This is a mistake of history that it is about to happen (doctor1).*

Interviewees also frown on the cutting policies which, according to the narratives, have gone beyond limits. A policymaker notes that through such phrases as ‘red line’ and ‘the lowest point’; and a doctor talks about a mistake in Greek history due to large reductions in health spending. Thus, it certainly seems that the Troika has gone overboard with regard to reductions in fiscal deficits (Spiegel Online, 2013). As a result, the effects of those truly painful austerity measures have affected the Greek population (Yannopoulos. 2010).

The next sections of the chapter will analyse some of the major changes implemented in the Greek NHS during the recession in order to help in the restructuring of the country. Admittedly, all changes are within the spirit of the NPM philosophy and have been imposed in line with the recommendations of and control by the Troika.

**EOPYY- National Organisation for Provision of Healthcare**

One of the most important changes that took place during the recovery period concerns the abolition of the multiple insurance funds and the development of a new unified health insurance fund, called EOPYY (Goranitis et al., 2014). The changes targeted at better monitoring and control of health resources as well as at re-organisation of the primary healthcare network (Explanatory Memorandum 3918/2011).They also meant to ascertain the equal provision of health benefits to the majority of the Greek population (Antonopoulou, 2014). However, according to the narratives, the prevailing picture is a mixed one when it comes to whether implementation of the new unified fund has been successful. As representatives of the three key actor categories discuss:

*The EOPYY was very roughly created. I am sure it will fall completely out. We anticipated that from the beginning. It was the right idea but the way the social security funds, i.e., the Health Fund were absorbed, was wrong. It was a constitutional coup. Based on the law, the TSAY* [name of the Health Fund] *did not need any aid from the State. Even though it was voted not to be absorbed by the EOPYY, another law was voted after a week and it put it back within EOPYY. This is a clear violation of constitutional legitimacy. It proves that this country is the last hole of the ‘zourna’* [traditional conical oboe whose bottom hole is for show only] *in dignity, we are finished (doctor1).*

*With the creation of EOPYY we could achieve two important reforms. First is the creation of PFY. In this way we would also unify the primary healthcare services not only of ESY but of the other funds, which were scattered. And the second reform was the rationalisation of the financing system because in that case we could know who pays what and why he pays. And, of course, we could eliminate the inequalities. And that is because different types of services are offered by IKA, other services are offered by the Small Businesses and Trades Insurance fund* [OAEE] *and others by the fund of engineers; a chaotic situation with strong reactions, which made the politicians pull back. No one had a strong political will (policymaker1).*

*The Greek population did not easily accept the operation of EOPYY because they were used to a different system. Each insurer had his own fund; he knew that he would go to IKA, or to OAEE in order to cover his needs in terms of prescribing medicines or to consult his doctor. Definitely when you have a unified fund, things are more integrated and easier controlled. However, there are problems in the implementation stage plus that the multiple funds had big debts which have not been paid back by the EOPYY (manager4).*

Most of the narratives exemplify that a Unified Health Insurance Fund is a meaningful reform that assists in controlling resources and delivering better health services to citizens. That is in line with NPM philosophy which focuses on systematic organisational monitoring and on customer orientation (Diefenbach, 2009b). However, almost all interviewees argue that the EOPYY’s early implementation is quite arduous due to various problems such as the smaller funds’ debts, problems of coordination but also resistance from unions and noble funds. A policymaker denotes the power of trade unions against reforms (Sotiropoulos, 2004) and the absence of political determination. Indeed many of the key players express their negativism towards trade unions which mostly serve partisan interests and, to a lesser extent, the interests of employees.

In the narrative above a doctor demonstrates the magnitude of the reform’s implementation in Greece. He describes it as a constitutional coup bringing in mind the radical nature of reforms in the Thatcher and Reagan era (Osborne and McLaughlin 2002, Lynn 2006). According to him, the integration of the Health Professionals’ fund in EOPYY met with the doctors’ fierce resistance (Unified Insurance Fund of Independently Employed 2012, Minogiannis 2012). Those reactions forced the government to retreat from its decision as had been customary until then. Last, the fund was integrated in EOPYY after all, this time under the Troika’s pressure (Ekathimerini 2012b, Unified Health Insurance Fund 2012). Even though one manager admits that there is better coordination of resources with one health insurance fund he concludes that its development is problematic at present, due to the lack of financial resources.

**E-prescription**

Another meaningful change that took place during the Troika’s tenure is the electronic prescription system involving the electronic distribution and control of pharmaceutical recipes and referrals for medical examinations using technology and telecommunications. It was a way to safeguard the validity, safety and transparency of the information distributed. In the previous chapter it was argued that the prescription of medicines obscured beneficial relationships between some doctors and the pharmaceutical companies because there was no control of the medicines’ quantity that each doctor could prescribe. Nevertheless, the majority of participants in the study felt that the implementation of an electronic system in this sector has already made valuable contributions.

*Even though the e-prescription has lots of problems, it is definitely one step forward. It could clearly be more user-friendly in order to help our doctors. However, the alternative is not to turn in the paper. Definitely there must be at least an electronic recording of information in order to check how many prescriptions a doctor records and to whom, in order to avoid phenomena of the past such as a man taking gynaecological medicines, and a woman taking testosterone (manager1).*

*E-prescription was a Troika intervention. It was imposed by Troika. In order to e-prescribe, you must develop a system, a software and many other things. […]At the beginning there were reactions and negativity. However, the plan advanced gradually so we can admit today that we have a successful e-prescription system. Hospital doctors, doctors in primary care and private doctors have adapted to it. There are also the pharmacies that have to accept it as well (policymaker1).*

*E-prescription was fought by those who were taking advantage of irrational prescription. Unfortunately, they were doctors who were making a living from the medicines and from the prescriptions. These cannot be characterised as doctors, end of story. You are doctor so you live from your science, not from the prescription. These people have reacted. One of the benefits of the EOPYY was the e-prescription. However, it doesn’t have the necessary administrative support, it has stagnated. As for myself, I cannot e-prescribe. I do not have time and if there are no secretaries, who is going to do it? This is a problem and people are waiting (doctor1).*

One manager talks about the usefulness of the electronic recording of information, denoting the need for procedures that monitor doctors’ activities in a new modernised Greek NHS (Ward, 2011). A policymaker highlights the role of the Troika in pressing for reforms such as the e-prescription system and a doctor complains about the unethical behaviour of some of his colleagues to react against e-prescription because of their personal benefits. It is evident from their accounts that the new system is not operating very efficiently. A manager believes that the new e-prescription system is not very convenient to the user and a doctor advocates that there is no time available for using the system as the hospital lacks the supporting staff. Many other doctors also complain about not having the time to deal with e-prescription. They all point out problems regarding the technical part of the new project reform that are worth citing. As key actors observe:

*Sometimes there are so many doctors that enter into the system in order to prescribe that the system collapses. You want to make an electronic registration of certain laboratory examinations, again the same thing. The system fails. I mean we want to develop something new and in the right direction but if it doesn’t have the appropriate structure nothing happens. In previous years, prescriptions were written with a pen and it took us half a minute - of course there were lots of irregularities -which we have overcome now. However, now we need one hour to record a prescription in the system (doctor4).*

*E-prescription has not been efficient enough because I think they do not want to control things as much as they could. They could press <Enter> and find the doctors that have made the foul move. It only needs one finger. If they want to do it, it is a simple command in the software. Definitely there are doctors now who would think twice before exceeding the limits in prescriptions. However, I heard the other day that a doctor in a regional city e-prescribed in one month €110,000 in medicines. This can’t be possible (doctor11).*

*I would say that most measures are concerned with the level of recording and monitoring and not with the efficiency of resources. For instance, now with e-prescription we know what we spend in medicines and how we spend them. However, we should use this tool in order to understand how we will allocate the resources and where we will need to emphasise. So I think we have not implemented the criterion of efficiency of resources yet (policymaker3).*

On reading the above narratives, it appears that the e-prescription system is not functioning in the most efficient way. One doctor maintains that the system collapses when there is a plethora of doctors prescribing online. Also, another doctor warns there is a gap in the new system as there is no strict control of the abusers and a policymaker recognises that the new reforms have started to measure and monitor resources but they have not reached the point of using them in the most competent way. Overall, the installation of the e-prescription system within hospitals showcases the growth of managerial yet flawed reforms.

**DRGS (Diagnostic Related Groups System)**

The use of DRGS as a way of financing hospitals is very popular and is used by many modernised health systems internationally. By that system, the price for treatment of a particular illness is predetermined. That gives the advantage of retaining and monitoring costs but also the advantage of increasing efficiency within hospitals (Economou, 2010). A doctor and a policymaker do express positive attitudes towards the change but they also show some uncertainty as to whether the reform has fully reached its actual goals:

*It is now obligatory to report the relevant DRGS in the discharge note of a patient. It is a step forward. Of course we observe divergence between the given DRGS and the actual days of the patients’ hospitalisation. This remains a problem. We see that we cannot cure one patient with the means that are given within hospitals in the predetermined time that is forecast by the DRGS. Perhaps changes need to take place in this sector (doctor12).*

*The DRGS was implemented in the Greek NHS but, again, it was a bit clumsily implemented. I mean, it took ten and fifteen years in order to apply in Germany and we tried to apply it in one and a half years. We did not actually follow the international practice which is to take the DRGS from a country that is already using it, i.e., Australia, and adjust it to our country. This needs time and money. It is difficult technical work. In Greece, however, we found an interim solution, very simple and very primitive in comparison with a real DRG-system (policymaker8).*

Several participants give the impression that the DRGS is not very well implemented in the Greek NHS. The doctor above explains that DRGS prices are not representing real hospital costs. A policymaker remarks that the Greek DRGS has been introduced within too short a period of time in comparison with other European healthcare systems. As a result, its implementation lacks sophistication. It was mentioned earlier in the historical overview that the application of the Greek DRGS in hospitals was recently checked by the Troika. Its officials had similar criticisms to make with that in the current narratives, indicating there should be better controls by the Greek authorities in order to improve its efficacy (TOVIMA, 2012).

**ESY.NET**

Esy.net is a relatively new online auditing system established in Greece in 2010. It serves to concentrate all the financial transactions of each hospital every month. Not only does it provide information about operational costs, it also shows important data on hospital operations such as: days of hospitalisation, bed occupancy, number of medical examinations, number of surgeries, number of medicines used, etc. (Antonopoulou, 2014). The most crucial dimension of Esy.net, however, is the transparency that it provides to every authorised person who can have access to all data. It has thus been ascertained that an audit culture has emerged in the Greek NHS. It signals the introduction of NPM approaches within the health sector (Simonet, 2008) and the need to measure resources and control expenditure. A policymaker and a manager observe:

*There is an online system of recording that has been established, named esy.net. Everything is transparent there now, the hospital expenses, everything. And these are checked. They are accumulated, they are evaluated-not in the best possible way though, but at least there is an evaluation. I mean there are some technical problems regarding the governance of electronic systems. Especially between the Regional Health Authorities and the hospitals. Actually, there is no central point that gathers and evaluates all these results. We are at the beginning of all this (policymaker5).*

*It is a very useful tool particularly for the central State. Every month we have to fill in specific fields in the system with all the economic transactions of the hospital activity. All these are concentrated in a data base so the Minister and the central State can have a complete picture of each hospital but also a general one of how things are developing. At the beginning there were some problems as in every new application. There was a divergence of 20-25% in comparison with real costs and we reached the previous month the divergence of 1-1.5% from the public accounting system (as it used to be named) speaking always with respect to my hospital (manager4).*

Several policymakers and managers assert that the Troika checks very regularly the hospitals’ financial data through the Esy.net. Managers in particular express their anxiety to provide a good financial picture of their hospitals within the required financial targets every month. Two managers share their experiences:

*Now with the Memorandum each hospital appears with its tables on the screen, and if the manager is not careful with expenses, he becomes embarrassed, and he undergoes further control because they ask him what kind of help he needs and so on (manager3).*

*Each month there is a meeting in the Ministry. The first five hospitals will be rewarded, and the last five, unfortunately they will be further checked. Also it is quite possible the last two managers will be replaced by others (manager8).*

It is rather obvious that the strict and regular auditing controls enhance transparency and make managers feel more accountable (Bolton, 2002). It also seems that a new performance appraisal system is about to be established in the sector of hospital management. Rewarding the ‘best hospitals’and the punishment or reward systems that Ward (2011) mentions are all part of NPM practices and ideology. The systems are accompanied by the placebo of innocuous forms such as “Employee of the Month” and “Awards for Excellence”. Curiously enough, respondents do not mention the kind of rewards awarded to the best performers.

The narratives also contain statements on the entrepreneurial spirit of managers. Many of the interviewees indicate that they appreciate the new established appliances of controlling and auditing as ways of improving efficiency within hospitals. Two of them state:

*Objectives have been set by the Ministry and each month we are checked. This makes us better. This is the way it should happen from now on (manager4).*

*I want my Minister to press a button, to enter in the hospital that I manage and see everything. I want him to check whether I have managed my objectives (manager10).*

Their accounts corroborate the fact that the new managerial changes are gradually being adopted within hospitals and more intensively now under the supervision of the Troika. What’s more, reactions are minimal. It is a typical NPM case of modernising the NHS by adding IT applications and having managers bring about change (Parker and Dent, 1996) since managers embrace close surveillance by their superiors through electronic systems. It can be thus safely estimated that managers do not face serious problems in implementing changes since they are willing to be checked by authorities and be transparent about their hospitals’ results. On that, one manager gives an excellent and articulate explanation about this unorthodox phenomenon.

*The impression that is given to me is that the NHS has been extremely ramshackle. The TV News was playing two anecdotal stories from the NHS every day. At the moment the system itself is being tidied up. That is to say the system itself understood that it could not continue in this way (manager3).*

The above comment reveals a hidden reality of the Greek NHS that the critical realism approach helped to unveil. The system has been fighting against itself in order to survive. There were no more resources left to be wasted or any chances for purposeless and unethical manoeuvres. Almost all of the respondents expressed their resentment either against an NHS element or against the system overall. The majority would welcome NPM policies and some actually proposed managerial practices that could save the NHS from past mistakes. That instantly brings to mind Thatcher and Reagan who wanted to avoid bureaucratic stagnation and fight against wastage in order to generate efficiency in the public sector (Osborne and McLaughlin 2002, Lynn 2006). The mechanisms towards doing so, will be discussed in the following sections.

**Price Observatory**

Another important change that has been imposed is the Price Observatory in Health. It is an online database with registered prices of medical equipment and consumables. Every health organisation is then compelled to purchase its supplies under the same technical specifications or models set by the Procurements Committee. The prices they pay must not exceed the registered prices as set by the Observatory (Mossialos, 2011). It is a system that ensured health expenditure is curbed and better monitored. A policymaker gives his opinion on that tool:

*An observatory of prices was developed for thousands of products of medical technology apart from medicines. An observatory of prices existed before but with another base of prices, where each hospital and the Greek NHS could buy pacemakers, reagents or anything else. However, the prices were very high and there was wastage of money. So the system started to adapt itself to a more rational and important base (policymaker1).*

In another narrative, one regional hospital manager calls the price observatory a very positive step. He took the initiative and conducted some research on his own, finding that the price of a STENT (medical instrument used for the treatment of coronary artery blockages) in Greece was the highest compared with hospitals in the rest of the world. He insists that there should be a central organisation conducting research on such issues but does admit that the operation of the price observatory is improving. Interestingly enough, his narrative also unmasks the ‘beneficial’ relationships between international companies and key Greek actors have been established at literally the expense of the country’s public sector. Still, progress has been made. As Krantz and Gilmore (1990) point out, managers diffuse the technocratic ideology of managerialism in order to engender productivity. In that particular hospital the manager encourages the limitation of wastage within the NHS. Further, he makes it clear that inspection and monitoring of public services is key to developing conscientious policies and management tools within hospitals: they are practices which enhance the business-like NPM paradigm within the impotent public sector of Greece (Mongkol 2011, Ehsan and Naz 2003), blocking in a way unethical behaviour.

**Introduction of Accounting Standards**

As mentioned previously, the primitive accounting system of the Greek public sector once had inhibited monitoring and control of available stock in public organisations (Kaklamanis, 2003). Nevertheless, several respondents, especially policymakers and managers, make a note of the new accounting methods within hospitals:

*Another aim was the introduction of a double-entry system. It did not exist in the hospital before. I mean, there was a public accounting system but it was very simple and did not give you additional information. We only had two buckets and in the one you were throwing the expenses and in the other the revenues. We cannot manage and control a hospital with this system. Cost accounting was also introduced some days ago. In order to be effective, however, there should be cost analysis per department. This could help us know how much one patient in the department costs (manager6).*

NPM reforms would not work out without improved techniques in accounting and auditing central to the operation of NPM reforms (Le Grand and Bartlett, 1993). Apart from controlling available stock, they serve to calculate with precision hospital budgets and restrict unnecessary spending. All respondents who mentioned to the new accounting systems view it as quite a positive step and some have already witnessed positive outcomes.

**Health Map**

The Health Map of the country belongs in the same category with the monitoring tools intensively implemented within the Greek NHS at present. The integration of the country’s medical profile constitutes solid evidence-based information as it indicates the health status of each region and its healthcare needs (Nikolentzos, 2008). Seen in that light, an updated health map is an essential tool for specifying and allocating human and financial resources efficiently in each region (Law 3172/2003). Its usefulness is further proven by the fact that it measures and evaluates the efficacy of each health action; and ascertains steps taken in order to improve the health status of the local population. Two policymakers point out:

*The health map is a task which began 15 years ago. It has been activated over the last five years. There is definite progress. Its infrastructure has reached 90%. However, it needs more time to become a useful tool for policymakers. […] Let’s not forget that we are waiting for a political decision for the map to be completed. There should be a special department in the Ministry of Health. It has been enacted by the law but there is no employee in the department (policymaker1).*

*We continue to construct the health map. Not only in terms of data collection and their registration into the system but also in terms of acquiring the culture to work with evidence. […] What hinders the integration of the map is the lack of an appropriate culture and of course it is also the fear of exposure. Many people are afraid they will be exposed because of the published data and measurements (policymaker7).*

Schimank (2005) advocates that for a change to be successful in the public sector, the implementation of new managerial tools and measurement practices are required. In the case of the Health Map as a managerial tool, narratives explain that the main goals of the reform are not fully achieved. A policymaker complains about the political indifference to speed up the reform. His rhetoric condemns the slow development of this tool which began 15 years ago and has yet to be completed. His exasperation aside, his statements show all too well how arduous the process of implementing managerial reforms in Greece is (Papoulias and Tsoukas 1994, Pelagidis 2005, Economou 2010, Sissouras 2012). Another policymaker highlights the political distortion that exists in the NHS by arguing that the Health Map of Greece was delayed on purpose. He asserts that some people did not want to work with evidence-based information probably because this would hamper their personal interests.

**Mergers and Closures of Hospitals and Clinics**

Mergers of public organisations reduce costs thereby effecting cost savings and efficient resource allocation. In the Greek case, all respondents admit that the excessive number of hospitals in Greece has led to their being understaffed and underused. Moreover, interviewees admit that most patients prefer central hospitals to regional ones hoping to obtain better service. During the interviewing period, mergers and closures were already taking place. Key NHS stakeholders share their experiences:

*Mergers of hospitals occurred wherever it was proved that hospitals were unnecessary. The best example is in Pyrgos, Amaliada and Krestena* [Peloponnese towns]*. These are three hospitals, with Pyrgos in the middle, and a new hospital in Amaliada which has been built 20 minutes nearby and draws lots of resources. Krestena is the nearest health centre. This has happened due to clientelism and lack of planning. It’s a common case of voters wanting a hospital in their regions and politicians say ‘we must build a hospital there’(policymaker1).*

*Mergers represent a good opportunity to save some money. We are still working on it. For instance, our hospital had four premises in different areas. One of them merged with the main building of the hospital. We also had two cardiology clinics which were reduced to one. The same happened with two gastrological ones and two orthopaedic ones. We believe that by the end of the year all the mergers will have been completed (manager2).*

*We underwent a forced merger, because one clinic did not have any personnel. More extensive mergers are planned in the future. They will close four to five clinics more. Everything is clumsily made, without being supported by data evidence or being based on the real needs of this country. There are no economic criteria. In our hospital they will only keep the clinics with directors. They don’t care if the other clinics work properly or if they have small costs. And this is happening due to politicking reasons (doctor17).*

As a policymaker highlights, the inordinate number of hospitals came about so as to satisfy the local governments’ political appointees: once more, political patronage thwarts the Greek public health sector (Kickert, 2007). A hospital manager confirms that the mergers of clinics have been happening in his hospital as well and argues that it is a good opportunity for cost cutting. In that sense, what he implies is that NPM reforms are on the right path. However, as a doctor explains, there is no strategic analysis as far as the closures or mergers are concerned. This resonates with Sotiropoulos (1996), Pelagidis (2005) and OECD (2009c) who maintain that the lack of a planning process constrains potential reforms. The same argument was also noted in the previous chapter.

**Key Players’ Perspectives on NPM in the Greek NHS**

Several of the respondents expressed positive attitudes regarding the managerial spirit and tools being embedded into the public health sector. A policymaker appreciates that the key Greek stakeholders started realising that since health comes at a substantial cost that cost has to be carefully monitored by the appropriate tools. His statements are a clear sign that rationalisation and fiscal moderation as promoted by NPM (Hood and Jackson 1991) are on the way. However, the use of the future tense in his narrative connotes that the implemented managerial tools have not reached their final stage. A doctor outlines the need for raising competition between public and private hospitals which again refers to NPM’s entrepreneurial spirit (Gaynor et al., 2010); and a manager suggests public private partnerships as a means towards increasing hospital efficiency (McKendrick, 2002). Still, he admits that he would prefer hospitals as non-profitable organisations, stressing that the public character of health should not alter.

*For all the things there is a positive side. Here, the positive side are the tools of management and the change of mentality. For many years we had a very bad mentality and we were sucking on the sweetie of free public health. Health has costs. It does not have a price, but it does have a cost and we need to know this cost. We need to know how many resources we have, how many resources we can allocate and which are the actions that will multiply our resources and will not diminish them. Therefore, we are now in the positive side to try to establish a set of management tools. We should have done these things many years ago in order to better manage our resources. Despite the current negative economic situation, management tools will be established in hospitals (policymaker4).*

*I believe that the public sector will benefit from the private sector […] I wish there was public health and everyone could access it. However, if the public hospital could operate with the mentality of the private hospital (in moderation) it could only have gains. I mean, it is not possible for a puncture to cost € 6.6 in a public hospital and in a private one to cost €100. The public hospital could charge it at the price of €25. There should be a comparative price (doctor15).*

*I wish we could more easily invest in a hospital facility and I wish we could more easily establish public private partnerships. These are managerial tools that could be used within public hospitals. But if you ask me whether I would like to see hospitals as private enterprises I would prefer them to be legal entities governed by the Private Law but of a not-for-profit form. Generally I believe that hospitals, private and public, should be non-profitable. I don’t mean not to have profit but their profit should be reinvested (manager1).*

Although the literature supports that management has found strong resistance from health professionals in the UK (Davies, 2009), the picture seems to be much more nuanced in Greece. Only certain of the doctors interviewed seemed to be sceptical regarding NPM reforms. Their scepticism did not reflect any fears that they may lose their professional identity, as it happened in the UK (Davies, 2009) but their awareness that the means that could support such reforms are lacking. It is worthy of note that hardly any of the doctors mention in their narrative anything about the Medical Association of Greece, implying that the role of that professional body is not perceived as being very supportive of its members. However, that has not been the case in other countries such as the UK where strong action was taken by the relevant organisation to protect its doctors’ professional identity from NPM reforms (Gabe et al., 1991). Regarding the ambiguity expressed by Greek doctors on NPM, among the factors they anticipated as being potential threats to its success are the lack of resources, the lack of the appropriate mentality, and the lack of working under evidence-based criteria (Economou and Giorno, 2009). Three doctors claim:

*I do not believe that NPM can be successful because as I told you it is the structure that is problematic. For example, if I do not have an employee to work with, I cannot produce results no matter how much you whip me (doctor17).*

*In order to put NPM in the Greek health sector, the mentality should completely change. It is like you are trying to wear a very narrow dress to a very fat person (doctor10).*

*I believe yes, NPM has lots to offer. But the basis should be the development of evidence-based criteria and the strict compliance with these criteria. If we manage this in a public organisation then we would have managed a lot (doctor5).*

At the moment, the NPM paradigm is well and alive and slowly but steadily intruding into the Greek public health sector. According to the narratives, reforms are moving in the right direction; however, more effort should be made and more resources are needed for the successful establishment of reforms. Many of the respondents argue that it is the Greek mentality that should change so that people can rid themselves of antiquated, bad habits and learn how to be more efficient. At this point, the epigrammatic quote by Peter Drucker, the father of contemporary management theory, seems apt and decisively pithy: “Culture eats strategy for breakfast”. The concept of culture and mentality will be examined in the next chapter.

**The Way the Work Changed**

Interestingly, findings grasp the real picture by shedding light on how work has changed and on the new generative mechanisms that have been set into motion during the reforms’ establishment (Berg et al., 2008). The views regarding the efficiency of those developments in the working environment are somewhat mixed. It probably depends on the difference in hospital settings and the pace at which reforms have been progressing in each hospital. It also transpires that it is early days yet, and changes relying on the new tools and working practices have not been fully completed. Moreover, several respondents report acute scepticism and concerns over the lack of supplies and shortage of staff (medical, nurses, and administrative) due to lay-offs and hire freezes. Their accounts talk of a situation that only hampers their everyday job:

*I had one nurse who was specialised in the diabetic foot. Unfortunately, they removed her from the hospital due to the mobility programme of mergers. She was a unique nurse specialised in the diabetic foot, and they brought another ignorant nurse from a nearby health centre. Human Resources are not properly handled at the moment. You just can’t place anyone just anywhere (doctor16).*

Hence, a significant aspect that arises is the possibility of undermining the quality of treatment after the implementation of changes. Some doctors also explain that generic medicines that were brought to hospitals for being less expensive do not have drastic effects in patients whose recovery is thus delayed. Earlier, mention was made of Pollitt (2010) who argues that, without the necessary assets, reforms are arduous. That is further echoed by a manager who highlights the shortage of capable employees as middle managers who could potentially diffuse the managerial spirit within public hospitals (Parker and Dent 1996, Philippidou et al. 2004)

*I believe that we are in a transitory phase. We all concentrated on how to reduce costs but we did not have the luxury, the time, and the resources to look after the personnel. We should concentrate more on personnel. In 2010 public employees were working with very slow rhythms and now we tell them to work harder. They were walking before, and now we tell them to run 100 metres. Their salary has decreased also. […] I mean it is difficult for an employee that works in the public hospital 30 years to know how an organised hospital operates abroad or in the private sector. As a result, this creates the lack of a capable middle manager to whom the hospital administration can be delegated in order to transmit the managerial values top-down (manager6).*

In some of the stories told, doctors talk of noticing that procedures are becoming more standardised than before. This coincides with Landrain (2004) who outlines that NPM brings more bureaucracy within hospitals.

*We continue functioning. Difficulties exist in the supply sector. It has become more bureaucratic. It added more work. Now, we should order in advance the materials. But this can’t happen. There must be stock in surgeries. There was lots of stock available before the Troika’s tenure (doctor7).*

*The e-prescription is a positive step. However, it takes too much time and time is quite valuable because of the overloaded schedule of doctors and administrative staff. But, definitely, record keeping is important (doctor19).*

Other respondents express themselves more positively on the way work altered after the reforms. A doctor below expresses his satisfaction that there are no more supply shortages in his hospital. Although he works in a big central hospital, data reveal that regional hospitals, which cover lesser needs, are in a better state to show adequacy of materials.

*The last two months we had a complete coverage of the shortages. The biggest drama was in the first six months of 2012. At that time we did not have cleansing swabs or pure alcohol. We were buying them from the pharmacy opposite the hospital with our money. This year we are okay regarding also the reagents. We do not miss for anything (doctor10).*

A policymaker asserts that the new practices have brought more accountability:

*Some years ago, I could very easily give you €15 from the coffer. Now it will be published online and I have to explain why I gave you this money. Another example is the recruitment process. Now I have to do a series of procedures if I want to recruit you. I have to publish a call for expression of interest for the specific post in the organisation’s webpage, to invite candidates, to publish the names of those who answered to my invitation, and then to justify why I chose you for the specific post. I am now more accountable to the society that I serve (policymaker4).*

Many of the accounts assert that establishment of monitoring tools enhances the transparency and accountability of public hospitals (Simonet, 2008). The enhancement also helps in shrinking corruption as well as unethical practices by providers. Moreover, some respondents argue that some of the implemented tools provide some excellent opportunities for innovation. A manager discusses the establishment of a new initiative in his hospital:

*Even though we lack personnel we have carried out new innovative actions. For example, we have introduced an electronic system that facilitates the doctors’ visits to their patients. The doctor goes to the patient with a tablet without any nurses or any additional files and he marks any changes in the treatment. This goes directly through wi-fi to the Head of the clinic and the nurse is going to change the treatment if needed. We have also installed the electronic health records system and we will expand it in another clinic as well (manager8).*

All statements above reveal a certain emphasis on the managerial ideology –the technocratic notion that managers can change a public organisation by imposing their practices and values (Krantz and Gilmore, 1990). Elaborating on that notion, one manager contends that he took an initiative to train three nurses on how to do the DRGS encoding. Another manager also tried and reduced the waiting lists in the ER Department of his hospital by distinguishing the chronic cases from the emergent ones. According to his narrative the chronic cases are examined separately from the cases in need of surgical procedures with the result that operated on patients leave the hospital much faster than before. In spite of the initiatives discussed above, many of the responding policymakers and managers argue that the managers’ freedom at work is still restricted by the law. According to them, not only should they be entrusted with the task of moving permanent staff to different posts or to reward and punish employees but should also be delegated administration of hospital budgets. This is not to deny that managers can take initiatives but it does point out that they are not entirely free to administer a hospital as they see fit.

**Conclusion**

Chapter 7 has sought to analyse the key reforms being established in the Greek NHS under the supervision of the Troika with the cooperation of the Greek state. Even though it has been strongly argued that reforms in the Greek public sector did not flourish in the past (Philippidou et al., 2004), the evidence as submitted through the interviewees’ accounts confirms that, under the scrutiny of the Troika, implementation of a set of managerial tools and practices is in progress within the Greek NHS so as to help it overhaul its engines. It is also evident that those practices originated in the private sector and are in sync with the neoliberal, managerial, and market ideology that NPM and the IMF embrace (Plehwe, 2009).

Some of the key changes and interventions include the: Unified Health Insurance Fund, DRG-System, ESY.NET, Price Observatory, Health Map, e-prescription system, new accounting systems, and mergers of hospitals and clinics. All focus on managerial instruments that entail cost curtailment, transparency, monitoring, and controlling of the available resources. Their main aim is to create a public health system which will consume fewer resources and will be more efficient.

According to the narratives delineated by the study, the prevailing picture regarding the reforms’ effectiveness is rather modest. On the one side, respondents feel that the majority of monitoring tools and managerial practices are moving in the right direction and are in the process of producing the results expected of them. On the other side, they do not feel that reforms provide the maximum possible efficiency at the moment. Factors that burden the development of the new changes include lack of financial resources and lack of human capital to support the new interventions.

As far as the Troika and the austerity measures are concerned the respondents seem to be quite disappointed with the Draconian strictness of the budgetary cuts. They feel that the new policies focus only on the economic side and ignore or even neglect to tend to the ramifications on the health service and the population. In terms of the NPM paradigm as it has intruded within the Greek NHS, the data interestingly reveal that several respondents are in favour of managerial practices. It is quite likely that, having come face to face with the severity of the situation, their favourable views are a means of venting their frustration with and anger at the corruption and the excessive use of resources in the Greek NHS. However, it is important to note that the majority of the participants do not want a private NHS with private hospitals and reduced health spending. That possibly goes to show that although interviewees agree to accept NPM as an assistant they do not wish to put its ideology on a pedestal. In other words, they do accept some of the managerial practices but have not fully bought the stark market, managerial and neoliberal ideology that NPM brings with it. The next chapter examines the sustainability of reforms and indicates what should be done in order to ensure the existence and efficiency of the Greek NHS.

**Chapter 8: Sustainability of Reforms**

**Introduction**

Chapter 8 brings the findings section to a close. Its task is to take an attentive look at and analyse the feasibility of the new reforms; and to provide a clear picture of what the respondents’ predictions are on the future of the Greek NHS system. More specifically, the chapter seeks to fathom whether the interviewees believe that NPM reforms do reflect the aims of the Troika; and whether the Greek government will be able to solve the major problems in the country’s health sector. The chapter also delves deeper into the interrelationships between Greek NHS stakeholders and identifies any considerable constraints whose presence may adversely affect the reforms’ future development.

**Crisis as an Opportunity for Change**

As explained earlier, a financial crisis is usually considered a catalytic trigger where changes in a state’s situation are concerned (Olsen 1994, Karamanoli 2011). Despite the social ramifications that usually follow in the wake of a financial crisis, a prevailing power of neoliberal ideology, stemming from the government and the Troika, plays a pivotal role in transforming healthcare organisations (Lynn 2006, Harvey 2007, Fatemi and Behmanesh, 2012). NPM is regarded as a product of that neoliberal dogma. The majority of the study’s respondents believe that the crisis in Greece is an opportunity for change. However, there is cautious optimism as to whether the overall situation will improve. Accounts indicate that respondents do realise that opportunities for change do arise from the crisis but they are nevertheless frustrated with the austerity measures. Key players of the Greek NHS comment:

*Yes the crisis is an opportunity. But there is elasticity. When you realise that a hospital has made a big reduction in expenses during the past three years and you ask for more budget cuts in the next year, you then create a further problem. You are about to bring the collapse of it. You don’t help it in this way and you don’t reward it for the achievements so far. What I am trying to say is that we do not need any more horizontal policies. We want policies that differentiate procedures and people (manager6).*

*Troika was a window of opportunity and it did help with the insistence that it showed in order to reduce the expenditure. As I said before, it forced the political leaders to apply measures for cost reduction and efficiency. Therefore, we could argue that the contribution of Troika is positive. I am saying this because we knew in advance, before the Troika come to Greece, what we should have done in order to recuperate however we did not do it (policymaker1).*

*If they do not think seriously to find solutions, I do not believe that there will be a positive and a prosperous future. Only if we make rough and structural changes we might have the opportunity to achieve good results. I am not that pessimistic, but they should deal very seriously with the problem (doctor14).*

A manager stresses the fact that Troika focuses only on the economic side of the Greek problem and neglects the impact on the human factor. He proposes implementation of policies and measures that could improve the citizens’ quality of life which has deteriorated because of the crisis. Many of the interviewees express the same point of view. A policymaker asserts that Greek authorities were fully aware of the system’s inefficiencies before the Troika, but they did not spring into action until the Troika demanded it. In a similar manner, a doctor warns that Greece needs to take the reforms seriously in order to improve the situation. The above allegations clearly suggest that the majority of respondents see the crisis as an opportunity for change. That, however, did not deter them from expressing their worries over the future and the consequences.

Among the answers on ‘whether the crisis should be seen as an opportunity’, negative comments verging on the extreme came from doctors although it should be admitted that those views were few in number. In fact, doctors in this study are the only key players who directly experience the changes imposed upon them by policymakers and managers in their role of change agents. Case in point, UK doctors whose morale weakened following the NPM-style reforms and the severe cuts (Pollock, 2005). In Greece, the number of health professionals holding a fully pessimistic view appears to be small. And although the morale of Greek public hospital doctors seems to be just as affected, interviews reveal that the system and its actors have shown themselves to be more open to change:

*In my opinion, it would be difficult not only for Troika but also for God himself to organise the system. I am not sure I think the problem is that there are not the right people in the right posts. More trustworthy people should be found in order to deal with the doctor, the patient and their needs. Even if the Troika stays or leaves, I think nothing will change (doctor13).*

*The people that have created and brought up this system cannot fix it now. Either they cannot or they are not capable of doing it. I do not know which of the two emerges (doctor5).*

It follows from the narratives that great store is sent on the change agents in charge of reforms. A doctor stresses the need for more responsible agents in order to facilitate change (Parker and Dent, 1996). Similarly, another doctor questions the ability of professionals to reorganise the Greek NHS. Their views also highlight one of the core assumptions of NPM, the ideological one. To reiterate, many scholars have argued that the ideological aspect of NPM lies in the belief that managers can bring their knowledge and spread their values within public organisations in order to reform them (Krantz and Gilmore 1990, Cleveland 2000, Lapsley and Oldfield 2001). If truth be told, in the case of Greece, that argument cannot be made effectively, since past experience has shown that the performance of managers in Greek hospitals has been anything but satisfactory, let alone efficient (Liaropoulos et al., 2012). It can, then, be argued that a lack of capable managers and a shortage in human capital and other resources in the NHS may threaten the successful progress of NPM ideology and interventions (Pollitt, 2010).

**Sustainability of Reforms**

The historical background of Greek healthcare has shown that reforms in Greece did not find a breeding ground because of the country’s unstable political and economic climate (Sotiropoulos 1996, Pelagidis 2005, OECD 2009d). The only reason reforms have begun being implemented is the Troika with the blessings of the Greek government. To that purpose, the study participants’ views regarding the further development of the changes and the potential obstacles that could act in an inhibitory manner on the entire process shall prove interesting.

In this regard, the majority of the participants expressed their scepticism regarding the changes’ sustainability. Their opinions also reveal their quandary: on the one hand, they are convinced that current reforms should not be abandoned because the system cannot operate otherwise but, on the other, they feel cautiously optimistic about the chances of the situation improving in the long term:

*Τhe reforms that are occurring now are permanent as long as the Troika remains here. After the Troika leaves the country, discounts will start. That’s why they* [the Troika] *will return back soon. Even if we suppose that the programme will end by 2016, which I doubt, the Troika will be here again in two-three years’ time (policymaker8).*

*Reforms are not temporary. When a hospital is merged it is not a temporary solution. I only hope that they will last. I am optimistic. As I told you things are going well. We have already secured a certain amount of money. I hope it will work out. Otherwise we failed. We either cross the river or we keep settling deeper (manager8).*

*I believe that these reforms are permanent; however they are not the final ones. I believe there will be more reforms in the future, but I do not know in which direction. I do not know if there will be more applicable and correct decisions made from now on (doctor2).*

In the accounts above, one policymaker appears certain that Troika will be back in the country in a few years’ time. Α manager highlights a critical point in Greek history and optimistically greets the reforms’ development. Along similar lines, a doctor upholds the permanency of the reforms but does express some concerns about the establishment of additional reforms in the future and the effects those entail. A reason that might explain the above arguments is the past failures of the Greek NHS. People have realised that radical changes did not occur in the previous efforts that took place. As a result they feel frustrated when they anticipate that things are different now in the short-term under the supervision of Troika. Yet, the prevailing idea is that the long-term success of the reforms remains debatable due to the mistakes of the past.

**Culture and Mentality- the Main Obstacle**

It is not surprising that several respondents depict the mentality and culture as deeply rooted mechanisms acting as inhibitors on the development of reforms so far (Dent, 2003a). The majority of interviewees comment that if public organisations do not extricate themselves from old, entrenched customs and working habits, reforms will continue unimplemented and inactive. Their opinions come to confirm the fact that, without a doubt, the culture of an organisation and its employees’ working behaviour influences the feasibility and further development of reforms (Bolton 2002, Philippidou et al. 2004). Key players in the Greek NHS propose ways of dealing with such challenges in the workplace:

*Before reforms are put in action, the mentality of employees should change. This happens through discussion, education and training in order to help employees accept positively and without prejudice the new working methods. […] and staff should also have in mind that the rational management does not only include punishment, it has also rewards (doctor10).*

*Yes mentality can change but it needs time. It also needs the turnover of staff, which is difficult to happen now in the public sector. At the moment there are employees that have worked in the public sector for 30 and 35 years. They have worked there with another mentality since the first day of their appointment. It would be useful to renew this staff at an approximate 30%. It would contribute to the cultural change because a new employee will enter into a new system and will adapt himself more quickly. I imagine that the old staff will also adapt themselves but in slower processes. It usually takes one year in order to change an organisation with 1,500 individuals. […] Small training sessions and seminars in and outside hospitals are useful in order to help the staff’s adaptation. If they are not adapted, you fire them. This is how you make a culture within an organisation (manager6).*

*I could determine three important aspects that could change the organisational culture. First of all we intervene in the organisational structure and we define the job description of each employee. Second we apply an objective evaluation so that we don’t have everyone reacting through trade unions. And thirdly we change the organisational structures. This has not happened yet in the public sector. We should change the organisational structure of administrations and departments, and this will bring another organisational climate in the system of health. In this way we can force all these people to enter and follow the different types of mentalities (policymaker1).*

It should be pointed out that, at the heart of the respondents’ reflections on a change of mentality lies the appraisal system. It is one of the managerial tools that has been missing from the public sector thus disabling control and efficient management of resources (Sissouras, 2012). It has been noted previously that the majority of interviewees express their resentment regarding the lack of evaluation methods in the Greek NHS. According to Pollitt and Bouckaert (2000) the performance appraisal system is the focus of all the major NPM reforms in other countries. Furthermore, the NPM paradigm and its tools are seen as a way of changing a hospital’s organisational culture (Bolton, 2002).

According to the empirical evidence above, a doctor proposes the introduction of training programmes and evaluation systems so that employees may become accustomed to a new organisational culture. Along the same lines, a manager recommends that the existing, old staff be partially replaced. According to him, such a move will bring in new blood that could rejuvenate the organisational culture. He holds a more rational and managerial view when he argues that employees who do not adapt to the new working conditions should leave the organisation. Both narratives reflect that the mentality of managers differs from that of doctors (Exworthy and Halford, 1998): managers see efficiency and cost of resources as imperative, whereas doctors it is more a matter of incentives. As to the perspective of policymakers it is far more sophisticated. In practice, the role of a policymaker carries more responsibilities and complexities as they must delve deeper into a problem; shape holistic views; and put policies in place to generate sustainability. The weight of their duties is reflected in the account of a policymaker who makes three proposals that could help alter the intramural cultures of organisations. He proposes the introduction of a job description; reorganisation of the Ministries’ structures; and implementation of a performance evaluation system. His recommendations echo NPM basic practices and core elements (Diefenbach, 2009b). Several other respondents make similar suggestions which also relegate to NPM philosophy. Still, it should be reminded that the development of the Greek NHS system has historically shown that theory and practice are sometimes worlds apart, possibly even universes.

Two significant elements included in the proposals on how to change an organisational culture are training and education. Doctors in particular have pointed out that employees need the added confidence that appropriate education and training on new tools and working practices implies. More particularly a doctor argues:

*When they say “I will put some of this and some of that” the only thing they will achieve is a ragbag of reforms which neither old employees nor new ones could accept, because they will not have the appropriate education plus they are used to working with an old mentality (doctor14).*

Astonishingly, aspects of education and training are not included in the NPM bucket of tools and practices. Their importance is indicated in a doctor’s narrative: he is adamant that, without education, changes will not be easily accepted by public sector employees. Equally certain that those two parameters are indispensable was earlier the manager who took the initiative to train three of his hospital nurses in the encoding of the DRG-system. Therefore, even though Philippidou et al. (2004) mention that leaders can change people’s behaviour and organisational culture, it is also important to place emphasis on training and education as coping mechanisms to deal with reactions to change but also as a means to invigorate staff’s working skills. As the Troika continues to channel within the Greek NHS new NPM tools and practices, training employees is of paramount importance if the reforms are to be sustainable.

**Interactions between the Key Actors**

Another crucial factor which acts as a contributor to the successful development of the reforms is the interplay between key NHS actors: At the start of the NPM era in the British NHS, working relationships between doctors and managers had become rather thorny (Parker and Dent, 1996). Equally problematic seem to be the working relationships between the same groups in the Greek NHS as revealed by the accounts given during the interviews. Those relationships will be scrutinised so as to discover whether they could become a hindrance in the reforms’ sustainability.

Managers and policymakers comment upon their medical counterparts. Their views converge on similar assumptions. Some common principles have been deduced in Chapter 6 and are concerned with the superego of doctors, their professional autonomy, the power of their trade unions (Ward, 2011) and the lucrative relationships some have established with pharmaceutical companies. As stated by one policymaker:

*Primary care could contain the excess spending that medicine causes. Why hasn’t this occurred so far? Simply because all doctor’s specialties that have the contracts with the funds, i.e. cardiologists, pathologists, otorhinolaryngologists, oculists, gynaecologists, paediatricians, are afraid that they will lose their direct access in the clientele. So the decision for primary care is difficult to make because all those specialties are organised through trade unions, while the general practitioners have become one very small and ineffective lobby (policymaker9).*

It can then be argued that policymakers and managers are fully aware of the formidable power doctors wield. Knowing that, it is quite likely they up to this point, everyone had been making way for the doctors. Case in point, a manager of a large central hospital who admits that, since it is not possible to start a war against doctors, the only resort is to be insistent with and courteous to them. Another aspect that characterises the doctors of the Greek NHS according to narratives by some key players is the lack of cooperation between them. In fact, doctors themselves acquiesce that it is difficult to build strong relationships with their colleagues. Two doctors discuss:

*Inside hospital the communication between doctors is good. We organise oncology boards. However the communication with colleagues outside the hospital is bad. Actually it does not exist at all. So, if one of our patients has been operated on in another hospital, we cannot have any communication with the other hospital. Not only us. This is what happens generally (Doctor1).*

*Generally, there has been nothing conciliatory between doctors all these years. We did not have common working groups that could give us the opportunity to decide common policies in our sector. The scientific councils never worked out in a unified way. There was lots of competition and there was enormous pressure outside hospital. Human beings are vulnerable; doctors are human beings and are employees who can easily be corrupted. There was a huge fight, on behalf of pharmaceutical companies, to make money in Greece. These companies bought off the doctors’ consciences. I believe they destroyed the Greek NHS to a large extent (doctor10).*

In that respect, evidence has shown that relationships between Greek doctors are sometimes undermined on the altar of personal benefits. It was noted earlier that some doctors, because of their professional status, took advantage of the lack of monitoring mechanisms and established profitable relationships with companies and patients. A doctor has pointed out that health professionals are vulnerable to temptations and can be easily corrupted. One of his colleagues complains about the lack of coordination between health professionals which burdened the development of common policies and treatment protocols. Another one outlines that his medical director avoids collaboration within the hospital claiming that he has to ‘protect’ his own clientele. To put it bluntly, the more the patients doctors have under their responsibility, the more profit they stand to reap from the pharmaceutical, medical, and diagnostic companies and from their private practices if they maintain one.

Conversely, ample evidence shows that health professionals are not shying away from reporting their dissatisfaction with the managers and policymakers. The first bone that doctors have to pick is that there is no communication between them and the managers. Two doctors reflect:

*No, we do not have regular meetings with the manager. We go to his office only in situations of crisis in order to resolve a particular matter that we face. And usually we leave as we went (doctor15).*

*Of course not. We do not have meetings with the manager. And some of us have been chasing managers for serious problems. Sometimes they did not even accept to meet the directors of the clinics to discuss a serious problem (doctor16).*

It was mentioned earlier that the role of managers within Greek hospitals has not been of the outmost importance (Liaropoulos et al., 2012). In this respect, hospital managers cannot be considered as professionals with strong values and authority. Several managers and policymakers comment upon this and three of them assert:

*The intervention of the State’s legislative framework is so strict that it is extremely difficult to change the proceedings. Especially, the regulations of human resources management are so rigid that managers cannot achieve a simple tidying up of the personnel in their hospital (manager5).*

*Managers do not have the initiatives, or better say the autonomy, to develop policies. But, okay, they can do some minor changes of administrative character within hospital… this is allowed to them (policymaker1).*

*As a manager of a hospital I do not have any jurisdiction in recruitment, promotion, reward and punishment. I do not have any jurisdiction in removing doctors’ admission rights. And because I do not have this, conflicts are very often created. Because each doctor comes and tells me “I am the doctor and I decide. I want the specific medical equipment, I want the specific medicine, I do not want generic medicines, I do not want this, I do not want that” (manager1).*

It is clear in the statements above, that margins for manoeuvres by the managers are limited. It is all too clear that decision making within hospitals continues to be ministry-centred; moreover, full delegation to local authorities and, by extension, decentralisation is still in painfully slow progress. Those inabilities of the system to deal with reforms points at the public sector’s tenacious hold on formalism and legalism (Sotiropoulos, 2004). Even after a number of managerial reforms were implemented in Greek public hospitals, NPM teachings on disengagement from state interventionism (Ormond and Loffler 1998, Klein 2006) have fallen on deaf ears. Within that organisational framework the potential for harmonious relationships between health professionals and hospital managers is undermined. Worse, evidence has shown that many managers are political appointees and their legacy in managerial reforms is abandoned when a new health minister takes over and new managers replace the old ones.

In a similar context, doctors and managers express their beliefs about the policymakers. They claim:

*They [the policymakers] should spend a day in a hospital on their own (I hope not for something serious), so as to wait in the queue to pay the ticket, then wait for an X-ray, then wait for a stretcher bearer – usually there is no one available so you have to wait a long time, having all this panic inside a hospital. Then I am sure they will very easily find the solutions (doctor14).*

*Policymakers usually do not belong in the health sector. But even if they belong, still they are more politicians in profession because they have moved away from the health sector. What also matters is that above all they put in priority the political party’s interests and not the actual needs of the health sector (doctor6).*

*Policymakers do not have an explicit picture for hospitals and how these operate. The political factor plays a major role. In order to develop a health policy you should put aside the political factor, that is to say the favours and interests. This has not been applied in Greece yet (manager7).*

*If they* [the policymakers] *have never worked in the public hospital or a hospital in general, it is difficult to develop health policies. Theory is completely different from practice (manager6).*

Arguably, most doctors are not satisfied with the work the policymakers have undertaken so far. Managers point out that policymakers are not usually in close contact with hospitals. Adding to that, one doctor makes the cynical remark that whenever policymakers come to his hospital it is only for pure, unadulterated public relations. It is thus evident that the doctors’ needs are not fully met by policymakers. In fact, the majority of the respondents concur that there is no strong political will to create and follow new policies in the health sector (Papoulias and Tsoukas 1994, Pelagidis 2005, Economou 2010, Sissouras 2012). This is also indicated in the literature references above which show that the lack of political will continues its uninterrupted path in the Greek NHS.

**Doctors in Management**

According to the conceptual framework, the implementation of management within hospitals requires the active participation of doctors (Fitzgerald and Ferlie 2000, Llewellyn 2001, Dent et al. 2004, Pollock 2005). In that context, the key players’ perceptions on how doctors become conversant with management and how they become involved in their respective hospitals’ administration shall be examined.

Interviews with the study participants reveal their preferences for someone other than a doctor as a hospital manager. Their accounts indicate that, at present, doctors have no available time or the know-how to become involved in administrative affairs:

*A manager should not be a doctor. However, he should have knowledge about the medical service. He should go around the hospital and observe how the patients are treated in order to be able to manage such an organisation […] Moreover, his main concern should not only be to administer a hospital but also to find ways to bring more revenues, to raise investments, and open new horizons for the hospital (doctor5).*

*Doctors are using some services which might not be the best option. These services might be very expensive, and there is no one there in order to control them. […]I believe that hospital managers should not be doctors. However, they should have obtained working experience from the health sector because it is a very specialised sector. For instance, a manager from the automobile industry will need lots of time to adapt himself in the health sector. Health service is quite a different service (manager6).*

*The fact is that we take for granted that doctors can be good managers. This is a mistake. The education of doctors is to cure people and not to manage organisations. Therefore, their approaches many times are characterised as myopic, especially in matters of wider significance (policymaker8).*

Still, there is a considerable number of doctors who hold either a neutral or even a positive view on having a doctor in the post of hospital manager. Two doctors argue:

*I do not want as a manager someone who is not a doctor. If he comes from another occupational sector, he should stay there to become a manager. I mean, if it is to communicate with someone other than a doctor I have to use the language that I use when I talk to the grocer. I am not saying this in a disparaging way but shouldn’t we have a common code of communication with the manager? (doctor9).*

*Ι cannot accept having as a manager someone who is not a doctor. At the same time I cannot conceive of having policymakers who do not have the knowledge of medicine. I mean I do not understand the word technocrat. I need six hours to explain to him what I am doing (doctor15).*

Their opinions as stated above signal the gap of communication between doctors and managers. Their accounts identify the problem as being the managers who do not possess the appropriate knowledge that could enhance communication with health professionals. A Greek-Australian manager who is currently working in a Greek hospital, talks about a practice prevalent in Australia which requires individuals wishing to become hospital managers to take a full professional course that also includes modules on actual medicine. Admittedly, one of the most prevalent motivators in a hospital environment leading to efficient collaboration is finding a common ground for communication that will ensure a productive organisational culture.

Another interesting finding emerging from the interviews is the participants’ positive attitude towards doctors acquiring managerial skills. As a matter of fact, several interviewees, including doctors, believe that being in possession of management knowledge could be beneficial. Some, however, demonstrate that there is no spare time during which they could undertake managerial responsibilities:

*I think yes. It would be interesting to see doctors learning management. It ought to be at least a course module in the first year of the medical course. I think you need to have basic knowledge of economics in whatever you are engaged with. For example, we do not know what the word ‘cost’ means in the hospital that we work. […] If we all knew that the cotton costs €2,000 per month we would behave more rationally, as we behave in our houses (doctor5).*

*I studied management by myself when I was younger. However, I did not use my knowledge; only in how to organise my clinic. It is good to know, and it should be taught as a module at the universities. Many doctors do not have the knowledge. They should know how to organise a department and how the Greek NHS works (doctor1).*

*A doctor should also be a leader and not only a leader but also an effective leader. They have the ability to do it. There are some educational seminars running. This is a continuous goal that derives from the crisis. It was not happening before. The crisis has buffeted us (manager2).*

In the statements above, a doctor outlines the significance of management learning and concludes that it would help doctors to steward hospitals resources more responsibly (Llewellyn 2001, Dent et al. 2004). Another doctor argues that management helped him in organising his clinic. On the other side, a manager believes that doctors can be good leaders. Nevertheless, studies have shown that, historically, doctors cannot be transformed into managers (Klein, 2001). Yet, as time goes by, the number of doctors wishing to become involved in management is increasing (Forbes et al., 2004). In the Greek case, there seems to be a gap of communication between managers and doctors which, according to the respondents, could be bridged if each side acquired specialised knowledge on the other side’s field.

**Conclusion**

Chapter 8 was the final chapter of the findings section. It discussed the opportunities and threats that may at best guarantee or at worst threaten the sustainability of the new reforms in the Greek NHS. It also indicated that, overall, participants were cautiously enthusiastic about the reforms’ ability to fulfil their basic aims.

It is encouraging to realise that most of the respondents are optimistic and see the crisis as an opportunity to battle the inefficiencies of the past and contribute to the modernisation of the country’s health sector. Thus, it may be safe to assume that, so far, important strides have been made in the realm of public healthcare. Interviewees have offered valuable feedback on the situation prevalent inside healthcare organisations during this period of reform. Another thing that was also promising was that both managers and policymakers were milder in their criticism than doctors. Their conciliatory stand may be explained by the fact that their place is somewhat on the sidelines of the reforms’ tsunami whereas doctors are in its very core.

In terms of whether reforms are sustainable or not, respondents believe that the new installed tools and practices will continue to exist but they are not sure about the future of the NHS. Their main concerns seem to centre on past failures and the fear that there may be additional reforms which will end in more and painful austerity measures. The issue of the shortage of resources was found in previous narratives to be of a top priority (Pollitt, 2010). Another major issue regarding the sustainability of reforms entails the complex culture and lumbering mentality of the Greek public sector. According to the narratives new managerial practices such as training, education, set of job descriptions, applications of evaluation, reorganisation of public services should be established inside public organisations to help employees gradually change the way they think about work in the public sector.

This chapter also highlighted the significance of interrelationships between the key actors of the Greek NHS. Regrettably, research has shown that the quality of communication between doctors, managers and policymakers is strained. Not only do narratives reflect tensions among the three groups but they also indicate that relationships are fraught with problems; and that lack of collaboration may be expected even between doctors themselves. In that respect, it may be argued that, unless social conditions within public organizations change, the sustainability of reforms will be undermined. Surprisingly enough, the majority of doctors were shown to be willing to learn all about management and assume managerial responsibilities as long as they are given more time in which to do so. Their willingness flags their appreciation of managerial values and strikes a promising note that they may prove supportive of the reform and fiscal consolidation effort in the country’s healthcare organisations.

**Chapter 9: Discussion**

**Introduction**

The previous three chapters outlined the findings of the research. They explored the narratives collected from the key interest groups of the Greek NHS system: doctors, hospital managers and policymakers. The chapters revealed valuable and at times unusual insights from the Greek hospitals and offered a real view of the working conditions before and during the period of reforms. As a reminder, the integrated framework helped in addressing the aims and objectives of the thesis; and supported its analysis and discussion.

In this section, the three conceptual strands of the framework contribute to categorising the key discussion themes emerging from data collection. First, the NPM section depicts the embeddedness of the paradigm as practice and ideology as well as their interwoven nature in the Greek NHS and informs discussion on the impact of the crisis. It also generates early evaluations about the intrusion of the NPM and Hood’s seven dimensions in the country’s public healthcare. Those dimensions are: stress on discipline and parsimony in resource use; disaggregation of public organisations; competition in the public sector; private sector styles of management practice; hands-on managers; emphasis on output controls; and measurable standards of performance (Hood 1991; 1995). Next, Principal-Agent Theory, as observed in the case of the Greek NHS incorporates the interplay and manoeuvres of key stakeholders and unveils main findings about the idiosyncrasies of the healthcare sector and its workings. With its social ontology, Critical Realism illuminates the stratified organisational realities in the Greek NHS and provides a platform for the empirical exploration of the generative mechanisms and existing structures impeding or facilitating the implementation of reforms. The chapter also discusses the factor of power, whenever that is observed as a means of influence and control. The usefulness of the framework is outlined at the end of the chapter.

**New Public Management in the Greek NHS**

The literature review of the historic development of the Greek NHS and the integrated framework have shown little progress in terms of reforming and modernising the Greek public health sector in the past (Zampetakis and Moustakis 2007, Spanou 2008). Even though research indicates that the New Public Management approach had arrived as a reforming paradigm in Greece before (Abel-Smith et al.1994, Philippidou et al. 2004, Spanou 2008, Pollitt and Dan 2011) the efforts to improve the public service were put paid to (Mossialos et al. 2005, Economou and Giorno 2009, Sissouras 2012). However, this time, things seem to have been developing differently. The present research ascertains and evaluates those NPM practices and ideologies which have intruded into the societal system of Greece under the Troika’s directions.

*Stress on Discipline and Parsimony in Resource Use*

First, the issue of austerity measures is continuously raised throughout the interviews. In particular, many respondents asserted that the cost-cutting policies in health spending have gone beyond reasonable limits. That observation is echoed in expressions such as ‘pass the red line’, ‘go beyond the limits of rationalisation’, ‘a mistake in Greek history’, and ‘we operate on the borderline’. They all indicate the seriousness of the situation and the damage that such policies have caused in Greece (Stuckler and Basu, 2009).

Furthermore, salary cuts, which in some cases reached as much as 60%, public sector layoffs, and hire freezes hint at the neoliberal agenda of the IMF and the Troika: radical change is introduced with little regard for the people it impacts. The findings show that there has been a drop in employees’ morale, as was the case of health professionals in other countries who suffered the same consequences under the barrage of NPM reforms (Pollock 2005, Ostergren 2006). Additionally, many of the doctors interviewed voiced their concern over the shortage of administrative staff in hospitals due to lay-offs and hire freezes. It appears that doctors would prefer to examine more patients than to spend time with administrative tasks (Mannion et al., 2007), especially Greek doctors who are already under a heavy workload due to a rise in demand by patients and a decline in qualified personnel. Consequences of the austerity measures, on the population’s health include increased suicide rates, mental health problems, epidemics, and slow treatment of illnesses. The well-being of the Greek population has been adversely affected by dire economic conditions. No stronger evidence than that could corroborate the claim that NPM is a neoliberal doctrine. In sum, the thesis proves the implementation of NPM as a political project in the Greek NHS that serves mostly in spreading the gospel of the neoliberal agenda and ideology with all the antisocial policies those imply.

Therefore, the study refutes the argument of Pollitt (2007) who posits that NPM is not a neoliberal political doctrine simply because it is adopted by both right and left political regimes. Indeed, in line with Pollitt, history has shown that, in the UK. NPM has been used by both left and right governments, not, however, with the expected positive outcomes. Labourists adopted neoliberalism as part of Blair’s politics through the creation of very strong markets (Alvarez-Rosete and Mays, 2014) devaluating in that way public sector values. Similarly, when conservatives adapted neoliberal policies tension and animosity between managers and doctors within hospitals rose, and the quality of healthcare has been impaired (Pollock, 2005). A number of Greek governments had used managerial ideology and practices to fix the country’s healthcare in the past. Granted, the pace was smoother and far more incremental than it is today but the result was no overwhelming or noteworthy progress. This is the first time that a foreign power has forced upon a country so many debilitating managerial practices and ideology in such a short period of time. The present study records this historical juncture and demonstrates that, even though expenses and wastage have decreased as a result of austerity measures, there is no evidence that the quality of health has improved. On the contrary, several of the respondents denoted that health outcomes have exacerbated.

The mergers of hospitals and clinics provide another rich example of a major reform plan which suggests, in line with the WHO (2012), that there has been a push for efficiency savings in accordance with the NPM paradigm. In that context, most of the respondents are theoretically in favour of staff reallocation and resources, which is a crucial plan of action because of the shortages that the crisis has created. Apparently, that type of reform has been known to contribute to savings in health expenditure. The above coincides with the Thatcher and Reagan vision of using NPM as a means of tackling wastage and inefficiencies in the public sector (Osborne and McLaughling 2002, Lynn 2006). In practice, however, as far as the outcomes of mergers and closures are concerned, the accounts highlight those results’ crude adaptation due to inadequate strategic planning. The fact that relocation of staff did not occur according to the actual needs hospitals have, does give cause for concern. Indeed, many of the interviewees asserted that the lack of techno-economic studies has been blocking the successful implementation of many of the reforms.

Echoing Parker and Dent (1996), there is ample evidence in the data corroborating the fact that most of the reforms have focused on the fiscal adjustment of the health sector and not on the structural reorganisation of it *per se*. The above reflects the neoliberal ideology behind IMF reforms (Stigliz 2002, Plehwe 2009, Ruckert and Labonté 2012) which neglects local needs in favour of developing social welfare policies (Plehwe and Walpen, 2005) and fails to correspond to inefficiencies by means of structural changes. In other words, if the Troika was a surgeon, then, the impression would be that “Dr. Troika” is clueless as to why he is operating upon a patient. On the one hand, reduced public spending in Greece generated even more poverty and inequality than the economic crisis had. On the other, according to the narratives, human-related services such as health and social welfare were half-heartedly supported by the Troika by means of structural reforms. For example, no steps were taken to strengthen primary care or to stock hospitals with medicines and specialised personnel. In view of that, talking about reforms in public healthcare but being unable to provide even the most basic of routine treatments is impossible. It may then be safely assumed that the Troika and its NPM hobby horse have not been responding to the population’s needs and that there is no sign whatsoever of any customer sovereignty. The combined effects of the crisis and the austerity measures are expected to produce even more serious ramifications on the Greek population and the country’s NHS. And even though evidence from the analytical chapter suggests that NPM reforms should be applied selectively by taking into careful consideration each country’s dynamics (Larbi, 1999), that does not seem to have been the case with Greece. In sum, the reduction in public expenditures that the Troika has imposed creates more financial disparity in a country already weak and, in turn, stunts its economic development. It would have been more beneficial to focus all systematic efforts on boosting the country’s economic development by exploiting its dynamics and attracting foreign investments rather than apply brutal austerity measures.

Nevertheless, there is a pervasive belief among participants that NPM may offer integrated solutions that could help the Greek public sector to recuperate. They view it as a last resort. They believe in change, and they desperately want to fix the system and save their jobs. In broader terms, NPM can be seen as a coin with two sides. On the obverse, opportunities (mainly financial) that managerial reforms might bring shine brilliantly, but on the reverse, there is the dullness of the neoliberal ‘price’ that people have to pay. Further, it cannot be argued that reforms are less intense because Greece is a Southern European country as Sotiropoulos (2004) asserts. Nor can it be claimed that the Greek State now has the opportunity to do its own selective shopping of NPM tools as Pollitt et al. (2007a) maintain. Beyond any doubt, there is a high degree of NPM embeddedness in the Greek NHS. Given the fact that the overseer of reforms in Greece is the Troika, it is not surprising that the majority of citizens have become bitterly aware of the ramming-speed of neoliberal directions.

*Disaggregation of Public Organisations*

Even though the literature review has indicated that the Greek NHS is administratively separated into seven Health Peripheries, decision-making remains ministry-centred and managed by the government (Civil Service Union 1996, Argyriadis 1998, Makrydimitris 1999, 2003, Sotirakou and Zeppou 2006). The NPM review and practices have illustrated that the decentralisation and focus on autonomy and competition between regional hospitals has helped other countries such as the UK (Cooper et al., 2010) and Spain (Sunol, 2006) develop better provision of public health services.

In terms of the practices that could facilitate the decentralisation process in Greece, the literature has shown that the Health Map is an essential tool. It can offer the system valuable information by providing hard evidence of regional health needs which may then contribute to targeting successful allocation of resources. Essential or not, the Health Map measure though enacted by the Greek parliament, was never set in place properly. That failure generated a question for policymakers regarding the Health Map’s process of application and the reasons behind its delay. According to the study’s participants, the Health Map project began almost 15 years ago and has yet to be completed. Surprisingly, interviewees claim that, as it happened with many of the reforms up to now, it was political expediency and vested interests which delayed the map’s completion (Polyzos et al. 2008, Minogiannis 2012). Indeed, the present study’s integrated framework brought to light those hidden constraints which could burden reforms and exhaustively identified the vested interests of local politicians who prefer to work without evidence-based tools so as to protect their self-interests and have been delaying the Health Map project.

Another significant obstacle to decentralising the system is the Greek people’s culture and mentality. It is also manifested in Christensen and Lægreid (2007) who argue that the prevalence of cultural issues affects the sustainability of reforms. First, the study’s respondents outlined the issue of high demand by and congestion of patients in hospitals, especially in the urban areas. As there is no such thing as an organised primary care network, patients are accustomed to going to central hospitals, even for minor complaints. That is also associated with the fact that regional health centres are understaffed (most doctors prefer to work in urban areas) and lack many a specialty. Then, respondents denoted the lightweight role of the Regional Health Peripheries which have an adequate number of mainly administrative employees but the nature of their work remains bureaucratic in mentality. As declared by the study’s participants and at least until the end of the interview process, not much progress has been achieved by the Troika in the sector of strengthening primary and regional healthcare. And even though the first level of healthcare is the core of the Greek NHS, all respondents concur that it has not yet been effectively developed (Mossialos et al., 2005). A systemic change in the status of primary healthcare could decongest hospitals, which have now been thrown into the role of primary care health centres and contribute to valuable savings. It is the kind of reform that Greece has been in need of for decades. The thesis reveals that, all other factors aside, lack of financial and human resources has always been a deterrent to the achievement of that reform plan.

There have been efforts made by the Troika to decentralise decision-making within hospitals. For the first time, managers are delegated to regulate the financial status of the health organisations they administer. Such practices refer to the ideology of managerialism which emphasises the use of professional experts when trying to boost productivity in public organisations. Similarly, an improved and modern accounting system was established in hospitals as part of the managerial reforms contributed by the Troika towards generating better resource allocation and rationalisation within hospitals.

*Competition in the Public Sector*

Another main element of the integrated framework and of the NPM’s contribution is the use of market-type mechanisms to strengthen the competitiveness of public service. It is worth noting again that some of the proposed practices had already been implemented in the Greek NHS before the crisis. Cost-sharing policies, tickets to public hospitals (user charges), contracting out public services to the private sector (cleaning, security, catering), and selling public services to private companies are some of the managerial practices used by Greek public hospitals before the Troika’s arrival. Unfortunately, such initiatives did not have any visible effect on the Greek healthcare’s invigoration.

Officials sought in the first place to transform the Greek public sector into a market-oriented, managerial, liberalised institution. It is certain that some countries have made inroads using that transformational paradigm but the majority of states, especially those in developing countries, have had problems implementing the reforms because of institutional and capacity constraints (Mongkol, 2011). Greece is such a case. Admittedly, there could have been deeper structural reforms applied to facilitate the competitiveness of the Greek health sector. For instance, the development of primary healthcare and the staffing of regional health centres would have made an integrated network of health provision more attractive to investors: for instance, private insurance companies wishing to provide healthcare treatment to their policy holders could have contracted public hospitals at lower prices than those quoted by private companies.

Despite the fact that progress in establishing market-oriented reforms has been limited, Greek authorities do express some projections. Those are in the process of implementation and target the increase in the market dynamics of the Greek NHS. One of them regards medical tourism. Indeed, Greece’s popularity as a tourism destination, the empty regional hospitals waiting to be exploited, the mild Mediterranean climate, the unexploited natural resources (thermal springs, mountains, lakes, the sea) and the increasing unemployment trend among doctors offer an excellent opportunity for Greece to invest in medical tourism infrastructures and attract large numbers of international patients. Moreover, central and urban hospitals have been recently renovated and outfitted with state-of-the-art medical equipment; and public health services are more than affordable when compared to the cost entailed in private healthcare. Together, those factors all make up the ideal setting for market development of medical tourism. It is an investment that is also attractive to private insurance companies. The practice is already being applied in the Greek context (SKAI, 2011a) and is expected to prove quite profitable, should the country develop its medical tourism industry might internationally.

In terms of the market ideology that NPM brings with it, respondents expressed their fear that managerial implications, in combination with the stringent austerity measures, degrade public service and values. None of the interviewees accepted the shrinkage of the public character of health easily. They all believed that such a blend may bring about a complete takeover by the private sector where a private system of health would be established with patients paying to be treated. Paradoxically, they all acknowledged that managerialism may be the only means towards fixing several of the public sector’s inefficiencies. It may then be argued that the present study contributes to the discussion on the changing public sector in Greece during a period of financial austerity by drawing attention to the implemented radical changes and their outcomes. The analytical framework has contributed to the above by demonstrating that the interwoven nature of practices and ideology implemented in Greece at present pertain to the NPM paradigm. Be that as it may, the overall picture painted by respondents was that reform implementation has been proving quite an arduous process indeed.

*Use of Private-Sector Styles of Management*

The study’s empirical data has revealed that the implementation of electronic tools in Greek hospitals, a practice that was conspicuously absent before, has provided the fiscal consolidation needed to ensure operational continuity. It is worth reminding that hospitals consume the highest amount of the nation’s health expenditure. In that context, the thesis supports that the new management agenda has already contributed to saving much-needed financial resources and to implementing monitoring tools within hospitals.

The new and improved accounting methods were established in healthcare organisations through the use of an integrated information system with a view to surveying available resources and to inventorying and stocking them more efficiently. Study participants mentioned positive outcomes in terms of financial benefits, transparency of costs, and better management of hospital budgets. Some respondents went so far as to point out that provision of economic information in combination with clinical data would also enable to break down cost analysis per clinic and thus arrive at determining the exact cost of a hospitalised patient.

An integrated public health insurance fund was another implemented measure. It was a requirement of the 1983 principal Law of the NHS and even though it was reiterated by subsequent laws, the unification of the fund became possible only under the Troika’s supervision. Unsurprisingly, TSAY, the Medical Doctors’ fund, was strenuously opposed to that unification but, under the Troika’s neoliberal ideology, the fund’s demands were rejected. Interestingly enough, a doctor described TSAY’s absorption as a constitutional coup which showcased the victor in the power games between principals and agents.

Both the literature review and framework show that, when an organisation is subjected to reforms, its employees represent a crucial factor in the process (Philippidou et al., 2004). With regard to that feature, Greek participants suggested that a change to a managerial organisational culture could transform health professionals into more rational and responsible employees who could generate better service quality within hospitals. Moreover, it was encouraging to find out that Greek doctors would be willing to acquire managerial skills and be involved with administrative responsibilities if only they had more time available. The above accounts are salient to managerial ideology which appears to have become firmly ensconced into the collective brains of NHS interest groups and is expected to change the system’s structures accordingly. Nonetheless the predominant feeling over system normalisation and reform sustainability appears to be one of restraint due to the gravity of the economic situation and the past failures to bring reform about. In fact, going by the narratives, the entrenched cultural and mentality’s obstacles as well as the strict, cost-cutting measures as ushered by the Troika undermine the public service and the values it brings.

*Hands on Managers*

Another point outlined by respondents was the issue of shortages in staff and medical resources. In their view, the shortages are a major constraint obstructing the path of reforms towards success (Pollitt, 2010). Participants emphasised the need for ‘new blood’ inside the hospital system, in other words the need for new employees who would be better equipped in terms of know-how and competences and who would be determined to work differently than the parochial public bureaucrats. The sample’s middle-aged doctors in particular were quick to raise the alarm that no new doctors who could be trained and succeed them are available. Still, results have conveyed the impression that the emphasis was not always placed on having an adequate number of health professionals to staff hospitals but also on finding the people with the appropriate leadership skills who could steer an organisation and facilitate the development of its human and capital assets through the right tools and practices.

The role of the Greek hospital managers was one of the data’s findings. Even though, there have been managers at Greek hospitals for years on end, their role has never been upgraded and decisions about hospital operations continue to be ministry-centred. As all health public organisations are regulated by the Greek Government and none have any regulatory autonomy, hospitals managers are fairly defanged when it comes to wielding leverage for managerial action. Yet, the framework demonstrated not only the crucial role hospital managers play but also the fact that efficiency within an organisation may be achieved only if managers are free to manage and design their own strategies (Cleveland, 2000). There is ample evidence to show that, in previous decades, managerial manoeuvres in Greek hospitals were restricted by law and political patronage.

Nevertheless, findings also voiced the fact that managers have begun being held accountable to the Troika regarding the financial situation of their hospital. Further data reveal that all hospitals’ financial transactions are now transparent to the ministry and its foreign supervisors. As hospital managers explained, there are even sanctions in place for those who deviate and rewards for achievers. In terms of Greek public sector standards that is an all-time first. It is obvious that the Troika’s neoliberal ideology envisages the applicability of appraisal policies demonstrating the power the institution to leverage organizational culture.

Further, the findings have illustrated that, in the past, there was no one within a hospital with enough jurisdiction to steward the resources available. In their accounts, certain managers argued that they have started taking initiatives and being innovative so as to improve the work inside hospitals: another clear sign of the managerial ideology’s sovereignty over the Greek public medical system. In that regard and through the lens of the integrated framework, the thesis follows the course of changes at the workplace inside health organisations and highlights the importance of delegating more responsibilities to managers and autonomy to health organisations so as to decentralise decision-making and promote innovation and better monitoring of health resources (Niakas 1993, Radcliffe and Dent 2005). It is further argued that, as Philippidou et al. (2004) advocate, since leadership plays an important role in administering the public sector and since Greek politicians have proved ineffective leaders, as voiced by both literature and data, it might as well be the managers who undertake the task of administration. After all, their credentials point at their eligibility. Perhaps, assigning more responsibility to hospital manager may be one of the Troika’s new structural changes which would decentralise decision-making, removing it from under the Ministry of Health’s omnipresent decisions.

*Emphasis on Output Controls*

Another important dimension that emerged from the integrated framework and the NPM’s conceptual contribution is the control of public organisations through output measures (Hood, 1995). Monitoring mechanisms have been observed to contribute to allocating public resources efficiently and calculate their productivity after their use. In that sense, both literature and interviewee accounts have indicated that the Greek NHS was functioning without using evidence-based information, one of the main reasons behind dysfunctionalities and irrational spending (Economou and Giorno 2009, Minogiannis 2012).

Interestingly, participants indicated they are aware of progress achieved in terms of establishing productive data-collection tools so as to integrate into the Greek NHS an evidence-based working culture. The e-prescription system and the DRGS implemented at the majority of hospitals are evidence of that. According to accounts, those applications have already led to significant reductions in the astronomical sums involved in pharmaceutical expenditure, waste that was attributed to the doctors’ irresponsible behaviour of prescribing unnecessary medications and examinations. The blame was not entirely misplaced since a great deal of medical professionals had developed to their benefit relationships with pharmaceutical companies and private diagnostic laboratories, hence their unethical behaviour. As Ackroyd et al. (2007) and Ward (2011) demonstrate and the thesis data reveals, the availability and presence of evidence-based information provided by the newly established managerial tools restricted the power in decision-making doctors had had up to that point. That coincides with the observations by Papanikos (2013) which suggest that the memoranda introduced by the Troika challenged the interests of the privileged classes in Greece. In that sense, it is not only the influence of NPM as a persistent managerial ideology that is demonstrated, but also the dominance of its neoliberal ideology which, by intruding into professional autonomy succeeds in changing the working culture in Greece. Such realisations on the Greek NHS were not possible before the corroborative evidence provided by the recorded interviews data. Further, the research makes it crucially clear that the mesh of NPM practices and ideology jointly introduced by the Troika and the Greek government have contributed to restricting the corruption (Lambrelli and O’Donnel, 2011) which had been afflicting the Greek healthcare system for decades and was one of the key impediments in its development (Liaropoulos et al., 2012).

In the meantime, there are more managerial tools which are now into play and have been placed into systematic operation. Those are ESY.Net and the Price Observatory. Both are electronic platforms offering unique opportunities for the advancement of evidence-based medicine. On the one hand, ESY.Net displays directly online all financial transactions taking place within hospitals. On the other, the Price Observatory features an online database with fixed registered prices of the medical equipment and consumables from which each hospital purchases its essential supplies. There is also ample evidence showing that Esy.net and the Price Observatory contributed to the transparency of the hospitals’ financial information and provisions. As a result, they have endowed the system with more accountability (Simonet, 2008), a condition which had not existed before those systems’ implementation. It is indisputable that the above are vested with NPM market ideology whose aims are to strengthen the competitive edge of the Greek NHS by conserving and rationalising its resources.

With regard to the implementation process of the reported managerial tools, NHS players offered valuable feedback. They suggested that, with implementation of reforms having taken place in far too short a period of time, deficiencies in some of the installed managerial applications were bound to ensue. As to the e-prescription system, doctors complained that it now takes considerably more time to prescribe when using a PC than when writing by hand. It seems that the transition from paper-based to electronic recordkeeping systems has been a daunting challenge for most doctors. According to their accounts, electronic processing slows down even further and delays them when the system all too often becomes overloaded by the many users who prescribe concurrently. The evidence above coincides with the literature of NPM which stresses that the new managerial procedures may potentially create more bureaucracy than before (Landrain, 2004). Participants’ observations also indicate that this new way of drug prescriptions and recordkeeping cries out for improvement as it records e-prescriptions but does not have the capacity to reveal offender, i.e., those who have been overprescribing. In other words, it acts only as a measure of intimidation and not as a measure of strict and impartial monitoring. Nevertheless, empirical material pleasantly surprises by suggesting that pharmaceutical expenditure has declined. As echoed by some of the participating key players, it is to be hoped that reforms will advance as time goes by.

DRGS prices also provided grounds for criticism. Respondents complained that the determined prices do not correspond to the Greek reality of today. According to their statements, disease protocols and their prices were borrowed from foreign countries and were not adjusted to the Greek system, as there seemed to be no time for the necessary modifications. What is more, the transformation of the Greek public sector is still at its toddler stage and reforms have not been completely adapted to the system as yet. That seems to confirm the literature on NPM which maintains that, as time goes by, reforms become more normalised (Dunleavy et al. 2006, Turner, 2008) and are accepted by health professionals without undue resistance (Forbes et al., 2004).

*Measurable Standards of Performance*

Almost all respondents, especially doctors, voiced the need for an objective evaluation system within the Greek NHS. That contradicts the existing literature of NPM which has indicated that implementation of performance measurement systems caused discord and met with the strong resistance of the health workforce (Mannion et al., 2007) and of Norway (Ostergren, 2006). In the interviews the majority of Greek health professionals expressed their wish to be more appreciated, something that has never happened in the Greek NHS before (Karamanoli, 2011) due to clientelism and authorities’ inertia. It also reflects the staff’s strong commitment to health service. Surprisingly, some interviewees came forth and made their own proposals by suggesting an evaluation by independent foreign experts and international organisations. From those proposals it is abundantly clear that there is trust lost between doctors and the Greek authorities. It is also evidence of the level of the respondents’ dissatisfaction with the system and explains why managerial reforms, the ideology of rationalisation, and emphatic efficiency are greatly appreciated by most of the participants.

Further, the institution of hospital benchmarking was mentioned by respondents as having been established during the Troika’s tenure. It is the first time that the Greek NHS is witnessing the practice of rewarding the best hospitals and sanctioning financially underachieving hospitals by subjecting them to audits by foreign officials. In line with the reward and sanction policies for Greek managers, those new appraisal practices which explicitly spell strict controls and surveillance represent strong proof of the Troika’s neoliberal ideology. A comparative review of literature has demonstrated that other countries such as the UK (Klein 2006, Lapsley 2008, Simonet 2008) and France (Minvielle et al., 2008) had taken similar measures in the past so as to rectify their hospital sector in compliance with the NPM archetype. It should, therefore, be admitted that measures, such as the ones discussed above, have certainly generated cost efficiency in Greece as they have in other countries but do not suffice in streamlining the system.

In a similar context, many were those among interviewees who pointed at the need for heightened performance management and sound political leadership. According to their accounts, on the one hand that is necessary in order to avoid the unethical practices so common in the Greek NHS such as political patronage, grafts, and beneficial relationships. On the other, high-calibre management would encourage innovation and collaboration between health professionals. It is not entirely outside the realm of possibility that the respondents’ statements demonstrate their wish to see legitimacy restored within their hospital environment. That coincides with other some of the study’s findings which voice the willingness of Greek NHS players to implement managerial tools so as to save their jobs from the impending collapse of the Greek healthcare system. Overall, the thesis has ascertained that the Greek context is quite different and more volatile than other international contexts where NPM has been introduced. With the culprits being rampant corruption and the complete and utter disarray of government agencies, it is obvious that only urgent and incisive structural reforms could reverse the situation.

**Principals and Agents in the Greek NHS**

The thesis draws attention to the different power and motives between and tactics of the medical system’s principals and agents. Both relationships and manoeuvring have proved to be crucial when dealing with reforming the public sector. They contribute to understanding the major issues besetting Greek hospitals and indicate how the key actors have been engaging with the newly-established practices and ideology. In particular, the theory of the PAT upholds that, within organisations, conflict is usually rife between the principals and those (agents) who execute their orders. The conflict is usually due to a number of different ulterior motives and goals each side has and is also a result of asymmetrical power. That imbalance depicts the effort of the agents to protect their professional autonomy by withholding information on important aspects of their job.

PAT enhances the study’s findings by delineating the manoeuvres, power games, and relationships between the foreign principal (Troika), the domestic principals (policymakers and hospital managers), and the Greek medical system’s agents (doctors). At the outset, almost all interviewees were unanimous in denouncing the main causes that brought the Greek NHS to its knees. The findings show a convergence of the respondents’ views on the issue of the main inefficiencies of the NHS. Still, recurring throughout the data is the difference in the role and perspectives of the key NHS actors.

Day and Klein (1997), Exworthy and Halford (1998), and Lapsley (2009) have argued that many were the conflicts that arose in the UK between doctors and managers and doctors and policymakers while the British NHS was changing under the not-so-gentle prodding of the NPM paradigm. The thesis’s data reveals that the conflicts described by the authors are also present in Greek hospitals but they owe their existence to a different set of reasons. It is not the managers’ takeover that irritates Greek doctors as was the case with their UK counterparts. It is more a matter of the complete inertia and clientelism penchant of Greek officials. In their interviews, doctors blamed both policymakers and managers for not fostering close relationships with medical staff and hospitals. As a result the work of those two groups of key players has been perceived by doctors as unsuccessful.

A crucial remark made by the doctors was that policymakers cared only about their political fame and the political party they adhere to rather than working towards an effective NHS. In Greece, politicians behave in that manner because they have the power to do so without a single vestige of accountability. That relates to Lukes’s (2005) two-dimensional view of power which maintains that politicians have the capacity to enact laws and let certain issues of the political agenda fall through the cracks. It is the same type of exclusion the researcher heard in the sharp indictment by the responding doctors and it is probably one of the rare occasions when those professionals were asked about their problems and their opinions. The impotence to establish the appropriate legislative and regulatory regimes is mainly attributed to the never-ending changes between the governments but also to political reluctance. In particular, policymakers have been subject to criticism because of their short-term policies. It has been argued that they are attached to a Health Minister’s team so they give up their posts whenever the Minister’s duties are terminated. It is worth recalling that the average length of a Health Minister’s tenure is only 18 months (OECD, 2009a).

Further, there is abundant research evidence which indicates that there is no such thing as institutional memory in the Greek NHS. That is clearly reminiscent of the arguments by Polyzos et al. (2008) who maintain that politicians are urgently seeking to leave their ‘legal footprint’ and gain political fame but they abandon their plans all too soon. There are two reasons which may serve in clarifying the above. One of them is that politicians retreat in order to mitigate reactions and, thereby, avoid the political cost. The other is that politicians and policymakers do not possess the managerial skills, such as leadership, that would enable them to guide organisations and employees alike towards change. Their terms are so brief that their plans are not given sufficient time for implementation. Coupled with the lack of political technocracy and the absence of the determination to see long-lasting reforms through that is how the quality of the health sector in Greece is undermined (Mouzelis et al. 2005, Sissouras 2012). It is worth pointing out that a policymaker revealed during his account that the Troika is considering extending the tenure of some of the key officials in order to ensure consistency and continuation of reforms.

Before the Troika’s presence in Greece, managers, in their role of in-hospital principals, were appointed to posts in health organisations. Their task was to communicate the reforms to the agents (doctors) and ensure the hospital’s normal and efficient operation. However, according to the doctors’ narratives, the managers’ contribution to the improvement of the hospitals’ quality was lukewarm at best. The reason for the managers’ tepid involvement is due mainly to the fact that they are political appointees who lack either the necessary competence or the qualifications or both for such positions of responsibility. And although many have been the studies where hope springs eternal that practice will change (Theodorou 2002, Davaki and Mossialos 2005, Kostagiolas et al. 2008, Gogos 2011), the thesis has found that it well and alive and firmly in place. The interviews have indicated that, with a few exceptions, political appointees working as directors within hospitals still abound and are still as stripped of competences as ever. Oddly enough, the thesis found that they started having essential responsibilities only after the Troika’s interference, a sure sign of the foreign officials’ formidable power. As to managers themselves their accounts talk of their being under surveillance and, for the first time, controlled through a system of reward and punishment subject to their performance. That is another measure that brings to mind NPM practices and ideology which want managers to be free to manage organisations but subject them to performance appraisals.

Doctors were not left out from the prevailing neoliberal climate. According to what managers and policymakers reported, the information asymmetry doctors had been enjoying for so long was restricted: the new managerial tools imposed on hospitals provided the evidence-based information that had been missing thus far and made the doctors’ decision-making more visible. The e-prescription system was such a measure in that it limited the medical professionals’ unbridled prescription practices. Moreover, with the DRGS stabilising the cost incurred by each medical treatment, doctors were stripped of their spurious entitlement to charge arbitrary prices which stemmed from the lucrative ‘silent’ agreements they had with private diagnostic laboratories and pharmaceutical companies (Mossialos et al. 2005). All of the above are evidence of the three-dimensional view of the Troika’s power to change the system by incorporating a new form of organizational culture and ideology. Seen from that angle, it appears that the Troika has proved its ability to change the mentality of people going as far as to defy their vested interests and manipulate them in more managerial and neoliberal way of working by restricting their professional autonomy.

One intriguing fact to which the empirical material appears to be pointing is that there is no culture of professional synergy even between Greek doctors. Here, the argument is that the relationships between medical professionals survive in a complex system perennially fraught with corruption and bribery and devoid of either incentives or appraisal systems. It may then be anticipated that the unethical nature of the practices above impacts negatively on the doctors’ work. In corroboration of the analytical framework, Granovetter (1992) argues that there is an interrelationship between the social world and its economic system: the former affects the latter and vice versa. In view of the country’s critical conditions which seem to have been declining it may be surmised that effective working collaborations that could spur productivity on are difficult to form. For instance, findings reveal that there are doctors in the NHS who are not too enthusiastic about the creation of a primary healthcare network. They are the ones who do not wish to lose any clientele, a very real risk, were their patients to be first examined by those doctors’ colleagues or the General Practitioners, the ‘gate keepers’ in primary care. They are joined by a powerful medical elite organised under trade unions who are bitter opponents of any plans for such an institution. At the opposite bank, policymakers, managers, and a small portion of doctors favour the notion of primary care.

Another issue revolves round the acceptance of the reforms as Greek doctors are expected to oppose to changes due to their professional status and as a matter of securing their work autonomy in the NHS. In the UK, for example, health professionals reacted strongly in order to protect their own professional values and integrity against managerialism (Gabe et al. 1991, Parker and Dent 1996, Davies 2009). However, the Greek findings demonstrate that have been no such vehement reactions by Greek health professionals against NPM. Within their narratives, their discontent with the corruption, inefficiencies, and the repercussions of the crisis is such that they would prefer to see the new reforms resurrecting Greek healthcare. At first glance, most of the respondents do not seem to view the change as a private sector takeover, as indicated by the conceptualisation of NPM (Davies, 2009), but they are certainly concerned that it may take place in the foreseeable future. In this particular case, Greek doctors appeared frustrated and, unlike doctors in the UK (Lapsley 1994, Crouch 2003, Davies 2009), they talked at the outset of welcoming many aspects of NPM reforms. In view of their statements, it may be assumed that the new implemented structures are a rather ‘good fit’, binding actors to their working routine.

All of the issues discussed above call into question the efficiency in communication and relationships between the key players of the Greek NHS. Through the prism of the integrated framework and of the principal-agent theory, the present study probes into and identifies insightful views on the three different perspectives, roles, and power of the most important people in the Greek healthcare system. For instance, in line with the PAT, the study verifies that each one of the three interest groups thinks and acts rationally and according to its self-interests. Policymakers are more involved with politics and forming policies and are less engaged with the real situation inside hospitals and how implementation of their policies have been affecting that situation. In turn, managers seem to be more attached to the neoliberal ideology of NPM and their duty to promote it inside healthcare organisations and change the working culture. However, their manoeuvring is confined by political patronage and the ministry. It is not the same with doctors who have been observed as attached to another ideology, that of professionalism, and are still clinging to the bureaucratic and inefficient NHS.

What unites them all, however, is a sense that they all welcome NPM and the Troika as the rescue boat that will take them away from the storm that burst over Greece’s medical system. This is a surprise because in other countries’ contexts this did not appear to be the case. Without a doubt, the reforms’ long-term sustainability will greatly depend on the ability of the key actors to harmonise not only with the reforms but also with one another.

**Critical Realism in the Greek NHS**

Critical Realism contributed to interpreting the reality in the Greek NHS. It led to identifying and explaining the underlying mechanisms that had influenced the institutions in the past and continues influencing the form of the medical system’s structures. A broader analysis of such mechanisms is therefore entailed in locating networks, connections, and relationships involving agents and structures and how those are linked to furthering the objectives and sustainability of reforms in the Greek NHS. Out of the many hidden realities and mechanisms brought to light from primary and secondary data analysis, only the most distinct ones will be discussed.

One such mechanism is the permanent nature of public sector employment. The study has found that it has prevented the system from functioning properly as many public servants lack the adaptability, flexibility, and skills to adjust to change. The Troika’s reforms included attempts to reduce the phenomenon by reductions in force or staff relocation. However, those attempts may be regarded as half-hearted at best, since they were implemented post-haste and were not supported by preliminary, evidence-based studies. Worse, their impact on public employees was nothing short of fear and outrage. Another mechanism involves the long delay by the European authorities (European Investment Fund) to complete procurement competitions. Under the present circumstances, it may take as long as seven years for a competition to conclude. Consequently, hospitals are desperate for vital supplies, with medical equipment mentioned in most cases as an example. In the respondents’ opinion, even the existing medical machines are, in their most part, in dire need of repair or should be replaced by equipment that is more technologically advanced. Needless to say, if hospitals were to begin experiencing shortages in ‘heavy’ medical equipment on top of everything else, it would be tantamount to a disaster.

One important need that the thesis has identified is the need for a standardised evaluation system of health services. Such an oversight absence may explain not only the absence of records on defective medical apparatuses but other malfunctions as well such as the long waiting lists and shortage of specialised staff. Hopefully, the situation will improve over time by means of the managerial tools which can now provide evidence-based information.

Additionally, the thesis brings forth the dynamic, interwoven nature of the relationship between agents and structures. In that context, it discusses historical influences as a determinant of the agents’ structure. Such influences seem to have played and still play a crucial role in shaping the key players’ norms, mentality, and working culture (Ongaro 2008; 2009). Echoing Dent (2003a), clientelistic relationships and corruption in the Greek public sector are said to be rooted in the interplay and influences during Ottoman rule. Empirical data indicate the magnitude of the phenomenon by arguing that those practices are so ingrained into Greek healthcare that it will take many years, generations even, before they abate. That is due to the strong interdependence of agency and structure emanating from the contribution of Critical Realism. For instance, not only is clientelism created by the Greek stakeholders but it also determines them. That is clear in the accounts by hospital managers who argue without fear that they acquired their posts thanks to their connections with political parties. In other words, clientelism is not the exception, it is the rule. However, an optimistic note is struck by some exceptions among NHS stakeholders who are ideologically opposed to unethical practices such as bribery and clientelism.

The structure-agency theory of Critical Realism helped the researcher evaluate how the participants of the study interact with NPM reforms and ideology. In brief, the thesis has found that they appreciate the managerial progress that Troika brought, but reject the neoliberal ideological transformation that accompanies it. It also seems that the majority of Greek health professionals believe that the hurried pace of many of the reforms may be behind the deficiencies in implementation some of those changes have had. Respondents also voiced the need for education and training sessions on the new tools and appliances implemented so as to avoid resistance, errors, and delays. And even though neither education nor training appeared to have been included in the NPM toolkit, it stands to reason that they should have been a staple provision. How could reforms be incorporated into a system and form new structures if agents are not aware of their use and benefits?

What is more, adaptability and development of reforms also depend on the level of democracy and the opportunities given agents to come up with new improvements (Putnam, 1994). Regrettably, that is not the case with Greece. In its defence, the country experienced the strife resulting from a number of wars including a civil one, and later came under the inexorable dominance of its own political parties. Worse, at present, the Troika seems to be Greece’s new foreign ruler. Under those circumstances, initiatives at the local level are mostly restricted or under close surveillance. It is a situation sharply juxtaposed to Putnam’s contribution (1994) which outlines the importance of freedom of expression and its crucial role in a country’s development. With that in mind, the study illustrates that the implementation of NPM ideology and practices has taken different trajectories between countries because of the different contextual backgrounds.

**Usefulness of the Framework**

The effectiveness of the framework is corroborated by its proven ability to address the main aim and objectives of the thesis. Overall, it showed that the Troika’s interventions have helped the NPM paradigm to become firmly embedded in the Greek NHS. The framework’s three concepts brought together all the necessary elements, namely, reforms, human agents, and organisational mechanisms and structures. Subsequently, it contributed to understanding the neoliberal reforms and their development in the Greek NHS during the period of financial crisis. Linking between concepts helped reveal findings that would have not been detected otherwise. For instance, the structures binding actors to organisations arose from linking Critical Realism to the Principal-Agent Theory. Another example is the evaluation of reforms which ensued from the involvement of the principals and agents with NPM practices and ideology.

The framework served other functions as well. For one thing, it acted as an aid to the thesis’s research. First, it served as a tool of grouping the literature by setting a narrower context of the most important parts of the theory. Given the multidimensional and complex nature of organisations, its three concepts contributed to understanding and setting the general context. In doing so, it allowed the researcher to explore the Greek and foreign medical systems and look for reforming attempts, mechanisms, and structures that could potentially affect the progress of changes; and for the interplay between organisations and human agency. It thus built a coherent tool that was tested so as to compare and explore the evolution of the newly-established remedies. Having developed a multi-layered basis for interpretation of the rectifications in the public healthcare context, the framework contributed to identifying research gaps. It then generated questions which, through the interpreted primary data, could fill the gaps and build new knowledge. In other words, it served as a tool towards selecting the methods and sample most suitable for the study. Last, by means of its thematic analysis, it assisted in the interpretation of findings, steered the discussion, and empowered the investigator to speculate with some precision on which conditions enhance or burden the reforms’ successful applicability and sustainability in the Greek context. The following chapter ushers the thesis into its final conclusions by summarising its practical and theoretical contributions, its main impacts, and the areas of future research.

**Chapter 10: Conclusion**

**Introduction**

The tidal wave of the financial crisis that washed over Greece left the country’s health sector injured, vulnerable, and exposed, emphasising the need for public sector restructuring. This study is the first empirical research to address the influence of neoliberalism in the context of the radical economic reforms in the Greek NHS as introduced by the Troika after its arrival in Greece. An original theoretical framework based on New Public Management and supported by Principal-Agent Theory and Critical Realism acted as the study’s analytical device in investigating the new developments in Greek state hospitals. In acknowledgement of the above, the thesis maintains that, to a certain degree the NPM paradigm has contributed to altering the state hospitals’ traditional bureaucratic working ways which would have been impossible to do before the Troika’s intervention.

**Summary of Empirical and Theoretical Contributions**

The present study goes on to delineate the sharp contrast between the pre-Troika and inter-Troika realities in Greek NHS hospitals. The post-Troika position is not yet available. The tripartite committee is still in the country exerting its ever-present, not-so-benign influence while Greece is reeling from the political turmoil caused by a possible change in the political scenario as imposed by the newly elected left-wing government.

Initially, research draws attention to the historical development of the Greek NHS and the Pre-Troika conditions by analysing the policy making process through the literature review. In that context, a crucial gap between policy requirements and their actualisation is revealed. Similarly, the study identifies all the main causes behind the constraints stifling the required reforms: a legislative tug-of-war between Greece’s two, main political parties and the Health Ministers adhering to them; a lack of political will; economic factors and exigencies; resistance from hospital workers and their trade unions; poor planning; shortage of resources; lack of evidence-based information; and absence of managerial expertise. In that way, the thesis provides ample evidence that, as of the inception, of the Greek NHS, public health became a political football tossed between Greece’s political parties which wanted to score goals against each other so as to gain political prominence even if it were at the expense of Greek citizens and against the common interest.

Most empirical insights emanated from the framework’s contribution. First, the reforming insights were drawn from the theoretical contribution of New Public Management. By comparing related reforming paradigms and their outcomes from other countries the researcher was able to demonstrate that the Greek restructuring path bears the clear stamp of NPM and does not necessarily imply another archetypal Greek public sector reforming attempt that will be dashed. Nevertheless, under the guidance of the Troika, that path evolved differently than other countries: strewn with impossibly strict and excruciatingly painful measures, its focus has been concentrated mostlty on fiscal surveillance.

The study then draws attention to the radical changes that have taken place during the Troika’s tenure in Greece and takes an empirical snapshot of their impact such as the opportunities and threats that the introduction of the Troika’s NPM agenda has had. In that sense NPM may be likened to a coin. On the obverse, the coin depicts the positive impact of NPM managerial tools. For instance, the introduction and growth of electronic and digital applications in hospitals, together with the provision of evidence-based information have promoted efficacy of their operations. In turn, that gave rise to business opportunities for some such as contracts with private insurance companies and medical tourism investments. What is more, NPM monitoring tools have valiantly fought and won over medical subjectivity by bestowing transparency on the activities of health professionals making the latter far more accountable than ever before.

However, the NPM’s reverse side shows the negative ramifications of its tools and ideology. Study interviewees expressed their resentment with vicissitudes such as fiscal austerity measures, salary and health budgetary cuts, and more. Further, in confirmation of the criticism levelled against NPM, participants also claimed that those measures have focused only on budgetary management neglecting the need for long-term systemic investments. Their reactions were to be expected since it has been argued that Greece is a welfare state tenaciously clinging to legalism and formalism. The literature on NPM justifies the respondents’ discontent by arguing that the neoliberal ideology and tools international institutions such as the IMF promote in developing countries usually fail to meet social needs. Be that as it may, it is no secret that, in order to enhance quality and reinforce efficiency, the Greek public administration still stands in need of substantial structural improvements.

Nevertheless, no clear, overall picture can be shaped as yet. It is still early days and, as the thesis indicates, reforms in the Greek NHS are in a transitory phase. Expanding on that, the study also demonstrates that the established instruments are not fully operational and that reforms are far from being complete. How reforms will evolve in future hinges on the extent to which NHS professionals will be able to disengage themselves from the old, deeply-rooted, inefficient mentalities and mechanisms, denoting in that way that even the most abrupt and drastic changes may stumble on the omnipotence of traditional and habitual ill practices.

One of the present study’s significant contributions is the insights into the different types of key NHS stakeholders: doctors, hospital managers, and policymakers. Empirical studies into the collaboration between and among instrumental Greek NHS professionals are rare. The Principal-Agent Theory amply illuminated the tactics and games of power between and among those three types of professionals and the fashion in which they have been acting, interacting, and reacting vis à vis the reforms in the health sector. Probing into those issues, the thesis indicated that collaboration between those groups is characterised by distance and alienation.

Each group minds its own business and, as upheld by PAT, the incentives of each group vary or may be altogether different from the others’. Policymakers seem to care more about the political party they belong to and how to build effective public relations rather than lend an ear to complaints and improve problematic issues. Managers have limited authority. Their posts may entitle them to exerting power but managers themselves are not given licence to manage hospitals. Their strategic manoeuvres are restricted and involve only application of the Troika’s and the Greek government’s policies inside the hospital environment.

Even doctors seemed unable to get along with their own colleagues as they seem to lack either empowerment or integrity. That indication is in contrast with the case of British doctors who reacted fiercely to NPM reforms through their spokesperson, their proactive and powerful medical association which carried their voices to the appropriate ears. Greek doctors have evolved in a different way. Before the Troika, they had the power to resist reforms due to their professional dominance and stalwart lobbies. After the Troika, their attitudes have fundamentally changed. The very complex context of Greece has frustrated health professionals to such a degree that the majority welcomes the systemic changes and appreciates the acquisition of managerial knowledge and responsibilities. The present study pivotally shows that the system in Greece is so riddled with corruption, inactivity, and inefficiency –traits that worsened under the impact of the crisis – that its main actors, aware by now that the system is in desperate need of reform, are eager to change in order to see the whole situation improve. Their eagerness to do so is the reason why some of the respondents were positive towards the present study to the point of recommending that it be submitted to the Minister of Health. Nevertheless, the study still cautions that not only should a climate of trust be built between the NHS interest groups but also a common belief that the social good comes before self-interest.

The power held by the Troika’s foreign officials and the neoliberal spirit blowing over Greece at present were factors which were singled out by the thesis through a review of Lukes’s theory. It was shown that politicians and parties have lost much of their power to decision-making which was mainly characterised by the first and second dimensions of Lukes’s Theory of Power namely, to vote laws and leave on purpose important issues off the political agenda (i.e. to fight corruption). They are now forced, to meet and honour the demands made by the Troika which is standing wary behind the reins. The triumvirate’s firm hold is manifested in the third dimensional view of power through which it is revealed that the Troika has managed to bring change to the way people think and work. In fact, the thesis has captured some vivid insights indicating that the Greek people have started thinking more rationally.

The theoretical underlay of Critical Realism was also instrumental in uncovering the hidden mechanisms, structures, experiences and outcomes at the workplace in hospital. It thus led to interpreting how organisational realities form. Subsequently, it exposed inefficiencies of yore which are still haunting the Greek NHS and paved the way for the researcher to not only reveal the system’s flaws but also evaluate the applicability and sustainability of reforms. Further, the study identified history, culture, and mentality as having impacted and continuing to nurture the phenomena of bureaucracy, nepotism, and corruption, hindering reforms from taking roots. It additionally showed that clientelism and bribery are rampant in hospitals. They affect work by perpetuating corrupt practices such as the appointment of incompetent but well-connected personnel to vital public posts; and encourage uncontrollable spending of resources through pointless prescriptions and examinations. Other ills plaguing the Greek NHS and hampering the progress of human resources towards efficiency are the permanent nature of public sector employment, the lack of incentives or sanctions, and the nominal, lightweight, ineffectual role of managers.

This study’s theoretical contribution is an original framework and analytical device to identify and delineate ameliorations in Greek public hospitals through the intervention and under the strong pressure of the Troika. Reforms, human actors, and mechanisms: those are the three ideas which, intermeshed, form the contextual scheme. The framework’s nucleus consists of the NPM paradigm as that has been applied to other healthcare systems round the world in its role as a reforming model. Thus, the thesis has strongly argued that the PAT can explain both the adoption and implementation of NPM reforms by drawing attention to the people’s opportunistic behaviour. What a critical realist approach does offer is a framework for a better explanation and analysis of the situation inside hospitals, namely, a clearer analysis of the real problems within such organisations – including the Principal-Agent problem – and a guiding imperative for discovering the underlying mechanisms through studying these relationships and evaluating how organisational realities form before, after and during reforms. Once the framework’s settings were in place, the thesis was in a position to uphold that application and understanding of NPM in a country is advanced by integrating the Principal-Agent Theory and Critical Realism. It should be noted, however, that the study does not intend to develop a blueprint but, rather, build a comprehensive approach better able to deal with some of the intractable problems that have been shadowing the Greek NHS for ages.

The novel framework proved both quite effective and useful not only in meeting the aim and objectives of the thesis but also in guiding the study’s methodology. First, the core concept of NPM provided the existing literature and the basis for contextualising the Greek reforms in terms of ideology and practices. The core dimensions that were showcased steered the researcher towards designing questions corresponding to each dimension individually and examine the level of NPM applicability in Greece. Next, the Principal-Agent Theory through illuminating the interrelationships of key NHS players contributed to identifying the core sample of the thesis and in particular the groups mostly involved in shaping the NHS, i.e., policymakers, doctors, and hospital managers; and generated more questions to interview schedule which would lead to identifying the roles and engagement of those groups’ members in the reforming process. Similarly, Critical Realism, through its structured ontology, showcased the methods that would help reveal the historical background of the Greek medical system complete with its existing structures and politics of change. More importantly, it went on to explore through interviews the real-life experiences of NHS players. The framework also steered the empirical work, assisted in the interpretation of findings through key themes which, once explored, helped the researcher organise findings and steer discussion.

In sum, theoretical contribution of the thesis is that it linked all three models together, turning them into a substantial analytical tool which, applied to the Greek context, helped the researcher grasp the influence of NPM on organisations and their human resources. Still, the thesis argues that, despite the fact that NPM reforming paradigm enables comparative studies, it is necessary to turn to more theoretical strands in order to try and probe into the research context’s greyer areas when it comes to an issue as complex as public sector reforms.

**Practical Impacts of the Study**

The present study is harnessed to a number of practical implications. For one thing, it enriches the comparative literature of the NPM paradigm on the Greek case, thus contributing to the managerial, sociological, and political academic disciplines. The Greek case also lends its data to PAT and CR the study’s two, additional – and indispensable –conceptual contributors. The triad is a powerful tool for scholars to use as a conceptual base for interpreting, making sense of and understanding organisational realities. Second, it is instrumental in the discussion on the intrusion of the IMF’s neoliberal spirit in Greece, a traditionally bureaucratic European state. More specifically, it proves that there are differences in how public sector reforms evolved in each country examined. It goes to show that, even though NPM has been touted as a one-size-fits-all model offering universal answers and solutions for public sector reforms, there are other extenuating factors which may affect successful application of reforms implemented under the NPM prism.

Understanding the nature of the crisis in the Greek healthcare sector is no mean feat. In view of that, one of the present study’s values is that it offers well-researched glimpses into the issue, thus contributing to both the international appeal of and the criticism levelled against IMF policies as applied in countries in dire economic straits. In doing so, the study contributes to the debates and projections on the IMF’s future plans. More significantly, it comes with that kind of empirical evidence that provides food for thought, cautioning that IMF policies must be better calibrated to fit each country’s unique, political, cultural and economic profile. Last, it adds the NPM paradigm to the Greek literature, thus bridging the gaps, as outlined throughout the course of the thesis.

The present study has successfully identified a number of hidden realities usually found in such vulnerable and emotionally charged workplaces that hamper the proper provision of health service and the growth of reforms in Greece. In view of that, it is to be hoped that the study would be of some help to Greek officials in mapping, monitoring, and resolving serious and long-standing problems even if some of them have yet to be identified. Moreover, it could act as a guide towards effective funding and proper coordination of health services; and as evidence taken into account by policymakers wishing to ensure the success of health and social welfare policies under implementation. According to the study’s findings, one improvement would be building a strong primary care network enriched with health promotion and disease prevention policies. Such a viable option may potentially attract private investors, such as insurance companies, who are always on the lookout for low-cost healthcare providers. In turn, drawing private investment to Greece’s healthcare sector may help the medical tourism industry in Greece flourish.

To reach the study’s goals the researcher analysed Greek medical doctors as a professional group. It also probed into the difficulties doctors have been encountering because of the crisis. With those tasks accomplished, the research was able to showcase the in-depth knowledge it gleaned on the doctors’ mentality, practices, professional power, and interplay with other professions. Consequently, the study was empowered towards proposing innovative ways for management of human resources such as exploiting the doctors’ managerial capacities and emphasising the urgent need for further education and training of medical professionals in the newly established electronic or other systems. Through its investigation, the study was equally well equipped to point out that, for opportunities to become established as successful, it is imperative to have crystal-clear job descriptions, incentives for best practices and performance, fewer interventions from unions and political parties, increased responsibilities for hospital managers, and enhanced collaboration between and among health professionals.

By looking at the bigger picture, the researcher felt that his study should also draw attention to the challenges the Greek population has been facing. In so doing, the thesis raises questions about the effectiveness the broad European Union policies have when levering reforms at the domestic level. Those queries aim at raising awareness over the need for the EU and the Greek state to be extremely vigilant so as to protect Greek citizens from the repercussions of the crisis.

The researcher is hopeful that, by identifying the degree to which cultural and political influences are exerted on the provision of health services in Greece, management practices in state hospitals will be positively affected: at present, as the study shows, Greek politicians and policymakers do not have the know-how to streamline the entire system on their own. In view of that realisation, their achievements should come under closer scrutiny, and their role and responsibilities should be more strengthened. Although cautious on the subject, the present project confirms the need and provides the impetus for higher investments in health technology and medical tourism. More specifically, it acts as a trigger for actions towards forging such synergies between private and third-sector entities that would make public service more attractive and pave the way to international markets.

Last, the study’s findings include the factors that have been impacting on implementation of reforms in the complex setting of Greece. Subsequently, the integrated framework may prove of service to countries which have been or will be subjected to the iron maiden of the neoliberal policies adamantly advocated by the IMF and the Troika as the ideal solution to ailing public deficits. In that context, it would be immensely interesting to set the present framework as the common ground for analyses and comparisons in cross-national studies; and trace the outcomes, be they successful or not, of the Troika’s reforming agenda in different European states. Portugal, Ireland, and Spain are three very recent examples of European states having faced IMF policies. Greece, however, is still under the Troika’s demands while the countries mentioned have extricated themselves from the triumvirate’s tight grasp. Arguably, the framework may also be of use as a tool in longitudinal studies which examine the development of public sector reforms in different time frames albeit within the same country.

All of the study’s theoretical and empirical contributions described above further understanding of how public health organisations in Greece have been faring under the dubious auspices of the Troika during a period of a bitter financial crisis, what the role of those agencies’ key players is, and what Greek society stands to gain or lose.

**Future Study**

Despite the fact that the present thesis has demonstrated the forced embeddedness of NPM in Greece, it cannot be clearly determined whether the NPM paradigm has had an unequivocally positive or negative influence on the efficiency of Greek state organisations. In all likelihood, as there is still great ambivalence and ambiguity over the type of impact the reforms have had in Greece, the truth is to be found between the two. It is too soon to tell whether reforms in Greece have been complete successes or hopeless failures. Given the preliminary nature of the impact, it may, therefore, be of great interest to researchers to explore the development of reforms five years from now and evaluate whether NPM will eventually flourish as practice and ideology in the Greek context. It is quite likely that, once managerial tools and practices have matured and been adapted to the system, an evaluation of reforms may have greater objectivity. Moreover, it would be worth comparing the findings of the present thesis with those of future studies, to find out whether the current reforms have progressed and whether study projections will be confirmed. Indicatively, some of those projections are: will doctors assume further managerial responsibilities? Will the Greek state proceed to setting in place a strong primary healthcare network? Will Greek public services ever be rid of political manipulation, nepotism, and corruption?

The thesis also provides the impetus for further investigation in the area of public sector management worldwide. The global financial crisis and its repercussions forced many countries to rush to the side of their health and social welfare systems. In that context, it would be praiseworthy to provide a well-designed comparative study that could explore the impact of the crisis on each country’s health sector and the remedies that each state undertakes to overcome adverse circumstances. In future terms, such a study in future terms would indeed be invaluable: it would add to the international theories on public management and health systems, focus on contradictions and similarities, and hail innovative and sound policies.

Should there be any further research, it should focus on the professional background of doctors and, in particular, of those among Greek doctors who practice in the country’s NHS. What is more, their attitudes at work should be further explored. Any future studies should concentrate on the general nature of their everyday work inside public hospitals and how that affects their behaviour. In that context, their efficiency, performance, interactions with colleagues, skills at work, quality of life, and other variables could be analysed either through in-depth interviews or questionnaires or a combination thereof. Again, a comparative study between doctors of other countries working in state hospitals may contribute to designing successful human resources policies and reform programmes.

Last, it is worth mentioning for future reference that many of the study participants expressed themselves in favour of it. They appeared desperately eager to voice their complaints to someone other than the indifferent and corrupt ears within the ramshackle institution known as the Greek NHS in the hope that they may help in reversing the situation. Therefore, a future study targeting interviews with all types of hospital staff as well as with patients, may prove the missing link in identifying those groups’ concerns and, more importantly, the bones of contention between and among them. To reiterate, only satisfied customers within will bring about satisfaction without. It is possibly the only way to save the Greek NHS. Otherwise, the boat, which is already rocking, will take in more murky water and sink.

**APPENDIXES**

**APPENDIX 1: PARTICIPANT INFORMATION STATEMENT**

**(IN ENGLISH AND GREEK)**

**Research Project**

**Title: The practice and ideology of New Public Management (NPM): The Greek NHS at a time of financial austerity**

**Responsible investigator: Vasilis Charalampopoulos**

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**Sponsor: University of Stirling**

In order to decide whether or not you would like to be part of this research study, you should understand what is involved. This form gives detailed information about the research study. Once you understand the project, you will be asked to confirm your agreement to participate via email in advance of our meeting. When we meet I will again seek confirmation that you remain happy to be involved.

**WHAT IS THE STUDY ABOUT?**

Within the framework of my PhD dissertation I wish to conduct a research study with the following objectives:

Explain the characteristics of the Greek public healthcare in terms of health policies and working conditions within public hospitals

Investigate and critically evaluate the success or failure of the successive reforms in the Greek NHS and track the formation of a National Health Service and implementation of NPM as a political project

Ascertain factors that contribute and impede the adoption of New Public Management in the Greek NHS.

Explore the impact of the crisis on the current and future development of the Greek NHS and identify opportunities to reform

**WHO IS CARRYING OUT THE STUDY?**

Charalampopoulos Vasilis (MSc)is a PhD student at the Stirling Management School, Stirling, UK. He holds a Bsc (Hons) in Business Administration from Salford University in Manchester, UK, a MBA in International Business from Grenoble Ecole de Management, France and a Master of Arts (MA) in Industrial and Organisational Psychology from University of New Haven, US. His research interests include the public administration, health policy, health reforms, and New Public Management (NPM). Vasilis has working experience from a private bank in Luxembourg, from a public organisation in Greece and he has been tutoring on an undergraduate degree for one year in UK.

Sharon C. Bolton (BA, PhD) is Professor of Organisational Analysis and Head of Stirling Management School, Stirling UK. Her research interests include emotion in organisations, public sector management, nursing and teaching, gender and the professions, dignity in and at work, the human in human resource management.  She has also worked as a Head of Department at the Business School of the University of Strathclyde, Glasgow UK and as Senior Administrator in the public and private sectors.

<http://www.stir.ac.uk/management/staff-directory/school-office/prof-sharon-bolton/>

**WHAT DOES THE STUDY INVOLVE AND WHAT ARE THE TIME COMMITMENTS?**

I wish to hear doctor’s views and perceptions about the repercussions of the economic crises to the health sector. I would like to understand what hospital managers think about the recent reforms suggested by Troika, Government and the Memorandum. Moreover, I would like to hear policy makers’ views on why it seems so difficult for a policy or a law to be implemented in the Greek NHS. To achieve this I would like to meet with you to discuss your views and perceptions. I am also keen to hear of any areas that you believe may be of interest to the topic.

I will be located in Athens until the beginning of June 2013. I would like to meet you during that period, at a time of your convenience. I can visit you at your office space if this is most convenient for you or else at a quiet place I could arrange for the interview as suitable. The meeting will take anything from an hour depending, to a large extent, on how the conversation evolves – and, of course, your time constraints. I will be guided by you. I may wish to talk to you again to clarify or elaborate on your experiences. With your permission I would like to tape our conversations. I will send you a copy of our conversation if you request me to do so.

**WHAT INFORMATION WILL BE KEPT PRIVATE?**

Your identity will remain strictly confidential and only my supervisor and myself will have access to information about you. Reports of the study submitted for public presentation and publication, which may include some of the content of our discussions, will not include any information identifying you unless specific permission is obtained from you.

The information you give to me will be anonymised and stored safely for the duration of the study. With your consent, it will also be kept for the duration of any follow-up comparative studies.

**CAN I WITHDRAW FROM PART OR ALL OF THE STUDY?**

Yes, your participation is voluntary and you may withdraw at any time without giving a reason. This may include withdrawal from our conversations or choosing not to answer a specific question. You may also choose to have the contents of your conversation removed from the study at any time. You will also have the opportunity to amend any information anytime during or after our conversation/s.

**WHAT IF I REQUIRE MORE INFORMATION?**

When you have read this information, Vasilis is happy to further discuss the research with you and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Vasilis or Sharon at the University of Stirling:

**CharalampopoulosVasilis:** [vasilis.charalampopoulos@stir.ac.uk](mailto:vasilis.charalampopoulos@stir.ac.uk), [billathens@gmail.com](mailto:billathens@gmail.com)

**Professor Sharon Bolton:** [sharon.bolton@stir.ac.uk](mailto:sharon.bolton@stir.ac.uk)

**ΠΛΗΡΟΦΟΡΙΕΣ ΓΙΑ ΤΟΝ ΣΥΜΜΕΤΕΧΟΝΤΑ**

**Ερευνητικό Έργο**

**Τίτλος: Η πρακτική και η ιδεολογία της Νέας Δημόσιας Διοίκησης: Το Εθνικό Σύστημα Υγείας την περίοδο οικονομικής κρίσης.**

**Υπεύθυνος Ερευνητής: Βασίλης Χαραλαμπόπουλος**

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**Χορηγός: University of Stirling**

Προκειμένου να αποφασίσετε για το κατά πόσον επιθυμείτε να λάβετε μέρος στην έρευνα αυτή χρειάζεται να κατανοήσετε το περιεχόμενό της. To έντυπο αυτό σας παρέχει λεπτομερείς πληροφορίες. Εφόσον κατανοήσετε τη μελέτη θα σας ζητηθεί να επιβεβαιώσετε ότι συμφωνείτε να συμμετάσχετε σε αυτή, πριν πραγματοποιηθεί η συνάντησή μας, μέσω τηλεφώνου ή ηλεκτρονικού ταχυδρομείου. Όταν συναντηθούμε θα ζητήσω την επιβεβαίωση της προθυμίας σας άλλη μια φορά.

**ΤΙ ΑΦΟΡΑ Η ΜΕΛΕΤΗ;**

Στα πλαίσια της διδακτορικής μου διατριβής, επιθυμώ να συντάξω μια ερευνητική μελέτη με τους εξής στόχους:

*Να περιγράψω την κατάσταση που επικρατεί στα νοσοκομεία και γενικά στο χώρο της δημόσιας υγείας στην εποχή των μνημονίων και των κρατικών περικοπών.*

*Na διερευνήσω τα χαρακτηριστικά των πολιτικών υγείας του ΕΣΥ, και να αξιολογήσω την επιτυχία ή την αποτυχία των διαδοχικών μεταρρυθμίσεων.*

*Να διαπιστώσω τους παράγοντες που συμβάλλουν ή εμποδίζουν την υιοθέτηση των εργαλείων της Νέας Δημόσιας Διοίκησης στο ΕΣΥ.*

*Να διερευνήσω τον αντίκτυπο της κρίσης στην τρέχουσα και μελλοντική ανάπτυξη του ΕΣΥ και να προσδιορίσω τις ευκαιρίες για μεταρρυθμίσεις.*

**ΠΟΙΟΣ ΚΑΝΕΙ ΤΗ ΜΕΛΕΤΗ;**

***Ο Βασίλης Χαραλαμπόπουλος (ΜSc)*** εκπονεί το διδακτορικό του στο Stirling Management School του Πανεπιστημίου του Stirling στη Σκωτία, Μεγάλη Βρετανία. Έχει σπουδάσει Οργάνωση και Διοίκηση Επιχειρήσεων στο Πανεπιστήμιο του Salford στο Manchester της Μεγάλης Βρετανίας, και είναι κάτοχος δύο μεταπτυχιακών, ενός MSc από τη Σχολή Διοίκησης της Grenoble στη Γαλλία και ενός ΜΑ στη Βιομηχανική και Οργανωσιακή Ψυχολογία από το Πανεπιστήμιο του NewHaven στην Αμερική. Τα ερευνητικά του ενδιαφέροντα περιλαμβάνουν τη Δημόσια Διοίκηση, την Πολιτική της Υγείας και το Νέο Δημόσιο Μάνατζμεντ. Πριν ξεκινήσει τη διατριβή του, ο Βασίλης εργάστηκε στον ιδιωτικό τομέα στο Λουξεμβούργο, σε δημόσιο οργανισμό στην Ελλάδα και ως βοηθός διδασκαλίας στο Πανεπιστήμιο του Strathclyde στη Γλασκώβη.

***Η SharonC. Bolton* (BA, PhD)** είναι Καθηγήτρια Οργανωτικής Ανάλυσης στο Πανεπιστήμιο του Stirling στη Σκωτία της Μεγάλης Βρετανίας. Τα ερευνητικά της ενδιαφέροντα περιλαμβάνουν τη διοίκηση στο δημόσιο τομέα, τα συναισθήματα στους οργανισμούς, νοσηλευτική και διδασκαλία, φύλα και επαγγέλματα, αξιοπρέπεια στον εργασιακό χώρο και η διοίκηση ανθρωπίνων πόρων. Πριν την ακαδημαϊκή της καριέρα, η Sharon εργάστηκε σε ανώτατες διοικητικές θέσεις στον δημόσιο και ιδιωτικό τομέα.

<http://www.stir.ac.uk/management/staff-directory/school-office/prof-sharon-bolton/>

**ΤΙ ΠΡΑΓΜΑΤΕΥΕΤΑΙ Η ΕΡΕΥΝΑ ΚΑΙ ΠΟΙΟΙ ΕΙΝΑΙ ΟΙ ΧΡΟΝΙΚΟΙ ΠΕΡΙΟΡΙΣΜΟΙ;**

Επιθυμώ να συζητήσω με γιατρούς, διοικητές νοσοκομείων και πολιτικούς υγείας και να ακούσω τις απόψεις και αντιλήψεις τους σχετικά με τις επιπτώσεις της οικονομικής κρίσης στη δημόσια υγεία, καθώς και για τις αλλαγές που επέφερε η Τρόικα και το Μνημόνιο. Επίσης θα με ενδιέφερε να μάθω τη γνώμη των ειδικών της υγείας όσον αφορά τη μέχρι τώρα δύσκολη εφαρμογή των πολιτικών και νόμων για τη λειτουργία του ΕΣΥ καθώς και την άποψή τους για το μέλλον των νοσοκομείων και της δημόσιας υγείας, δεδομένων πλέον και των οικονομικών εξελίξεων.

Για ακριβώς αυτό το λόγο, επιθυμώ να σας επισκεφτώ και να συζητήσουμε διεξοδικά τα παραπάνω ζητήματα καθώς επίσης και άλλα ενδιαφέροντα ζητήματα γύρω από το θέμα τα οποία δεν έχουν υποπέσει στην αντίληψή μου. Θα βρίσκομαι στην Αθήνα έως τα τέλη Ιουλίου του 2013. Θα επιθυμούσα να σας συναντήσω μέσα σε αυτή την χρονική περίοδο, οποιαδήποτε στιγμή μπορείτε να διαθέσετε για την έρευνα λίγο από το χρόνο σας. Θα μπορούσα να επισκεφτώ το γραφείο σας ή να σας συναντήσω σε κάποιο άλλο μέρος κατάλληλο για τη συνέντευξη. Η συνέντευξη θα διαρκέσει από μισή έως μια ώρα, ανάλογα με τη εξέλιξη της συζήτησης και φυσικά τους χρονικούς σας περιορισμούς. Θα σας αφήσω να με καθοδηγήσετε σε αυτό. Ίσως χρειαστεί να σας συναντήσω κάποια στιγμή ξανά για διευκρινίσεις ή περισσότερες λεπτομέρειες. Με την άδειά σας θα ηχογραφήσω τη συζήτησή μας και θα σας αποστείλω αντίγραφο εφόσον το επιθυμείτε.

**ΠΟΙΕΣ ΠΛΗΡΟΦΟΡΙΕΣ ΘΑ ΠΑΡΑΜΕΙΝΟΥΝ ΕΜΠΙΣΤΕΥΤΙΚΕΣ;**

Η ταυτότητά σας θα παραμείνει απολύτως εμπιστευτική και μόνο ο εγώ και η επικεφαλής της έρευνας Sharon θα έχουν πρόσβαση σε πληροφορίες σχετικά με εσάς. Αναφορές της μελέτης θα δοθούν για δημόσια παρουσίαση και δημοσίευση που μπορεί να περιλαμβάνουν περιεχόμενο των συζητήσεων, χωρίς όμως να περιλαμβάνεται πληροφόρηση που μπορεί να αποκαλύψει την ταυτότητά σας, εκτός και αν δοθεί ειδική άδεια από εσάς.

Οι πληροφορίες που θα μου δώσετε θα διατηρηθούν ανώνυμα και με ασφάλεια κατά τη διάρκεια της μελέτης. Με τη συγκατάθεσή σας, θα κρατηθούν επίσης και για ακόλουθες συγκριτικές μελέτες.

**ΜΠΟΡΩ ΝΑ ΑΠΟΣΥΡΘΩ ΑΠΟ ΜΕΡΟΣ ΤΗΣ ΜΕΛΕΤΗΣ Ή ΟΛΟΚΛΗΡΗ ΤΗ ΜΕΛΕΤΗ;**

Ναι, η συμμετοχή σας είναι εθελοντική και μπορείτε να αποσυρθείτε οποιαδήποτε στιγμή χωρίς να το αιτιολογήσετε. Αυτό μπορεί να αφορά απόσυρση από τις συζητήσεις μας ή την επιλογή του να μην απαντήσετε σε κάποια πιθανή ερώτηση. Επίσης μπορείτε να ζητήσετε να αποσυρθεί το περιεχόμενο της συζήτησης από τη μελέτη οποιαδήποτε στιγμή. Θα έχετε ακόμα τη δυνατότητα να προσθέσετε πληροφορίες οποιαδήποτε στιγμή κατά τη διάρκεια ή και μετά τη/τις συζήτηση/εις μας.

**ΑΝ ΧΡΕΙΑΖΟΜΑΙ ΠΕΡΙΣΣΟΤΕΡΗ ΠΛΗΡΟΦΟΡΗΣΗ;**

Αφού διαβάσετε αυτές τις πληροφορίες με πολύ χαρά μπορούμε να συζητήσουμε επιμέρους απορίες που πιθανώς να έχετε. Αν επιθυμείτε να μάθετε περισσότερα μπορείτε οποιαδήποτε στιγμή να επικοινωνήσετε μαζί μου ή/και με τη Sharon στο Πανεπιστήμιο του Stirling, στη Σκωτία:

**Βασίλης Χαραλαμπόπουλος**: [vasilis.charalampopoulos@stir.ac.uk](mailto:vasilis.charalampopoulos@stir.ac.uk), [billathens@gmail.com](mailto:billathens@gmail.com)

**Καθηγήτρια Sharon Bolton:** [sharon.bolton@stir.ac.uk](mailto:sharon.bolton@stir.ac.uk)

**APPENDIX 2: PARTICIPANT CONSENT FORM**

**(IN ENGLISH AND GREEK)**

**The practice and ideology of New Public Management (NPM): The Greek NHS at a time of financial austerity**

**Vasilis Charalampopoulos**

Stirling University Management School

*I (the participant) have read and understand the Participant Information Statement, and any questions I have asked, have been answered to my satisfaction. I understand that my participation is voluntary and I agree to participate in this research, knowing that I may withdraw at any time. I acknowledge the role I will take in the study and the time involved has been explained to me. I understand that my involvement is strictly confidential and no information about me will be used in any way that reveals my identity. I have been given a copy of the Participant Information Statement to keep.*

Please also delete as appropriate:

I **agree/disagree** to have my interview audio-recorded.

I **agree/disagree** for my data to be retained by the researcher for comparison purposes for later studies.

I **agree/disagree** to preview results of research if requested before they are used.

Participant’s Name:…………………………………………………………………

Participant’s Signature:…………………………………………Date: ……………

Please return this page to:

**Βασίλης Χαραλαμπόπουλος**

Amisou,

TK 17124,

Nea Smirni,

Athens

Or

Stirling Management School  
University of Stirling  
Stirling FK9 4LA  
Scotland, UK

**ΣΥΓΚΑΤΑΘΕΣΗ ΣΥΜΜΕΤΕΧΟΝΤΑ**

**Η πρακτική και η ιδεολογία της Νέας Δημόσιας Διοίκησης: Το Εθνικό Σύστημα Υγείας την περίοδο οικονομικής κρίσης.**

**Βασίλης Χαραλαμπόπουλος**

Stirling University Management School

*Εγώ (ο συμμετέχων/ουσα) έχω διαβάσει και κατανοήσει τις Πληροφορίες για τον Συμμετέχοντα και όποιες ερωτήσεις έχω απευθύνει έχουν απαντηθεί ικανοποιητικά. Κατανοώ ότι η συμμετοχή μου είναι εθελοντική και ότι συμφωνώ να συμμετέχω σε αυτή την έρευνα, γνωρίζοντας ότι μπορώ να αποσυρθώ οποιαδήποτε στιγμή. Αναγνωρίζω ότι ο ρόλος μου στη μελέτη και ο χρονικός ορίζοντας έχουν διευκρινιστεί σε μένα. Κατανοώ ότι η συμμετοχή μου είναι άκρως εμπιστευτική και καμία πληροφορία δε θα χρησιμοποιηθεί κατά τέτοιο τρόπο ώστε να αποκαλύπτει την ταυτότητά μου. Μου έχει δοθεί ένα αντίγραφο της κατάστασης Πληροφοριών για τον Συμμετέχοντα.*

Επιπλεόν, (παρακαλώ διαγράψετε όπως αρμόζει):

**Συμφωνώ/Διαφωνώ** να ηχογραφηθεί η συνέντευξή μου.

**Συμφωνώ/Διαφωνώ** να διατηρηθούν τα δεδομένα από τον ερευνητή για συγκριτικούς σκοπούς επόμενων μελετών.

**Συμφωνώ/Διαφωνώ** να δω τα αποτελέσματα της έρευνας αν ζητηθεί πριν χρησιμοποιηθούν.

Όνομα Συμμετέχοντα:…………………………………………………………………

*(Κεφαλαία Γράμματα)*

Υπογραφή:………………………………………… Ημερομηνία: ……………

Παρακαλείσθε να επιστρέψετε αυτό το έντυπο στην Διεύθυνση :

**Βασίλης Χαραλαμπόπουλος**

Αμισού,

17124,

Νέα Σμύρνη,

Αθήνα

ή

Stirling Management School  
University of Stirling  
Stirling FK9 4LA  
Scotland, UK

**APPENDIX 3: DOCTORS’ INTERVIEW GUIDE**

**Opening the interview:**

First of all let me thank you for giving me the opportunity to discuss with you this most important issue of health in Greece during the difficult crisis years.

**Current Situation**

What is the current situation in hospitals?

What are the main problems that doctors face nowadays in their workplaces?

**Reforms**

How do you appreciate recent reforms in health sector imposed by Troika? Have you anticipated any changes or improvement?

One of the reforms was the e-prescription. Have you anticipated any changes?

What do you think about the mergers of hospitals? Do you believe there were reasons to happen? Did they bring about some benefits?

What about the implementation of DRGS? Have they been implemented in your hospital?

What do you think about the creation of the Unified Healthcare Fund (EOPYY)? Did it bring any financial benefits yet?

Were there any strict controls about the right implementation of reforms by Troika?

One of the strongest Troika’s requirements was the reduction of public spending. Was there any need to restrain public expenditure to the health sector?

Do you believe that cost savings in health expenditure has transferred the cost to patients?

Were there any other ways to increase efficiency in the Greek NHS? Any other measures that Troika should have taken but it has failed to do it?

**Hospitals and Health Professionals Relations**

Do you think that hospitals are managed effectively?

In terms of equipment and human resources needs, is your hospital fully covered? Do you miss any kind of specialty?

Is there an adequate performance assessment system for personnel in hospitals? Is there any adequate performance assessment system for services (i.e. long waiting lists, bed capacity)? If not, do you think that there should be one?

Is there a systematic quality control system (i.e. adequateness of medical equipment) taking place in hospitals?

Is there any kind of miscommunication between hospital staff (i.e. hospital managers and doctors?) If yes how do you think it can be resolved?

Do you meet with hospital manager regularly? Does he or she take into consideration your main concerns?

Do you think that a hospital manager should better be a doctor or to be from another job category?

Do you think that doctors would like to acquire managerial knowledge and be more involved with managerial duties?

**Past failures**

Why according to your opinion it seemed so difficult for a policy or a law to be implemented in the Greek NHS so far?

Do you think that policy decisions makers had difficulties to understand and evaluate the real situation in the work places of health?

What do you think should have been done so reforms could be more easily implemented?

**New Public Management**

In Europe there is a tendency to strengthen the public sector and make it more competitive by introducing criteria and ideology from the private sector. Do you think that this paradigm is spread in the heath public sector of Greece by Troika?

In that sense do you believe the introduction of management tools borrowed by the private sector within hospitals can provide solutions related to efficiency and quality of care?

Don’t you think that health in Greece is losing its public values and is becoming more privatized in this way?

**Sustainability and Future Predictions**

Do you believe that the implemented changes are temporary or will last longer?

Do you believe that the crisis will be an opportunity for the Greek NHS in order to reform?

If the economic recession will continue to hit the country which do you think will be the future of the Greek public health sector and the hospitals?

If you could, what would you change in hospitals and what would you change in the public health more generally?

**APPENDIX 4: HOSPITAL MANAGERS’ INTERVIEW GUIDE**

**Opening the interview:**

First of all let me thank you for giving me the opportunity to discuss with you this most important issue of health in Greece during the difficult crisis years.

**Crisis Situation**

What are the main ramifications of the current economic crisis for the public health sector?

What are the challenges that you as a Hospital Manager have to face nowadays at work? Is there any support offered by the government, Ministry of Health?

**Reforms**

How do you appreciate recent reforms in the health sector imposed by the Troika and the Government? Have they resolved any of the problems?

One of the reforms was the e-prescription. Have you anticipated any changes?

What do you think about the mergers of hospitals? Do you believe there were reasons to happen? Did they bring about some benefits?

What about the implementation of DRGS? Have they been implemented in your hospital?

What do you think about the creation of the Unified Healthcare Fund (EOPYY)? Did it bring any financial benefits yet?

Were there any strict controls about the right implementation of reforms by Troika?

Are the reforms suited to a public organisation in Greece?

One of the strongest Troika’s requirements was the reduction of public spending. Was there any need to restrain public expenditure to the health sector?

Do you believe that cost savings in health expenditure has transferred the cost to patients?

Were there any other ways to increase efficiency in the Greek NHS? Any other measures that Troika should have taken but it has failed to do it?

**Hospitals**

Were there any reductions in hospital budgeting? If yes what percentage has been reduced?

In terms of equipment and human resources needs, is your hospital fully covered? Do you miss any kind of specialty? What about the situation in regional hospitals and health centers?

Is there an adequate performance assessment system for personnel in hospitals? Is there any adequate performance assessment system for services (i.e. long waiting lists, bed capacity)? If not, do you think that there should be one?

Is there a systematic quality control system (i.e. adequateness of medical equipment) taking place in hospitals?

How many years is your term period?

Do you have any specific goals to complete within your term period? Is there any contract of performance?

Do you have firm guidelines or you are free to take initiatives?

Don’t you think that your tenure is too short for major changes to be accomplished?

What is your relationship with other health professionals in the hospital? Do you meet with them regularly?

Do you meet with the Minister of Heath and policy makers regularly? Do they take into consideration your main concerns?

When you take a decision do you think more as a manager or as a doctor?

**Past failures**

Why according to your opinion it seemed so difficult for a policy or a law to be implemented in the Greek NHS so far?

Do you think that policy decisions makers had difficulties to understand and evaluate the real situation in the work places of health?

What do you think should have been done so reforms could be more easily implemented?

**New Public Management Perceptions**

In Europe there is a tendency to strengthen the public sector and make it more competitive by introducing criteria and ideology from the private sector. Do you think that this paradigm is spread in the heath public sector of Greece by Troika?

In that sense do you believe the introduction of management tools borrowed by the private sector within hospitals can provide solutions related to efficiency and quality of care?

Don’t you think that health in Greece is losing its public values and is becoming more privatised in this way?

**Sustainability and Future Predictions**

Do you believe that the implemented changes are temporary or will last longer?

Do you believe that the crisis will be an opportunity for the Greek NHS in order to reform?

If the economic recession will continue to hit the country which do you think will be the future of the Greek public health sector and the hospitals?

If you could, what would you change in hospitals and what would you change in the public health more generally?

**APPENDIX 5: POLICYMAKERS’ INTERVIEW GUIDE**

**Opening the interview:**

First of all let me thank you for giving me the opportunity to discuss with you this most important issue of health in Greece during the difficult crisis years.

**Current Situation**

Could you describe the current situation in the public healthcare in general?

Have the hospitals been affected by the crisis?

What is the current role of the Regional Health Peripheries? What are the challenges that they have to face?

**Reforms**

How do you appreciate recent reforms in the health sector imposed by the Troika and the Government? Have they resolved any of the problems?

One of the reforms was the e-prescription. Have you anticipated any changes?

What do you think about the mergers of hospitals? Do you believe there were reasons to happen? Did they bring about some benefits?

What about the implementation of DRGS? Have they been implemented in your hospital? What do you think about the creation of the Unified Healthcare Fund (EOPYY)? Did it bring any financial benefits yet?

Were there any strict controls about the right implementation of reforms by Troika?

Are the reforms suited to a public organisation in Greece?

One of the strongest Troika’s requirements was the reduction of public spending. Was there any need to restrain public expenditure to the health sector?

Do you believe that cost savings in health expenditure has transferred the cost to patients?

Were there any other ways to increase efficiency in the Greek NHS? Any other measures that Troika should have taken but it has failed to do it?

**Hospitals**

Do you think that hospitals are managed effectively?

In terms of equipment and human resources needs, is your hospital fully covered? Do you miss any kind of specialty? What about the situation in regional hospitals?

Is there an adequate performance assessment system for personnel in hospitals? Is there any adequate performance assessment system for services (i.e. long waiting lists, bed capacity)? If not, do you think that there should be one?

How about the completion of the Health Map? Has it been finalized?

Is there a systematic quality control system (i.e. adequateness of medical equipment) taking place in hospitals?

Do you meet with health professionals regularly? Do you take into consideration their main concerns?

According to your opinion did the introduction of managers bring major changes to hospitals?

Do you think that a hospital manager should better be a doctor or to be from another job category?

**Past failures**

Why according to your opinion it seemed so difficult for a policy or a law to be implemented in the Greek NHS so far?

Do you think that a policy decision maker had difficulties to understand and evaluate the real situation in the work places of health?

What do you think should have been done so reforms could be more easily implemented?

What about the short tenure of Health Ministers? Should it change in order reforms to be supported and successfully implemented?

**New Public Management**

In Europe there is a tendency to strengthen the public sector and make it more competitive by introducing criteria and ideology from the private sector. Do you think that this paradigm is spread in the heath public sector of Greece by Troika?

In that sense do you believe the introduction of management tools borrowed by the private sector within hospitals can provide solutions related to efficiency and quality of care?

Don’t you think that health in Greece is losing its public values and is becoming more privatized in this way?

**Sustainability and Future Predictions**

Do you believe that the implemented changes are temporary or will last longer?

Do you believe that the crisis will be an opportunity for the Greek NHS in order to reform?

If the economic recession will continue to hit the country which do you think will be the future of the Greek public health sector and the hospitals?

If you could, what would you change in hospitals and what would you change in the public health more generally?

**APPENDIX 6: SAMPLE INFORMATION**

**Doctors**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **Specialty** | **Date** | **InterviewMethod** | **Health Organisation** | **LengthofInterview** |
| Doctor 1 | Surgeon-Oncologist | 09/04/2013 | FacetoFace | Central Hospital | 35min |
| Doctor 2 | Neurosurgeon | 21/04/2013 | Telephone | Regional Hospital | 25min |
| Doctor 3 | Paediatrician | 31/05/2013 | Telephone | Regional Hospital | 45min |
| Doctor 4 | GeneralPractitioner | 21/04/2013 | Telephone | Regional Hospital | 31min |
| Doctor5 | ResidentCardiologist | 15/04/2013 | FacetoFace | CentralHospital | 1hr17min |
| Doctor 6 | Pathologist | 23/03/2013 | FacetoFace | Central Hospital | 30min |
| Doctor7 | GeneralSurgeon | 23/07/2013 | FacetoFace | Central Hospital | 25min/not recorded |
| Doctor8 | Cytologist | 12/04/2013 | FacetoFace | Central Hospital | 30min |
| Doctor9 | ResidentCardiologist | 05/09/2013 | FacetoFace | Regional Hospital | 40min |
| Doctor10 | Cytologist | 10/04/2013 | FacetoFace | Central Hospital | 49min |
| Doctor 11 | Nunclear Physician | 09/10/2013 | FacetoFace | Central Hospital | 55min |
| Doctor 12 | ResedentPathologist | 17/08/2013 | FacetoFace | Central Hospital | 29min |
| Doctor13 | Pulmonologist | 12/04/2013 | FacetoFace | Central Hospital | 25min |
| Doctor 14 | Anaesthesiologist | 12/04/2013 | FacetoFace | Central Hospital | 35min |
| Doctor15 | Cytologist | 26/06/2013 | FacetoFace | Central Hospital | 34min |
| Doctor16 | Diabetologist | 11/10/2013 | FacetoFace | Central Hospital | 25min |
| Doctor17 | Pulmonologist | 24/05/13 | FacetoFace | Central Hospital | 32min |
| Doctor18 | Dermatologist | 13/03/2013 | FacetoFace | Central Hospital | 26min |
| Doctor19 | Gynaecologist-Oncologist | 13/09/2013 | FacetoFace | Central Hospital | 25min |
| Doctor 20 | Psychiatrist | 09/10/2013 | FacetoFace | Central Hospital | 25min |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Date** | **Interview Method** | **Health Organisation** | **Length of Interview** |
| Manager 1 | 09/04/2013 | Face to Face | Central Hospital | 51min |
| Manager 2 | 05/08/2013 | Face to Face | Central Hospital | 33min/not recorded |
| Manager 3 | 30/03/2013 | Telephone | Regional Hospital | 1hr02min |
| Manager 4 | 04/04/2013 | Telephone | Regional Hospital | 48min |
| Manager 5 | 19/06/2013 | Face to Face | Central Hospital | 54min |
| Manager 6 | 18/07/2013 | Face to Face | Central Hospital | 46min |
| Manager 7 | 17/06/2013 | Face to Face | Central Hospital | 44min |
| Manager 8 | 13/05/2013 | Telephone | Regional Hospital | 29min |
| Manager 9 | 24/04/2013 | Telephone | Regional Hospital | 35min |
| Manager 10 | 25/05/2013 | Skype | Regional hospital/central | 1hr42min |

**Managers**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Specialty** | **Date** | **Interview Method** | **Length of Interview** |
| Policymaker 1 | Professor/ex-Politician | 01/07/2013 | FacetoFace | 1hr26min |
| Policymaker 2 | Professor/Politician | 25/07/2013 | FacetoFace | 40min |
| Policymaker 3 | MinistryofHealth/Politician | 05/07/2013 | FacetoFace | 34min |
| Policymaker 4 | Director of a Public Health Organisation | 24/05/2013 | FacetoFace | 52min |
| Policymaker 5 | MinistryofHealth/Politician | 05/07/2013 | FacetoFace | 36min |
| Policymaker 6 | Professor/Politician | 23/05/2013 | FacetoFace | 32min |
| Policymaker 7 | Professor/Politician | 03/06/2013 | FacetoFace | 41min |
| Policymaker 8 | Professor/HealthExpert | 12/06/2013 | Skype | 48min |
| Policymaker 9 | Professor/HealthExpert | 20/06/2013 | Skype | 1hr05min |
| Policymaker 10 | Professor/HealthExpert | 22/01/2014 | Skype | 1hr14min |

**Policymankers**

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FEK 94/99 “Minimum Requirements for the Organisation of Working Time, in Compliance with EU Directive 93/104/EC”

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FEK  Β 1702/2011 “Diagnosis-related Group System (DRGS)”

Law 2868/1922 “Concerning Obligatory Insurance of Workers and Private Employees”

Law 6298/1934 “Concerning the Institution of Social Security”

Law 4169/1961 “Concerning the Agricultural Social Insurance”

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Law 2889/2001 “Improvement and Modernisation of the National Health System”

Law 3172/2003 “Organisation and Modernisation of Public Health”

Law 3230/2004 “Establishment of an Administration System through Goals and Measurement of Performance”

Law 3260/2004 “Regulations of Employment System and Issues of Public Administration”

Law 3235/2004 “Primary Health Care”

Law 3329/2005 “ESY and Social Welfare”

Law 3370/2005 “Organisation and Operation of Public Health Services”

Law 3389/2005 “Pubic Private Partnerships”

Law 3528/2007 “New Code of Public Employees that egulates Personnel Management Issues, including Hiring and Compensation Rules

Law 3580/2007 “Procurement Procedures of Bodies Regulated from Ministry of Health and Social Welfare”

Law 3754/2009 “Employment Regulations for doctors of ESY and other Provisions”

Law 3868/2010 “Improvements of ESY and other Provisions of Ministry of Health”

Law 3918/2011 “Structural Changes in the System of Health and other Provisions”

Law 4025/2011 “Reconstruction of Institutions of Social Solidarity, Centers of Rehabilitation, Reforming of National System of Health and other Provisions”

Explanatory Memorandum 3370/2005

Explanatory Memorandum 3868/2010

Explanatory Memorandum 3918/2011

Explanatory Memorandum 4025/2011

1. Law: 6298/1934 [↑](#footnote-ref-1)
2. Law: 2868/1922 [↑](#footnote-ref-2)
3. FEK 2592/1953 [↑](#footnote-ref-3)
4. Under the Law 4169/1961 [↑](#footnote-ref-4)
5. Law: 1397/1983 [↑](#footnote-ref-5)
6. Law: 2071/1992 [↑](#footnote-ref-6)
7. Law: 2194/1994 [↑](#footnote-ref-7)
8. Law: 2519/1997 [↑](#footnote-ref-8)
9. FEK: 94/99 [↑](#footnote-ref-9)
10. Law: 2889/2001 [↑](#footnote-ref-10)
11. Law: 3172/2003 [↑](#footnote-ref-11)
12. Article 1, Law 3172/2003 [↑](#footnote-ref-12)
13. Law: 3235/2004 [↑](#footnote-ref-13)
14. Law: 3329/2005 [↑](#footnote-ref-14)
15. Law: 3370/2005 [↑](#footnote-ref-15)
16. Law: 3580/2007 [↑](#footnote-ref-16)
17. Law: 3754/2009 [↑](#footnote-ref-17)
18. Law: 3868/2010 [↑](#footnote-ref-18)
19. FEK B 1702/2011 [↑](#footnote-ref-19)
20. Law: 3918/2011 [↑](#footnote-ref-20)
21. Law: 4025/2011 [↑](#footnote-ref-21)
22. Law: 3230/2004 [↑](#footnote-ref-22)
23. Law: 3260/2004 [↑](#footnote-ref-23)
24. Law: 3528/2007 [↑](#footnote-ref-24)
25. Μedical subjectivity leads in turn to an imbalanced services consumption (via physician agency) which on occasion cannot be justified and leads to elevated costs and inefficiencies (Minogiannis 2012 p.72) [↑](#footnote-ref-25)