7. Shifting ideational paradigms in public health: Connecting design and implementation in Greek health policy

Vassilis Karokis-Mavrikos and Maria Mavrikou

INTRODUCTION

The Multiple Streams Framework (MSF) has long enjoyed prominence as an analytical tool for the study of policy change (Kingdon 1984). Scholarly applications have spanned contexts and policy fields (Jones et al. 2015) and have been highly successful in uncovering the mechanisms underpinning policy shifts, especially in the decision agenda (Herweg, Zahariadis and Zohlnhöfer 2018). As change is dynamic, recent accounts have extended the MSF's focus to the implementation stage (Fowler 2019; Sager and Thomann 2017). An emerging challenge in the literature concerns connecting policy design and implementation (Fowler 2022; Zahariadis and Exadaktylos 2016) to understand why some bills provisioning radical change succeed in shifting policy trajectories but others do not. We intend to contribute to this research agenda through a longitudinal account of public health policy in Greece. We apply the MSF toolkit to the study of public health policy change, centering our analysis on two focusing events: the 2003 SARS outbreak and the Covid-19 pandemic. The first triggered the institutionalization of public health policymaking for the first time in Greece's modern history (Bill 3172/2003) and the second tested the degree of entrenchment of the new paradigm nearly two decades later. In doing so, we evaluate the interrelation of policy design and implementation and uncover contextually-driven insights for the potential theoretical advancement of the framework.

RESEARCH DESIGN

Our approach builds on the insights of Blum (2021) and Zahariadis and Exadaktylos (2016) (also see chapter 5, this volume) as we view streams couplings during agenda-setting and decision making as fragile and potential decouplings during implementation as detrimental to structural change. We decide to zoom in on the mechanisms which maintain or disrupt couplings and determine whether and how they are connected to the process of policy adoption. As a result, we first explore how the first dedicated public health Bill in Greece's modern history was introduced in 2003 after two decades of neglect and then evaluate how the drivers and resisting forces behind the reform have influenced its implementation trajectory. Guiding our analysis are two hypotheses:

H1: The rise of public health to the decision agenda was the outcome of successful policy entrepreneurship, which extended the focus of policy change beyond the health services sector.

H2: Resisting forces in the policy and politics stream, which persistently impeded the establishment of a public health system, have developed into drivers of decoupling during implementation.

Our hypotheses are inspired by the relevant literature (Mavrikou 2021; Zilidis 2005), echo the MSF logic and capture the interrelation between policy design and implementation which underpins the study. Furthermore, they support a hypothesis-generating design (Levy 2008), allowing the identification of mechanisms which could inform further MSF theorizing and be tested in future applications of the framework.

To guide the analysis, we employ a qualitative, process-tracing approach grounded on primary sources. In studying the mechanisms of policy change for public health in 2003, we rely on legal documents – Bills, parliamentary deliberation transcripts and policy evaluation reports – and 42 semi-structured elite interviews with relevant policymakers and experts between 1983 and 2003. Interviews were conducted in two waves (January 2018–January 2019 and February 2019–February 2020). Criteria for participant selection included occupation, involvement in the drafting of legislative proposals and the timing of policymaking participation. The processing of data from the first wave further informed the selection of respondents for the second. Interviewees were guaranteed anonymity and are referenced with their occupation. Questions were drafted in alignment with the five MSF structural elements – the problem, policy and politics streams, policy entrepreneurs and windows of opportunity – and were adjusted across interviews depending on the role and experience of each respondent.

We complement our data with further document analysis, 20 additional interviews and a survey of 261 stakeholders in Greek public health policymaking today to evaluate the reform's implementation trajectory and capture the degree of entrenchment of the holistic paradigm to health.[1] The MSF-guided structure was maintained for both data collection and processing. Respondents were selected through purposive and quota sampling to maximize response rates and ensure representative participation from an intrinsically small-N sampling frame (Etikan et al., 2016; Acharya et al., 2013). Occupation and age were selected as the two core criteria and the intended sampling distribution was determined after the institutional mapping of stakeholders. Our sampling process aimed for the equal and analogous representation of 85 percent of our sample from stakeholders in the Public Sector, the Private Sector and Research Centers/Universities and the equal and analogous representation of the remaining 15 percent of our sample from participants in NGOs/Patients Associations and the Media. Moreover, to include both veteran and novice stakeholders, we aimed for the equal and analogous representation of participants in the over 60, under 30 and 31–40 age groups for 30 percent of the sample and the equal and analogous representation of participants in the 41–50 and 51–60 age groups for the remaining 70 percent of the sample. Our survey produced a response rate of 52 percent (261/503) and our participants fitted the intended profile (Figures 7.1, 7.2).

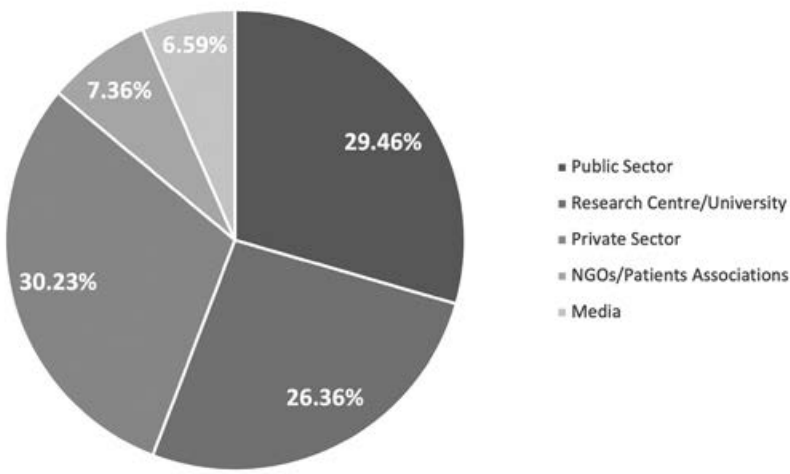

Figure 7.1 Sample occupation

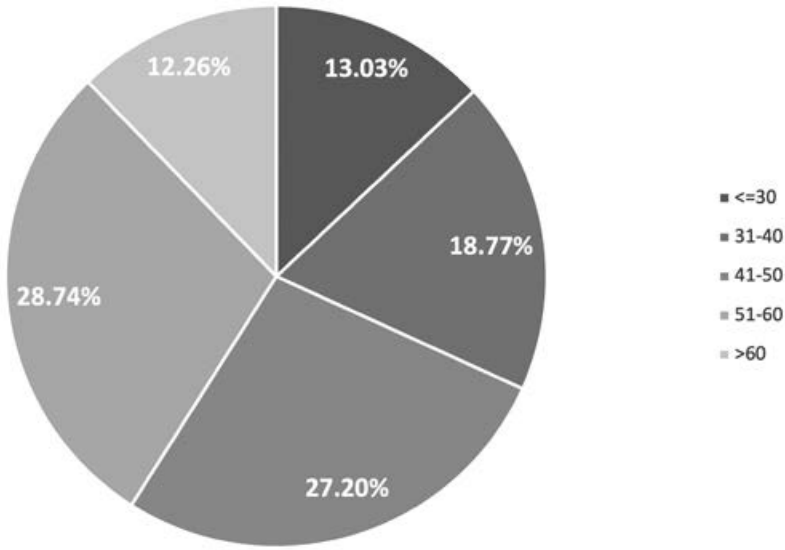

Figure 7.2 Sample age

1983–2003: FROM HEALTHCARE TO PUBLIC HEALTH

Following the fall of military dictatorship in 1974, Greece entered a modern era of parliamentary democracy. Democratic transition was accompanied by a frenzy of reforms as institutional configurations and policymaking processes had to be built from scratch. In health, the modern outlook of the sector was introduced by Bill 1397/1983, which established the Greek National Health System (GNHS), a public system of healthcare services. Over time, a medicine-centric perspective came to define sector's policymaking with pressing public health problems remaining unaddressed and ideas advocating the establishment of a public health policy framework struggling to emerge.

The Problem Stream: Public Health Problems Accumulate Without Established Feedback and Monitoring Mechanism

Driving the establishment of the GNHS in 1983 was a willingness to institute universal healthcare coverage by the socialist PASOK Government. "At the core of the system's vision lied equality: in access and in the level of care received" (interview with former health policy advisor). However, during the following decades, health inequalities emerged as one of the dominant

problems facing the sector. "Truly universal healthcare coverage was fundamentally incompatible with the financing model underpinning the GNHS, which included multiple public insurance funds with separate budgets reimbursing different subgroups of the Greek working population" (interview with Ministry of Health (MoH) staffer). As the financing regime remained unmodified, inequalities kept growing exponentially. By 2002, findings of the World Health Organization (WHO) and the Greek National School of Public Health showed that income, education, and occupation could predict services usage at the panhellenic level, while those most in need appeared insufficiently treated by the public system (National School of Public Health 2002).

Extending health inequalities, a continuous rise in chronic and infectious diseases signified an unhealthy Greek population on the aggregate and pointed to structural deficiencies beyond secondary care. During the 1990s, Greece experienced frequent resurgence in the spread of measles and exhibited the highest death rate from tuberculosis among all Member States of the European Union (WHO 2021; Maltezou, Spyridis and Kafetzis 2000; Abel-Smith et al 1994). Meanwhile, avoidable mortality rates and unhealthy population habits showed consistent increase between 1980 and 2003, with Greece topping the EU in percentage of smokers (National School of Public Health 2007; Tountas et al. 2009). In the turn of the twenty-first century, "child obesity rates reached epidemic proportions" (interview with specialist doctor and former health policy advisor) with over 40 percent of boys and over 30 percent of girls being considered overweight or obese by 2003 (Georgiadis and Nassis 2007; Jackson-Leach and Lobstein 2006).

Nevertheless, these developments repeatedly failed to instigate debate around public health deficiencies as Greek health policy between 1983 and 2003 was devoid of formal attention-mobilizing mechanisms. "Instruments dedicated to consistent monitoring, evidence-based advisory and policy evaluation were massively underdeveloped" (interview with health economics expert and former health organization director). Despite legal provisions, evaluative and advisory bodies at the central and regional level – such as the Central Council for Health and Regional Health Authorities – faced long delays in their establishment, understaffing, and marginalization. As a result, the impact of indicator monitoring and policy feedback – two recognized driving forces of issue recognition in the MSF's problem stream – was neutralized.

Ultimately, it was focusing events bringing problems to light, such as the AIDS outbreak in the 1980s "illuminating state gaps in prevention and communication" (interview with community care expert). As issues built up cumulatively, they were brought to light with increased momentum during subsequent public health crises. In 2003, the looming threat of SARS-Cov-1, amidst Greece's preparation for the hosting of the 2004 Olympic Games, "brought simultaneous attention to systemic failures, institutional deficiencies

and lack of management and coordination planning for public health" (interview with public health policy advisor to the Minister of Health). As renowned epidemiologist Dimitris Trichopoulos categorically stressed "emergency adjustments could never cover for the years and years of undermining public health policymaking" (Foura 2003). Together with developments in the politics stream, as outlined in the following sections, the SARS-Cov-1 epidemic triggered the opening of a window of opportunity for public health reform.

The Policy Stream: Politicization and Implementation Gaps Limit Venues for Public Health Policy Entrepreneurship

Regardless of the magnitude of issues, achieving policy change demands innovative ideas as "solutions chase problems" in the MSF logic (Kingdon 1984). In Greek health policy, the development and dissemination of ideas for public health had to overcome institutional fluidity and intense politicization which limited the availability of policy venues and reinforced the sector's dominant medicine-centric paradigm.

With public health remaining outside the realm of consideration in the founding law of the GNHS in 1983, "secondary care received the bulk of infrastructure investment during the first half of the 1980s" (interview with former director of Regional Health Authorities). Ideas promoting a shift of focus to public health were first generated by primary care specialists, who "advocated for higher investment in prevention, primary care and community care and higher interconnectedness between these domains and hospital services under the dogma of integrated care" (interview with primary and community care specialist and former MoH health policy advisor). During the late 1980s and early 1990s, these prevention and primary care experts exercised policy entrepreneurship through the health sector's formal policymaking channels, but their strategy proved ineffective.

Overtime, the de facto policymaking process for health significantly diverged from the *de jure* institutional design. Senior advisory instruments such as the Central Council for Health became weak and marginalized. Frequent changes in personnel through political appointments and the limited uptake of ideas by the MoH led to the Council's reports and proposals "rotting in the ministry's drawers" (interview with former Minister of Health). Beyond the Central Level, attempts by this first wave of policy entrepreneurs to advance a public health agenda from within – through Local Health Centers, the first point of contact with the system of services – were impeded by jurisdictional conflict and implementation gaps. The involvement of segmented insurance funds in primary care had introduced a second supervising ministry to the field – the Ministry of the Employment – increasing institutional friction. Moreover, the non-establishment of Regional Health Authorities, provisioned

to oversee hospitals and Local Health Centers and transfer needs-based guidance to the MoH, "had left the street and the top levels of policymaking disconnected" (interview with former Local Health Centers coordinator). As a result, the efforts of policy entrepreneurs proved unsuccessful both in achieving influence over policymakers and in instigating dialogue within the policy community to refine and soften up policy alternatives for public health.

The failed policy advocacy brought to light the fact that meaningful policymaking venues in Greek health policy were few and heavily controlled. As politicization and non-implementation perpetuated, agenda-setting and decision-making turned increasingly centralized. For example, the abolishment of the Central Council for Health was followed by the establishment of two Special Secretariats within the MoH to undertake its duties (Bill 2071/1992), further narrowing the scope of instruments involved in policymaking. Meanwhile, the frequent institutional turnover highlighted that in Greek health policy, venues could be created at will, serve temporary functions, and be easily abolished after. As a result, policy formulation between 1983 and 2003 took place exclusively in dedicated reform design committees. They were set-up to deliver reforms, worked under the direct supervision of the Minister of Health, and were disbanded following the submission of a draft Bill. For policy entrepreneurs, no matter the content of their proposals, this regime offered uncontested levels of access and influence on policymakers. For governments, it allowed direct control over discussed and accepted alternatives and it enabled the evidence-based legitimation of decisions through the involvement of selected experts.

Throughout the 1980s and the 1990s, experts and advisors involved in the drafting of Bill 1397/1983 proved most successful in populating the reform design venues. Taking advantage of non-implementation and public administration undermining, these stakeholders "capitalized on their previous experience in policy formulation and forged strong connections with policymakers" (interview with former Minister of Health). Over time, they engaged in repeated role switching, occupying political, administrative, and scientific positions and extending their presence and influence in the policy subsystem. Between them, this group of policy entrepreneurs shared common preferences for maintaining the status quo and "addressing emerging challenges through minor adjustments to the established paradigm" (interview with specialist doctor and former health policy advisor). "Actors with a medicine-oriented outlook and the willingness to prolong their involvement in policymaking would persistently promote different implementation tracks for the same set of legislated policies" (interview with public health expert and former health organization director). As a result, ideas extending the focus of policymaking from hospital services to public health would struggle both to emerge and to be communicated to policymakers.

Driven by the experience of failure, the prevention and primary care specialists who had first introduced public health alternatives to the Greek health policy sector during the late 1980s, re-evaluated their strategy during the late 1990s. First, inspired by international developments and external policy feedback, they reformulated the content of their pet proposals. New international trends, epitomized by a strong emphasis on the social determinants of health in WHO's guidelines and evaluation reports (Ashton and Seymour 1988), coincided with an independent evaluation of the Greek health policy sector by a Committee of Foreign Experts in preparation for the country's entry to the European Single Market. "Although the Committee's findings and recommendations, highlighting the narrow focus and subpar administrative capacity of the Greek health policy paradigm, did not find short-term policy responsiveness, they proved crucial in shifting the perspective of public health policy entrepreneurs" (interview with health economics expert and former member of advisory committees in health). More specifically, the stressing of the need to acknowledge and manage the intrinsically multisectoral nature of public health policymaking incited a new wave of policy advocacy, promoting the institutionalization of the holistic perspective to health and the establishment of an independent system of public health services. Seeking to achieve value acceptability, policy entrepreneurs disassociated the proposed new system from the GNHS, as it would further include services in prevention, primary care, hygiene, the environment, social policy etc. (interview with public health expert and former reform design committee member). Moreover, championing technical feasibility and resource adequacy, they argued that "many of the system's components were already in place but lacked coordination and a common orientation towards fostering better population health" (interview with public health expert and former health authorities' director).

Second, with an added decade of systemic presence, public health policy entrepreneurs realized the need to pursue the establishment of a dedicated reform venue in order to successfully reach and influence policymakers; a strategy of venue creation (Mavrikou 2021). As such, they followed a fundamentally different advocacy approach, steering away from formal policymaking channels and administrative instruments and instead pursuing the establishment of a distinct policy entrepreneurial identity within the policy community. Although they functioned less as an organized collective and more as tacitly like-minded agents, they exhibited common tendencies in "highlighting the distinction of public health and hospital care in the public and the policy dialogue and reiterating the idea of an unrecognized system of public health services, extending the health sector" (interview with public health specialist and member of reform design committees). When a suitable window of opportunity would arise, policy entrepreneurs for public health

aimed to be in a position credibly claim the creation of a dedicated venue for public health reform.

The Politics Stream: Powerful Organized Interests, Turnover in the Ministry of Health and Governance Modernization

In Greek health policy, the establishment of the GNHS in 1983 generated short-term ideological polarization, but its consolidation drove long-term ideological convergence. Viewed as a flagship initiative of the PASOK Government, the system of public hospital services was contested by the right-wing leading opposition party of New Democracy, "with prominent party members promising its abolishment if a change in government was to occur" (interview with health economics expert and former medicines organization director). However, fearing the political cost of doing away with free healthcare, New Democracy withdrew its reactionary agenda once in power and consolidated the GNHS with Bill 2071/1992. Ever since, both major parties exhibited commonality in preferences vis á vis health policy, opting to accept the structural blocks of the established policy paradigm and to diverge only in organizational and administrative matters. As such, "reforms would usually re-legislate previously unimplemented provisions with marginal differences in their proposed implementation trajectories" (interview with MoH staffer). Bills would mostly serve political and re-election considerations as "Greece is a country where reforms are named after ministers; a minister who does not deliver a reform, even if change is minimal, is politically stigmatized" (interview with former Minister of Health).

While the impact of government turnovers was decreasing, as ideological variance faded away, interest group influence persistently grew. Overtime, among organized interests, hospital doctors and insurance funds turned out to be most successful in enabling and blocking the adoption of reforms. Hospital doctors served as a powerful ally to the PASOK government in the 1983 GNHS founding bill and capitalized on their special status as exclusively subordinate to the MoH. Being the cornerstone of the GNHS, "they developed the ability to veto unfavourable proposals from the agenda-setting stage and were highly supportive of policy entrepreneurship promoting the preservation of the status quo" (interview with health policy advisor and doctors' association representative). Insurance funds, having maintained their independent status "despite provisions for unification in early drafts of bill 1397/1983", used their interconnectedness with business and workers interests beyond the health sector to block their organizational or institutional reformation (interview with management expert and former MoH policy advisor). In the year 2000, intentions to establish a universal health payer by Minister of Health Alekos

Papadopoulos caused his resignation, as he lost backing by the party leadership which was unwilling to clash with the segmented insurance funds.

In the rigid politics stream, it was the appointment of Papadopoulos's successor, Minister Konstantinos Stefanis, in 2002 that re-instigated momentum for reform. The incumbent PASOK Government, led by Prime Minister Kostas Simitis, had been re-elected two years earlier with a pre-electoral agenda of governance modernization. More than half-way into the four-year government term, "the Prime Minister was feeling pressure to deliver on his ambitious promises with respective legislative output" (interview with former PASOK MP). Although the ideological approach to health policy had remained stable, revitalizing governance through a public health reform arose as a possibility. Meanwhile, in the context of crisis produced by the SARS-Cov-1 epidemic and the residual turmoil from Papadopoulos's resignation, Minister Stefanis felt added pressure to deliver a marquee legislation. Shortly after his appointment, the Minister declared in the EU Council of Health Ministers, during the Greek Presidency, that "the pandemic should not be the cause to exercise public health policymaking but be a reminder of the ever-present state responsibility for public health" (European Parliament, 2003).

Bill 3172/2003: Policy Change for Public Health

The developments in the politics stream and the multitude of public health problems in the problem stream produced a suitable window of opportunity for policy entrepreneurs to pursue streams coupling for public health. Nevertheless, the sector's idiosyncratic policymaking process – centralized, and dependent on temporary policy venues – and the well-consolidated policy paradigm continued posing formidable impediments. Ultimately, the shift in the strategy of public health policy entrepreneurs since the mid-1990s proved instrumental in navigating the previously insurmountable obstacles. Both the vision for public health as a field and a system of services extending the health sector and the decision to not meddle with the organization of insurance funds decreased potential conflicts with powerful organized interests. Meanwhile, the adoption of the holistic perspective and the emphasis on coordinating established but disconnected services – to satisfy technical feasibility and resource adequacy – rendered the proposed policy alternatives compatible with demands for governance modernization. Recognizing the prevailing political winds, policy entrepreneurs for public health explicitly promoted the establishment of a public health policymaking framework as a governance response to a multifaceted crisis – the SARS-Cov-1 epidemic – and a legacy reform for Greece's upcoming hosting in the Olympic Games in 2004. Therefore, we confirm H1.

In 2003, policy entrepreneurship for public health succeeded, as a dedicated committee for reform was set up under the supervision of Minister Stefanis and was populated exclusively by public health advocates. Urgency and the avoidance of friction with the established status quo allowed the uncontested drafting, submission and adoption of the reform. Bill 3172/2003, the first public health legislation in Greece's modern history, formally recognized that the exercise of all public policy can impact the population's quality of health, instituted an independent and intersectoral system of public health services with distinct aims and functions and provisioned the dynamic readjustment of intended outcomes based on new evidence inputs.

2003–2022: Re-evaluating the Policy Paradigm

Nearly two decades after disruptive policy change in agenda-setting and policy adoption, Greece came face to face with another major public health crisis, the Covid-19 pandemic. Extending our MSF analysis to the country's strategic response to the Covid-19 outbreak, we assess the implementation trajectory of Bill 3172/2003, evaluate whether couplings were maintained, and explain how pervasive but unaddressed contextual idiosyncrasies of the design stage prove instrumental for the entrenchment of the new policy paradigm. To do this, we focus on the following three components: participation, which includes elements of the policy and the politics stream, monitoring, which encapsulates the dynamics of the problem stream, and the interplay between holistic public health delivery and medicine-centric care, which illuminates the overarching policy outlook.

Participation

Faced "with a threat policymakers and experts alike knew very little about but which inherently called for evidence-informed responses" (interview with doctor and Rector of the National and Kapodistrian University of Athens), Greece was provisioned to manage the pandemic through a system of consistent inputs, scientific processing, and informed outputs. Between 2003 and 2005 (when Bill 3370/2005 complemented Bill 3172/2003), three instruments with dedicated expertise in public health were established: the National Council for Public Health (NCPH), provisioned to serve as the chief scientific advisory instrument, the General Secretariat for Public Health, provisioned to serve as a hub of administrative public health expertise within the MoH, and the Centre for Disease Control and Prevention (KEELPNO), provisioned to contribute to the management of infectious and non-infectious diseases. Nevertheless, shortly after the Covid-19 outbreak reached Europe in February 2020, an 11-member National Committee for the Protection of

Public Health against Covid-19 was succeeded by a 26-man Committee for the Response to Emergency Public Health Threats from Infectious Causes, which was in turn complemented by a 10-member Committee for the Coordination and Monitoring of Governmental Policymaking. Much like before, with the adoption of Bill 3172/2003, the Greek approach showed reliance on ad hoc instruments.

The chief public health authority, the National Public Health Organization (NPHO) – a rebranded version of KEELPNO – was attributed a mostly administrative role, focusing on the registering of cases and the dissemination of guidelines and recommendations. When asked to evaluate its contribution to the management of Covid-19, stakeholders in Greek public health policy ranked it below interventions of extraordinary nature (such as the social distancing measures) as well as hospital units' transformations, with a mean score of 7.21 out of 10 (Figure 7.3). "The NHPO performed beyond expectations but that was because of transparency and executive consistency; not because of showing leadership as equivalent authorities did in, for example, Scandinavian countries" (interview with epidemiologist and MoH advisor during the SARS-Cov-1 epidemic).

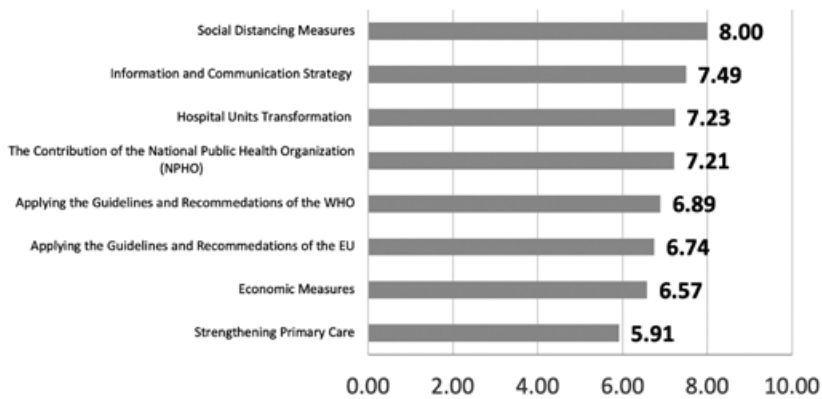

Figure 7.3 *Contribution of interventions to the management of Covid-19 (average evaluation)*

Moreover, the first pandemic-driven legislative revision, introduced in March 2020 (Bill 4675/2020), abolished the NCPH and replaced it with a Committee of Public Health Experts, which "is yet to report any work" (interview with former health authorities' director). Despite having been introduced as "an advisory instrument of the highest ranking in public health matters, reporting directly to the MoH, the Council never received serious political atten-

tion, becoming progressively more and more marginalized". "When I was appointed NCPH President, I asked for a team of staff to run a study on the determinants of health. I was presented with a couple of unqualified political appointees who had just graduated high school" (interviews with two former NCPH presidents).

Ultimately, the development of a decentralized system with meaningful specialized public health instruments was hindered by the same policymaking tendencies which marginalized public health considerations in the decades before the adoption of Bill 3172/2003. Politicization remained the norm. The staffing of all newly established public health bodies and authorities was subject to political appointments, "which were not always meritocratic" (interview with health economics expert and former hospital manager). As a result, long-term policy advocacy was rendered impossible. In the short-run, changes in government were accompanied by the drafting of various "Action Plans" for public health, often in cooperation with the WHO, but these were rarely acted upon. "There were pandemic response plans produced both between 2008–2010 (under a PASOK administration) and between 2014–2019 (under the left-wing SYRIZA administration). Nevertheless, facing the Covid-19 pandemic, the New Democracy administration did not rely on any of them because provisioned preparatory work had not been carried through and because they were drafted by opposition parties" (interview with communications expert and former coordinator of Public Health Action Plans).

Last, while permanent instruments were marginalized, temporary venues continued being favored to meet policy demands – as confirmed by the numerous Committees leading decision-making during the Covid-19 response. When asked about resources which most contribute to the exercise of public health policy, 64.37 percent of stakeholders selected scientific justification and research as essential while only 19.16 percent selected quantifiable aims (Figure 7.4). In a regime which inherently promotes the legitimation of politically-influenced decisions rather than the evidence-informed pursuit of public health outcomes, value acceptability is favored over technical feasibility for the survival of policy programs.

Monitoring and Managing the Quality of Health

In the Greek public health policy framework, complementing inclusive and scientifically-informed policymaking was to be the consistent monitoring of quality of health indicators to address emerging challenges and correct the trajectory of implementation if outcomes did not align with the intended goals. As such, at the start of the Covid-19 pandemic, the timely and accurate registering of cases was defined as a top priority for Greece. "The government intended to stay on top of the disease's development and contain clusters of infections

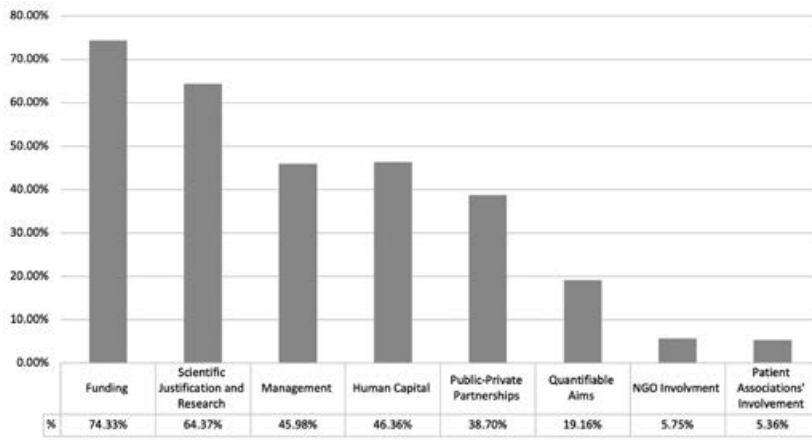

Figure 7.4 Resources contributing to better public health policymaking

before they mass-spread" (interview with member of the Covid-19 Specialists Committee). Faced with the pressures of a rapidly spreading disease, alarming deficiencies in monitoring infrastructure shortly came to light.

Despite the presence of dedicated instruments for epidemiological surveillance, Greece never established comprehensive disease registries. First, in the absence of primary care gatekeepers, "disease cases were only registered if patients were hospitalized" (interview with doctor and former hospital manager). Second, without self-reporting mechanisms and universal access to patient files, no aggregate data could be processed and comorbidities remained unassessed. Third, Regional Health Authorities – eventually set up in 2001 after two decades of re-legislation – were assigned to supervise and manage unreasonably large territories, with limited executive power. "The Sixth Regional Health Authority is managed only by a chief administrator and two deputies and covers [an area of] nearly one-fourth of the country" (interview with former Minister of Health). Facing a pandemic, Regional Health Authorities could not hire additional personnel to meet demands while "Regional Health Labs had been locked up for years due to lack of staffing and equipment" (interview with former Regional Health Council President). Last, KEELPNO's loss of credibility and eventual abolishment once again undermined institutional continuity. Ultimately, the same drivers that did not allow the mobilization of policymakers' attention to public health problems before the voting of Bill 3172/2003 – i.e., the lack of feedback and monitoring mechanisms – also prevented the new institutional framework from addressing emerging needs.

As a result, contact-tracing infrastructure for Covid-19 had to be built from scratch. Over time, a cases and vaccinations registry, connected to a digital prescription system and digitized patient records, was developed. However, emergency solutions during conditions of crisis rarely address widescale policy failures (Mahoney and Thelen 2010). Covid-19 monitoring was assigned to the Ministry of Civil Protection, with the government seeking to capitalize on administrative expertise. Ultimately, without decentralized monitoring instruments, it became a common sighting for "Deputy Minister of Civil Protection Kostas Hardalias and Infectious Diseases Specialist Sotiris Tsiodras to jump on helicopters so to assess rises in cases in rural areas" (interview with former health authorities' director).

"Expectedly, after the first lockdown was lifted in May 2020, Greece persistently struggled to contain local and regional outbreaks in their early stages" (interview with member of the Covid-19 Specialists Committee). By November 2020, a University of Athens initiative for the testing of water to monitor the concentration of infections had emerged as the most successful surveillance mechanism.

Submitting their evaluations to our survey in the midst of the first two waves of the Covid-19 pandemic, stakeholders in Greek public health policy ranked the monitoring and measuring of the population's quality of health with 4.54 out of 10, less than the middle evaluation value of 5. Moreover, all other systemic functions regarding threats and needs assessments were ranked among the least fulfilled in the current operation of the Greek public health system. The containment of health inequalities and the assessing of socio-economic determinants was ranked with 4.12, the measuring and improving of health services effectiveness with 4.14 and the setting of aims for the population's quality of health with 4.23 (Figure 7.5). The aggregate stakeholder insights show consensus admittance that long-standing problems which the 2003 public policy framework was designed to address remain prevalent – most prominently, health inequalities – and that the Greek public health system has failed in most aspects of health indicator surveillance.

Complementing these findings, a 2020 NPHO report further stressed that "in Greece, data, apart from being inadequate – and often outdated –, they are also difficult to process, compare with other inputs, and be used to inform interventions". Meanwhile, chronic diseases – especially ischemic heart disease, lung cancer and diabetes – largely linked to unhealthy lifestyles and delayed diagnoses, remain drivers of alarming rates of early mortality (Vollset et al. 2017). All in all, public health problems are now increasing, fact which the pandemic has helped to amplify.

Figure 7.5 *Degree of fulfilment of public health policymaking aims (average evaluation)*

Holistic Approach to Health or Still a Medicine-Centric Paradigm?

Extending problem recognition and policy participation, the outbreak of the Covid-19 pandemic further exposed the balance of priorities in Greek health policy vis-á-vis public health. This last element is crucial in the study of coupling persistence, as it lies beyond the structural features of the policymaking process. Rather, it captures whether the principles and ideas underpinning change have successfully shifted the perspective of the policy community and the goals of future policymaking. In a sector that was dominated for over two decades by a strong medicine-centric orientation, the entrenchment of the holistic approach to health when dealing with public health matters is essential for policy change to be defined as successful.

At the start of the Covid-19 pandemic, "making sure the GNHS would not collapse was our primary aim" (interview with Prime Minister Kyriakos Mitsotakis). Immediately after the Committee for the Response to Emergency Public Health Threats from Infectious Causes was set up as the chief policy advisory instrument, "it was branded as a Committee of Infectious Disease Specialists by many experts, politicians and the public" (interview with former Minister of Health). Among the Committee's members, half specialized in infectious diseases, most were professors of medicine, a few specialized in

epidemiology and none in public health. Especially in the early stages of the pandemic response, the priorities of Greek policymaking were predominantly oriented towards the sustainability of the hospital sector and relied on the guidance of medical experts (Zahariadis and Karokis-Mavrikos 2022). Governance reflexes pointed to the absence of a holistic perspective, in stark contrast with the policy paradigm which Bill 3172/2003 sought to introduce.

According to the WHO, and as quoted in all Greek Health Action Plans since 2016, "health in Greece is hospital-centric, as it prioritizes therapy over prevention. There is no referrals system, and, in practice, there is no network of public health services" (WHO 2016). Among Greek public health policy stakeholders, as shown in our survey responses, the nature of public health remains most closely associated with traditional, care-oriented fields, specifically prevention (selected by 73.18 percent), hospital care (selected by 56.70 percent) and primary care (selected by 42.53 percent). On the contrary, only 36.02 percent of participants in the Greek public health policy community consider the evaluation of health needs and only 34.48 percent consider the containment and elimination of health threats as crucial descriptors of the nature of public health (Figure 7.6). Importantly, these latter two are listed as the defining features of public health policymaking in the Greek legislative framework.

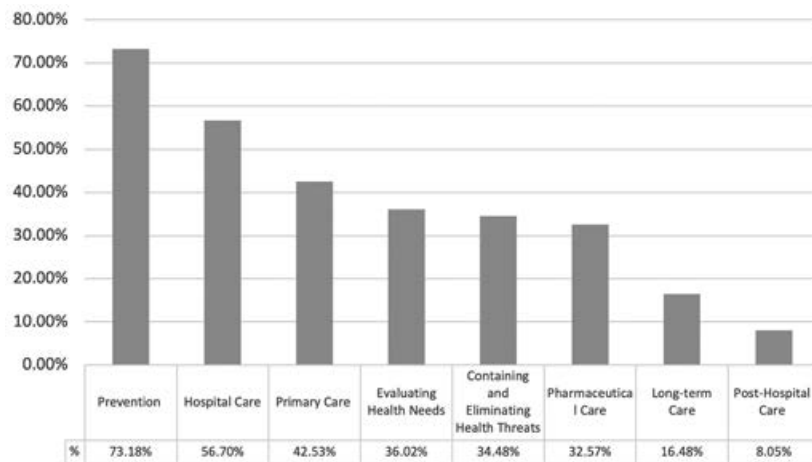

Figure 7.6 Fields which best describe the nature of public health

Moreover, when asked to select essential scientific fields aiding public health policymaking, the majority of stakeholders pick medicine (85.06 percent), epidemiology (82.38 percent) and health economics (49.04 percent) as their top options. Statistics, linked to monitoring and the pursuit of measurable

systemic outcomes are selected by only 37.16 percent of respondents while communications, social and political sciences, connected to the holistic perspective to health, are selected by 12.26, 9.58 and 7.65 percent of stakeholders respectively (Figure 7.7).

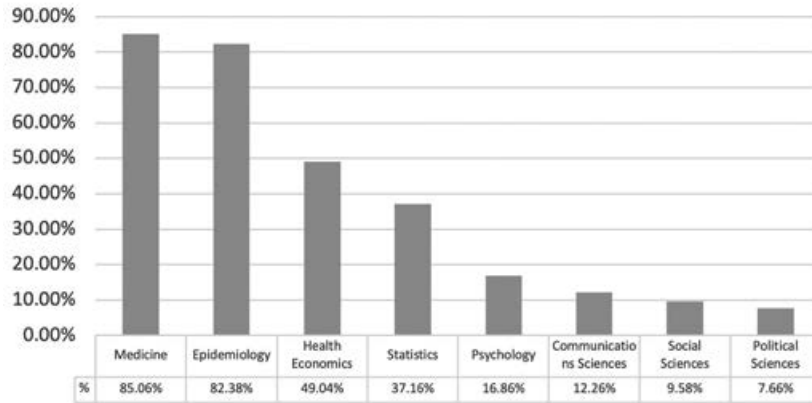

Figure 7.7 Scientific fields which can best support public health policymaking

On the aggregate, there is consensus admittance among Greek public health policy stakeholders that the current functioning of the Greek public health system does not serve the holistic approach to health. In a dedicated question, 68 percent of respondents evaluated the degree to which the holistic approach is promoted with scores from 0 to 5 out of 10 and only 2 out of the 261 participants gave perfect or near-perfect evaluations of 9 and 10 (Figure 7.8).

Following the passing of Bill 3172/2003, entrepreneurship for public health was not followed through with the development of organized public health lobbying or the institutionalization of public health expertise. The persistence of politicization, implementation gaps and public administration turnovers deprived public health policy entrepreneurs from venues to maintain momentum and continue steering policy outcomes in times of normalcy. Meanwhile, the governance outlook attributed to the 2003 reform impacted its legacy, disassociating it from the health sector's policy progression. As a result, within the Greek health policy community, the dominant perspective to the goals and means of the policy paradigm did not shift in accordance with the new public health principles. As shown by the aggregate insights of our survey, public health policy stakeholders still maintain a care-centric orientation and agree

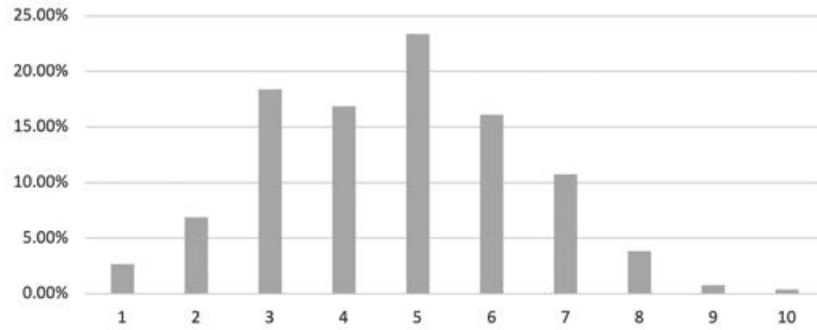

Figure 7.8 *Degree to which the Greek public health system serves the holistic approach to health*

that the current functioning of the Greek public health system is not in accordance with the holistic approach to health.

> The truth is that bill 3172/2003 passed through parliament without much deliberation but, unfortunately, it also did not have the greatest impact. It should be mentioned that the legislative content is impressive, but the provisions fail to develop an implementation map, which curtails their momentum. If you read the bill carefully, it describes epidemiological monitoring strategies, policy programs for the documentation of health needs, combatting inequalities etc. However, what was lacking was interventions to the public policymaking process which would allow such aims to be fulfilled by public policies" (interview with public health expert and MoH policy advisor).

CONCLUSIONS AND DISCUSSION

Innovative bills do not always renovate policymaking as the scope of change is contained during implementation. To understand why, we have concluded, focus may need to be shifted to structural features of the policymaking process, which manifest in the design stage and prove pervasive throughout. Our longitudinal process tracing application of the MSF to Greek public health policymaking uncovered the driving forces behind the passing of the first dedicated public health Bill in Greece's modern history in 2003 after two decades of resistance and the causes of streams decoupling since.

The agenda-setting phase of Greece's marquee public health reform – Bill 3172/2003 – was defined by repeated failures in policy advocacy as ideas struggled both to break through and to reach policymakers. In the policy stream, the legacy of the country's NHS-founding Bill proved pervasive. Intense politicization, implementation gaps and the absence of expertise beyond medicine produced a highly homogeneous policy community with

a clear hospital-centric orientation. In the politics stream, ideological convergence between major parties and the high infiltration of policymaking outcomes by organized interests – most prominently specialist doctors and insurance funds – contributed to the preservation of the status quo. In the absence of a public health policy framework, public health problems, such as rises in infectious diseases and health services inequalities, faced a cumulative building up but struggled to mobilize attention. The undermining of administrative instruments neutralized the impact of policy feedback and indicator monitoring as mechanisms bringing issues to light. Ultimately, policy entrepreneurship to promote a public health outlook within the NHS fell victim to the absence of institutional venues as the true locus of policymaking lay beyond formal policymaking channels. Administrative turnovers – and more rarely crises – triggered the opening of windows, led to the establishment of ad hoc policy design instruments, and produced bills which would re-legislate previously unimplemented provisions.

Policy entrepreneurs for public health, driven by systemic experience and external influxes of ideas, revisited their strategy since the late 1990s. First, they identified the need to pursue advocacy through venue creation and second, they embraced the holistic perspective to public health, speaking of a system of services which would extend the health sector. In 2003, the SARS-Cov-1 epidemic coincided with a tumultuous resignation in the MoH leadership and pressures in the political stream for the PASOK Government to act on its modernization agenda. Having built a distinct identity as public health experts and strategically aligning their pet proposals with a governance reformation, policy entrepreneurs succeeded in populating a dedicated design committee for public health reform. The adoption of Bill 3172/2003 introduced the holistic perspective to public health in Greek policymaking, however, despite establishing a new system of services and new policy goals, it did not address the policy process pathogenies which had impeded change since the 1980s.

As a result, the new policy paradigm failed to be entrenched and stream decoupling ensued. The Covid-19 pandemic brought to light that Greek public health policymaking remains rudimentary in terms of institutions and resources, underdeveloped in terms of function and marginalized in terms of policy priorities. Our analysis of the implementation trajectory for Bill 3172/2003 confirmed H2, that "resisting forces in the policy and politics stream which persistently impeded the establishment of a public health system have developed into drivers of decoupling during implementation". More importantly, we were able to uncover the mechanisms driving this process and identify that all of them connect to contextual features which defined policy design.

First, politicization and implementation gaps re-emerged, only this time extending to the new public health instruments. Both plagued policy continu-

ity, minimized recurring public health debate and stagnated the generation of new ideas in the primeval soup. Moreover, they had an indirect impact on the problem stream as they maintained the limited contribution of policy feedback and indicator monitoring in bringing problems to light. The Covid-19 pandemic, a focusing event, was the first time public health came to the epicenter of governmental attention since the 2003 reform. Second, the perpetuation of venue creation and interest group infiltration allowed the containment of the magnitude of policy change even after the reform had been introduced. The same set of stakeholders that had opposed public health policymaking in the past were allowed continued involvement in future policy decisions, while governments could once again operate with limited checks and balances. The resorting to multiple ad hoc committees, populated predominantly by medical specialists during the Covid-19 response epitomizes the institutionalization of this idiosyncratic practice. Last, propagated by the aforementioned developments, the non-emergence of consistent public health entrepreneurship did not allow the policy community to embrace the new outlook; the holistic perspective to health. As highlighted by our survey, Greek public health stakeholders still view public health through a care-centric lens. The governance angle attributed to the 2003 reform, although perhaps essential for its passing, was detrimental to its legacy. To this day, in the eyes of most, it has not been viewed as a structural disruption to the trajectory of Greek health policy.

The conclusions have the potential to instigate future research agendas for the MSF. First, applications of the framework in contexts of institutional instability – with fluidity, politicization and public administration undermining – can corroborate conclusions on the marginalization of policy feedback and indicator monitoring as problem stream mechanisms as well as on venue creation as an essential policy entrepreneurship strategy. Second, future research is also encouraged to explore further the linkages between design and implementation for the persistence of streams couplings. Across contexts, addressing institutionalized patterns of problem recognition, policy participation and interest accommodation which impede change are perhaps essential prerequisites for reforms to produce paradigmatic shifts, no matter how ambitious the new means and goals of policy programs are. If such mechanisms become systematically evaluated across case studies, the framework's capacity in better assessing the dynamic phenomenon of policy change could be enhanced greatly.

NOTE

1. Both the interviews and the survey were conducted between 15.07.2020 and 13.12.2020.

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