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The strategy of venue creation: Explaining health policy change in Greece

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Abstract

How do policy entrepreneurs affect policy change in environments of institutional instability? The literature has predominantly explored policy entrepreneur strategizing in contexts with established institutional settings. In this paper, we argue that under conditions of institutional fluidity and a weak and politicized public administration, venue creation is the more frequently encountered and the more likely successful strategy. We define venue creation as the entrepreneurial strategy of setting-up institutional arrangements of finite duration, predominantly in the form of committees, delegated exclusively with designing reforms. We test our hypothesis in the Greek health policy sector. We explore two policy instances: the unsuccessful attempt at a public health reform in 1992 and the successful introduction of radical policy change for public health in 2003. We employ a process tracing approach spanning thirty years, processing primary data (elite interviews and documents) applying the Multiple Streams Framework (MSF). We find that under conditions of institutional fluidity and administrative weakness, policy entrepreneurs failed in their pursuit of change using venue shopping in 1992 but succeeded through venue creation in 2003, confirming our hypothesis. We conclude with insights for contingent policy entrepreneurship success, the MSF and patterns of policymaking in Greece.

Keywords

policy entrepreneurs, policy change, Multiple Streams Framework, public health, Greece

Introduction

How do policy entrepreneurs affect policy change? The voluminous amount of literature on the impact of policy entrepreneurs (Frisch-Aviram et al., 2018; Mintrom, 2019) maintains that they employ several tools to help to bring about policy change. Featuring prominently are strategies: persuading, networking, framing, brokering, and advocating. Using the case of Greek public health policy and embedding our argument within the Multiple Streams Framework (MSF), we argue that the effects of strategy are contingent, depending on policy venue creation and institutional attributes. Under conditions of institutional fluidity and a weak and politicized public administration, policy entrepreneurs will be more successful in influencing policy change when they pursue the strategy of venue creation. The literature assumes that the aim of policy entrepreneurs is to navigate between favorable and unfavorable institutional venues (Pralle, 2003; Baumgartner & Jones, 1993). Instead, we claim that, in some instances, venue creation is more frequently encountered and is likely to be a more successful strategy because it enables well-connected policy entrepreneurs to steer the process more directly toward desired outcomes.

We examine two cases: the unsuccessful attempts at reforming a highly centralized and ineffective Greek health system in 1992 and the successful public health reform of 2003. We chose health policy because it represents a fundamentally important sector, from budgetary and quality-of-life perspectives, with significant interrelations to other sectors. While no one policy sector represents the entire policy process, innovations and changes in healthcare send signals to be studied in other policy sectors as well (Kingdon, 1984). We chose Greece because it is a country of perennial resistance to policy change (Kazakos, 2005). Its health policy community includes a relatively stable number of stakeholders: doctors, private healthcare and insurance providers and the pharma industry (Sisouras, 2012). We chose cases before 2010 because the decade under IMF supervision, from 2010 until 2020, imposed a prolonged intermission from policymaking normality under a regime of external policy conditionality (Spanou, 2020). Hence, to highlight contextually driven entrepreneurial strategizing, one should research major policy developments before 2010.

The article first examines the literature on policy entrepreneurial strategies. We ascertain that studies are predicated on the assumption of institutional stability and that they seek to advance insights by focusing on more fluid contexts. Next, we situate our argument within the MSF and argue that, in cases of weak and politicized bureaucracy and institutional fluidity, the option that is more likely to be successful is venue creation. This involves creating new policy venues with characteristics shaped by policy entrepreneurs. These types of venues are used to install entrepreneurs at the core of the policy process and therefore help to determine the eventual outcome. We then empirically probe the argument by examining two Greek attempts at policy change, 1992's unsuccessful attempt and 2003's successful public health reform. We conclude with implications for arguments of entrepreneurial strategic success, the MSF, and public health policy reforms.

Strategies of Policy Entrepreneurs

Policy entrepreneurs are individuals "inside (...) or outside government, but not just looking in" who seek to capitalize on the ambiguity of policymaking and to influence policy outcomes (Kingdon, 1984). They are defined by their willingness and commitment to invest their limited resources in policy advocacy through patterns of strategic action (Herweg, Zahariadis & Zohlnhöfer, 2018). Most of the literature focuses on features of agency and follows an attrib-

utes-skills-strategies logic to illuminate the mechanisms through which policy entrepreneurs influence public policy outcomes (Arnold, 2020; Mintrom, 2019). We focus on strategies because they help to shape the eventual outcome and we show that even the widely used strategy of venue shopping supposes the existence of a menu of venues from which to choose.

Research has produced a collection of policy entrepreneur strategies, which we distil here in five categories. *Using and expanding networks* has been shown to facilitate both the origination, and the communication, of ideas for policy change. Operating in cross-jurisdictional networks facilitates developing and extending the appeal of alternatives to like-minded actors through interactions with "outsiders" to the policy subsystem (Mintrom & Vergari, 1998). Moreover, as change is rarely conditional on the interests of a single policymaker, or the institutional authority of a single venue, working inside networks enables policy entrepreneurs to gain access progressively to key stakeholders, to forge alliances, and to wear down resistance to change (Béland & Katapally, 2018)

Sub-sets of this category include *working with advocacy coalitions* and *narrative building*. Mobilizing like-minded stakeholders is the key to success (Sabatier, 1988). As long as policy entrepreneurs are able to frame and articulate the preferences of actor coalitions in their policy proposals, they can mobilize a dynamic shift to the prevailing beliefs within policy subsystems, generating large support for policy change (Shin & Lim, 2020; Mintrom & Vergari, 1996). In cases where policy entrepreneurs argue on behalf of coalitions exhibiting some degree of organization, *narrative building* strategies may be employed, portraying how the suppression of the non-dominant coalition's beliefs have deprived the subsystem of an effective policymaking trajectory (Cartwright, 2017).

Policy entrepreneurs may also *collaborate through entrepreneurial coalition-building*. Although, in early MSF accounts, policy entrepreneurship was predominantly viewed as an individual activity (Kingdon, 1984), scholarship has since shown that policy change is often promoted by "teams and not just one heroic, lonely individual" (Petridou, 2014). Collective entrepreneurship usually comes about when entrepreneurs lack political capital and/or resources (Tang, Cheng & Cai, 2020) and seek collaboration with like-minded entrepreneurs for increased access and influence (Cohen, 2016). Particularly in conflictual policy settings, collective entrepreneurship has been found to contribute to "organizing out" and neutralizing opposition (Johannesson & Qvist, 2020).

Problem framing is another widely identified strategy in the literature. Policy change often demands installing "a new and unfamiliar" way of thinking about problems (Turner, Alabi & Race, 2020). Therefore, strategically using evidence to construct frames around salient issues may be integral to fostering acceptance of a policy proposal (Petridou & Mintrom, 2021; Mintrom & Luetjens, 2017). The strategy of problem framing is often associated with *venue shopping* and *venue shifting* (Baumgartner & Jones, 1993). These strategies enable the establishment of new policy images: new perspectives to the problems facing a sector and new understandings of available policy options. Strategic success for policy entrepreneurs is conditional on identifying the most accepting and influential venue within the subsystem to promote a new policy image (venue shopping), or identifying an appropriate venue outside the subsystem, through which they can extend or redefine the nature of the problem (venue shifting) (Baumgartner & Jones 1993).

The strategic use of policy space is not limited to venues, however. Particularly in cases of policy initiatives that span jurisdictions, policy entrepreneurs may try to *scale up the change process*, starting with those jurisdictions that pose the least resistance to change and gradually

accumulating pressures to expand (Mintrom, 2019; Mintrom & Luetjens, 2017). Furthermore, in promoting the technical feasibility of policy alternatives (Kingdon, 1984), policy entrepreneurs may engage in strategies of *leading by example*. Entrepreneurs who operate in formal political or administrative roles can opt to lay the foundational work for a large-scale reform, or to introduce elements in a pilot format so as to build up credibility (Petridou & Mintrom, 2021; Bakir & Gunduz, 2020; Cohen, 2012).

Most accounts of policy entrepreneurs' strategic success favour agency over context-driven causal explanations (Petridou & Mintrom, 2021; Bakir & Jarvis, 2017) and assume some degree of institutional stability. *Scaling up* and *leading by example* strategies revolve around building acceptance inside the established institutional setting; meanwhile, *using* and *expanding networks* and *collaborative entrepreneurial coalition-building* aim to penetrate the policymaking space to reach influential stakeholders. Finally, *problem framing* and accompanying venue alternatives (*venue shopping* and *venue creation*) rely on the relative influence of formal venues on policymaking outcomes. Our argument differs in perspective; we focus on a single strategy – venue creation – exploring policy entrepreneurial action under conditions of institutional instability and arguing that strategic success is contingent and context-driven.

Policy Entrepreneurs and the Multiple Streams Framework

Most of the insights on policy entrepreneurship have been generated through applications of public policymaking frameworks to the study of policy change (Petridou & Mintrom, 2021). Policy entrepreneurs, as agents driving policy innovation, operate within meso- and macro-level contexts, where outcomes are determined through the interplay between ideas, interests, and institutions (Hall, 1993). Therefore, placing the study of policy entrepreneurial action within the broader dynamics of policy change provides the requisite context for exploring the enabling conditions of successful strategizing.

We opt to situate our argument within the MSF. Having been the framework through which the notion of policy entrepreneurship was introduced (Kingdon, 1984), the MSF has guided most of the subsequent theorizing on the strategic success of policy entrepreneurs (Béland & Howlett, 2016; Jones et al., 2016). The framework minimizes institutional bias in assumptions because it operationalizes institutions only implicitly (Cairney & Heikkila, 2014; but see Zahariadis, 2016). Compared with the other major policy change paradigms, the MSF lies closest to the epistemological character of chaos and complexity theories, which capture our notion of fluidity (Capano, 2009). Meanwhile, it diverges from the traditional assumptions of uncertainty dominating policymaking (a condition that can be mitigated by boundedly rational policymakers obtaining greater information) and instead is founded on ambiguity, an inherently unmitigable condition, where the instability of preferences continuously renders policymaking outcomes unpredictable (Herweg, Zahariadis & Zohlnhöfer, 2018). As a result, the MSF is best-fitted to navigate the context of institutional fluidity that the analysis explores.

The MSF analyzes public policy change through five structural elements: three independent and ever-flowing streams (problem, policy, and politics), policy entrepreneurs, and policy windows. Using a single central hypothesis, the framework ultimately proposes that policy outcomes are the result of policy entrepreneurs capitalizing on (mostly) randomly occurring policy windows to couple the three streams through strategic action (Kingdon, 1984).

Each of the five structural elements is shaped by a set of independent variables. The *problem stream* includes the mobilizing mechanisms that enable certain "non-ideal" social conditions to reach the attention of policymakers (Herweg, Huß & Zohlnhöfer, 2015). These include policy

feedback, changes in regularly monitored indicators, and focusing events (i.e., crises, symbols, and personal experiences of policymakers). Problem definition occurs through solutions developed in the policy stream, as the MSF maintains that "solutions chase problems" (Kingdon, 1984). The *policy stream* consists of all ideas that policy entrepreneurs communicate over time. Only a few of these are developed into policy alternatives, having undergone some "softening up" to satisfy three "survival conditions": value acceptability, technical feasibility, and resource adequacy (Kingdon, 1984). Scholars have argued that more integrated policy communities tend to require more softening up for alternatives to enter the agenda, but typically demand less deliberation during decision-making than less integrated ones (Zahariadis, 2014). Finally, the *politics stream* captures the required political determination to proceed with policy change. Variables in the stream include the national mood, pressure group campaigns, and administrative or legislative turnover, with each offering prospects for vetoing or facilitating policy initiatives.

Policy windows are (mostly) random occurrences that allow policy entrepreneurs to couple the three streams through effective strategic action. They open either in the problem or the politics stream when developments in a variable prove to be disproportionately impactful (Herweg, Zahariadis & Zohlnhöfer, 2018). *Policy entrepreneurs* have a dual role in the MSF; they turn ideas into "pet" policy proposals through the mechanisms identified in the policy stream and engage in strategic action (as elaborated in the previous section) to induce stream couplings and produce policy change (Kingdon, 1984).

The Strategy of Venue Creation

The key to explaining policy change is to specify the coupling process and how the various elements interact with one another during open policy windows. An important piece of the puzzle is the strategy used to succeed in effecting change. We focus on this aspect and on one particular strategy: venue creation. We define venue creation as the entrepreneurial strategy of setting up institutional arrangements of finite duration, predominantly in the form of committees, delegated exclusively with designing reforms. Venue creation is a novel concept in the literature, akin to venue shopping but also preceding it. Venue shopping, which is the more established concept, assumes that there is a menu of venues from which policy entrepreneurs choose the one most favorable to their pet project. Because venues incorporate institutional rules, choosing one venue over another explicitly involves choosing one set of rules over another. In this particular case, the choice of venue implies that entrepreneurs deliberately choose the "package" containing favorably predisposed decision-makers and audience members and a set of governing rules that increase the chances of the option's appeal. For example, an option proposing budget cuts to hospital care would likely find a different welcome in a budget committee as opposed to a public health committee. The chances of its appeal increase significantly if it were debated in a budget committee. This strategy of venue shopping assumes that there are such committees available in a sort of menu. What if they do not exist, or they do not have the power to propel or bury policy options?

We posit a different strategy that increases the likelihood of success in contexts of institutional instability. We hypothesize that, *in settings of institutional fluidity and weak and politicized public administration, policy entrepreneurs will be more successful in influencing policy change when they pursue the strategy of venue creation*. Our argument takes one step back and assumes different scope conditions. Venue shopping assumes an institutionally stable menu of choice. But in many national settings in (not only) developing countries, institutional stability is the exception, not the norm. For example, in many Latin American countries, institutions affect and

are affected by policymaking instability, leading to constant change (Pereira, Singh & Mueller 2011). The same has happened in Greece (Spanou & Sotiropoulos, 2011). We define institutional instability as frequent change in the formal/informal rules and in the enforcement procedures of governance (Ostrom, 1990). We are not interested in the conditions of instability (e.g., Hall 2015), the mechanisms (e.g., Mahoney & Thelen, 2010), or the relationship between institutional stability and instability (e.g., Thelen, 2012; Lindner, 2003). Instead, we focus on the impact of instability on policy entrepreneurial strategies. We recognize that instability may be inefficient because it increases transaction costs through higher uncertainty (North, 1990), but we argue that it can also facilitate the emergence of a winning policy entrepreneurial strategy through venue creation.

We decompose instability in two dimensions: fluidity and administrative weakness. Institutional fluidity captures the frequent change, while administrative weakness conceptualizes the enforcement component. Both enable a more successful entrepreneurial strategy of venue creation. Institutional fluidity denotes considerable and constant change. There are no agencies with established objectives, or in cases where there are, objectives change based on prevailing political winds. In this case, the process of policymaking takes unexpected turns and may easily meet obstruction, become subject to power asymmetries or be hampered by the cost or uncertainty of expected policy change (Galik & Chelbi, 2021; Capoccia, 2016). Moreover, fluidity produces institutional ambiguity – in other words, overlap between jurisdictions – which tends to create turf battles or oversight. Both conditions are likely to lead to policy paralysis as one agency waits for the other to act, or is politically motivated to exclude the other from any decision. Such conditions favor the creation of new venues. New venues have the benefit of being highly relevant and specific to the problem at hand, as the agencies are established with specific objectives in mind. The new venue is more likely to lead to entrepreneurial success because it is tailor-made for the particular problem and the likely entrepreneur. Any obstacles to change are bypassed by changing the process. Placing the new venue at the center of the process, which is a likely scenario when there is no established policymaking process, facilitates the building of supportive coalitions. In addition, it alters existing policy networks by directing changes in the patterns of interaction and problem frames.

We operationalize administrative weakness as feeble and politicized public administration. The latter goes to the heart of enforcement capacity. Weak and politicized public agencies permit episodic or capricious implementation through corruption or coercion (Rose-Ackerman, 2004). These mechanisms in turn undermine resistance to change. Political opposition to a particular option is muted by being excluded from the process or being bought out by corruption. Because it is a new venue, members may be selected on wholly political criteria. In other words, while fluidity promotes entrepreneurial success through venue creation, administrative weakness undermines opposition to this success. As long as the prevailing political winds dominate the process, a new venue will be likely to increase the chances of entrepreneurial success. It is important to note that the new venue need not only be the outcome of a policymaker seeking to alter the process; it may also be the product of advocacy by a well-connected policy entrepreneur with political support. To sum up, entrepreneurial success through new venues is more likely under conditions of institutional fluidity and weak and politicized public administration.

Case Study and Research Design

Seeking to determine the conditions for successful policy entrepreneurship in environments of institutional instability, we explore policy change for public health in Greece. The country's health system includes stark contradictions. While the number of specialist doctors is sur-

prisingly high – jumping from 2.54 to 6.10 per 1000 of population between 1980 and 2020, almost double the OECD average of 3.5 – general practitioners are few, comprising just 5% of the doctor workforce in 2020 as opposed to an OECD average of 23%. More importantly, the number of hospital beds has been decreasing annually since 1990, standing at 4.18 per 1000 of population in 2019, less than the OECD average of 4.40 (OECD, 2020). At the same time, the policymaking landscape has been defined by persistent resistance to radical change across policy fields (Kazakos, 2005). The Greek health policy sector is populated by a stable and integrated policy community where "experts with multiple roles in different organisations and with close links to political parties" are a common sighting (Spanou, 2008). Crucially, the sector suffers from perennial "implementation gaps" and intense politicization, blurring institutional and administrative continuity (Sotiropoulos, 2004).

We examine two instances of attempted policy change in public health in Greece: one unsuccessful in 1992 and one that was successful in 2003. We rely on primary data to test our hypothesis. Employing the MSF as the guiding framework for both data collection and analysis, we use elite interviews, legislative documents (bills, parliamentary reports, and transcripts of parliamentary deliberation), policy evaluation reports, and unpublished drafts of alternatives shared by interviewees. Semi-structured elite interviews were conducted with 42 stakeholders who had held political or advisory roles in public health policymaking during the period of study. The interviews were conducted between April 2018 and February 2020. Document analysis followed a qualitative template format, with data categorized according to the framework's five structural elements and their respective sub-variables. The analysis presents the two process-tracing accounts and comparatively tests the hypothesis to draw conclusions on contingent policy entrepreneurial success.

Bill 2071/1992: Policy Entrepreneurs and Failure to Induce Change in Public Health

The Politics Stream: Institutional Fluidity and Intense Politicization

To understand the intense politicization and institutional fluidity of the system, we need to understand the legacy of 1983. In that year, the Greek health sector saw a major overhaul of its institutional landscape: "The new setting was founded on two pillars: a leading Ministry of Health (MoH) steering policymaking and a newly established National Health System (NHS) encompassing the operational dimension of health policy" (interview with health policy advisor and former MoH staffer).

Both the new institutional design and the balance of interests strongly reflected the political priorities of the socialist party in power, PASOK. Having won a landslide majority election in 1981, the party entered government with an agenda for radical change. In health, PASOK's renovative approach was expressed through political determination to proceed with instituting the NHS after six years of deliberation (since 1977), introducing publicly funded healthcare. During the policy's design, the government found an invaluable ally with tangible long-term potential in the form of hospital doctors. They had "clear demands for obtaining permanent public employment status" and, in return, were willing to offer their "unconditional support and commitment to the NHS initiative" (interviews with former doctor and hospital manager and former policy advisor and member of reform design committees). Meanwhile, in a hotly debated political choice, the PASOK government opted to maintain the "inefficient system of autonomous national health insurance funds" (interview with health economics expert and former public manager of health authorities). Operating under the supervision of the MoH and

representing different subsets of the Greek population based on occupation, the segmented insurance funds largely determined the level and quality of primary care through variances in their reimbursement. "Unwilling to face the political cost of clashing with powerful interests" and facing intra-party pressures[1], PASOK opted to cater heavily for hospital doctors and to avoid insurance fund unification, shaping the political priorities of health policy and manifesting jurisdictional conflict and ambiguity (interview with specialist doctor and former health policy administrator).

Together with the jurisdictional complexity and the disproportionate power divisions, a culture of intense politicization and undermining of public administration also emerged. The new health policy paradigm was founded on an incremental implementation plan to mitigate the lackluster administrative capacity. However, despite proclamations of "rationality", "willingness to employ best practices", and "a desire to foster multidimensional and targeted future policy design", the policy program ultimately relied on utopian expectations of long-term political commitment (interviews with: management expert and former member of reform design committees; public health expert and former MoH advisor; and primary care expert and former health center manager). The system's designated regional administrative instruments, awaiting necessary legal groundwork for their formal establishment, saw their responsibilities "absorbed by (politically controlled) bodies, most commonly General Secretariats within the Ministry of Health" (interview with former Minister of Health). Politicization further extended to newly established central advisory bodies, such as the Central Council for Health – tasked with producing evidence-informed policy recommendations and with drafting the National Strategy for Health – where all members of the board were subject to political appointment. In a mutually reinforcing loop, the lack of strong and independent administrative instruments increasingly facilitated dominant interest groups in "exerting their control over the system" and reinforcing the "*medicine-centric complex*" (interviews with: health economics expert and former MoH advisor; and specialist doctor and former health authorities' staffer).

In 1990, a change in government saw the right-wing New Democracy party rise to power, creating prospects of a shift in political priorities through legislative turnover. The large ideological distance between the left-socialist PASOK and the right-liberal New Democracy made radical shifts in policy likely across all sectors. Specifically in health, New Democracy had "strongly opposed the public system of health services" (interview with former PASOK MP) in public discourse during the previous decade. At the same time, the establishment of the European Single Market, coinciding with the New Public Health movement, exerted pressure for modernization (Ashton & Seymour, 1988). Nevertheless, the public character of the NHS enjoyed high levels of public acceptance and support, while organized interests were keen to maintain the status quo. Ultimately, the political stream in 1992 was politically ripe for change but public opinion and the balance of interests were not enthusiastic about the prospect.

The Problem Stream

By 1992, the country faced alarmingly poor levels of public health. Declining indicators primarily concerned infectious diseases. Between 1990 and 1991 Greece saw a 560% rise in annual cases of measles, followed by another 250% rise between 1991 and 1992, when 3,448 cases were reported (WHO, 2021). Meanwhile, the country was further affected by the worldwide

1 — The President of the Parliament, Ioannis Alevras, stepped down from his post during parliamentary discussions on bill 1397/1983 and threatened his resignation if insurance fund unification made it to the final bill. The President of the Medical Guild of Athens, Franklinos Papadelis, decided to step down from his post and to participate in the design of the NHS bill through a political position.

disease outbreaks of the time, reporting 800 cases of AIDS between 1987 and 1993 (Abel-Smith et al., 1994). Nevertheless, without established monitoring instruments, focusing events would often replace indicators in bringing alarming epidemiological developments to light. "In the case of tuberculosis, it was the mandatory medical scans for refugees which brought the threat to the surface" (interview with doctor and former health authorities' public manager). Ultimately, rapid spreads in infectious diseases were highlighting "the immense gaps of the state in prevention and coordinated communication" as well as "the lack of integrated care, i.e., the inexistence of institutional interconnectedness between primary care, social medicine, and public health" (interview with primary care specialist and former Health Council president).

At the time, policy feedback was virtually non-existent. Formal instruments tasked with policy evaluation were either under-functioning or awaiting establishment and no external assessments of Greek health policy had taken place. However, focusing events were initiating discourse among the policy community regarding the sector's problems. Unethical practices had become widespread, epitomized by "envelope payments" – i.e., illegal doctor "tips" by patients. The practice highlighted "the absence of checks and balances and the special status doctors had come to enjoy in the Greek NHS" (interview with public health expert and former MoH advisor). Furthermore, "Never-ending queues at hospitals", "people being treated at camp beds", and the rise of private spending on primary care all hinted at a disproportionate and unsustainable over-spending of resources on hospital care without substantive improvements (interview with former staffer at MoH Secretariats).

By the time 1992 rolled around, the problem stream showed that it was time for a change. Numerous stimuli "questioned" the direction of Greek health policy and the lack of public health policymaking.

The Policy Stream

When the first major reform of the Greek health sector was introduced in 1983, public health was "misconceptually equated with a publicly funded system of secondary care services" (interview with public health expert and former member of reform design committees). Despite proclamations of policy learning – with reformists explicitly stating that they tried to "replicate features of the UK NHS" – the absence of public health expertise, the medical orientation of policy advisors, and the high value placed on public hospitals by the socialist government limited the scope of focus for the new system (interview with management expert and former member of reform design committees). Characteristically, "the few public health services the country had inherited from its democratic and authoritarian past – such as hygiene authorities – remained an afterthought during the design of the new system, being temporarily allocated to Prefectures, [which are] administrative bodies with neither public health expertise nor meaningful institutional power" (interview with former Regional Health Council director).

In the run-up to 1992, three competing options for health policy change gained traction. First, the medicine-centric option found support among powerful interests. Favoring what was essentially the status quo were specialist medical doctors, forming the bulk of the Greek NHS, who capitalized on "their expertise", and who "engaged in constant role-switching between political and administrative positions" (interview with former WHO health policy advisor). Second, the liberal option of health reform emerged among the ideological opponents of the socialist left. "Some advocated for the abolition of the publicly funded system as a whole, while others proposed liberalizing private secondary care clinics" (interview with former health authorities' director). Policy entrepreneurs favoring this liberal approach aligned their interests with the New Democracy party. Their frame of ideas was founded on "delimiting the responsi-

bility of the state in protecting and promoting the population's health, extending citizen choice in health services, and promoting healthy individual lifestyles" (interview with community care expert and former MoH policy advisor).

Nevertheless, none of these two options offered a viable solution to the sector's problems as they lacked public health specifics. There was no "defining public health policymaking, identifying the field's institutional components, and establishing mechanisms to foster and maintain a healthy population" (interview with public health expert and former member of reform design committees). Instead, a group of public health policy entrepreneurs pushed a third idea: mitigating the adverse effects of a disproportionate systemic focus on secondary care. "This set of policy entrepreneurs included experts on prevention, primary care, infectious diseases, and management" (interview with former health authorities' director). They advocated "eliminating inequalities in primary care through the unification of insurance funds", proceeding with "decentralization to facilitate integrated care", establishing monitoring mechanisms at the regional and the national level, and promoting prevention over treatment (interview with primary care expert and former local health center manager).

Since the passing of bill 1397/1983, resource adequacy had emerged as the core criterion for ideas surviving within the policy stream. More than merely a recurring problem, the financial sustainability of Greek health policy had developed into a prime political priority for all major parties. Unfortunately, the importance of technical feasibility was trivialized under the illusion of long-term implementation planning. All in all, amidst favorable conditions for reform, alternatives for public health policy change existed within the policy stream, demanding effective strategizing by the advocating entrepreneurs to complete the merging of the streams.

Unsuccessful Strategizing and Policy Failure

After eight years of socialist rule, a conservative party came to power in 1990, opening a policy window in the political stream. At the same time, pressure for policy change had amassed within the problem stream as both the failures of the policy paradigm and the standing deficiencies in public health had surfaced. Policy entrepreneurs had developed proposals to improve public health by promoting prevention through primary care, advocating systemic integration beyond secondary care, and calling for a shift towards a culture of a healthier Greek population. With all the necessary conditions for change in place, reform depended entirely on effective policy advocacy. Ultimately, the strategic efforts of public health policy entrepreneurs faced increasingly insurmountable barriers due to the sector's institutional fluidity with its consequent jurisdictional conflict and lack of powerful administrative instruments.

More specifically, strategic action took the form of venue shopping and scaling up change processes from within, in both an isolated and a collective fashion. First, public health policy entrepreneurs sought to advance policy proposals through central advisory venues, the most prominent being the Central Council for Health. Nevertheless, despite being established as the chief institutional epistemic instrument, responsible for drafting and updating the National Strategy for Health, the Council saw its proposals "rot in the Ministry of Health's drawers" for nearly a decade (interview with former Minister of Health). In 1992, after New Democracy had assumed power, the political administration characterized its status as "a useless, bureaucratic instrument" (Parliament Proceedings, 1992). Second, regional venues provisioned to undertake supervisory responsibilities in primary and public health matters were still awaiting implementation. Despite the willingness of public health policy entrepreneurs to pursue advocacy through the designated policymaking channels of bill 1973/1983, the implementation gaps facing Health Regions and Regional Health Councils enhanced jurisdictional ambiguity

and deprived entrepreneurs of potential allies and favorable institutional venues. Meanwhile, MoH General and Special Secretariats, tasked with temporarily absorbing the responsibilities of unimplemented instruments, maintained a strictly executive role. Intense politicization and frequent personnel turnover did not allow them to develop into venues for mid- and long-term policy design.

Finally, local health centers, "the vanguard of primary care", were left under-supervised, under-funded, and under-staffed (interview with primary care expert). Crucially, being the only established venues with responsibilities for primary care within the NHS, they served as the arenas through which public health policy entrepreneurs sought to advance change from within. Entrepreneurs, both unilaterally and through tacit collective action, attempted advocacy through undertaking managerial roles in local health centers. However, promoting enhanced integration and coordination with hospitals generated interest-group resistance because it implied dilution of power by adding new participants to the policy community. Similarly, the involvement of the Ministry of the Interior and the presence of autonomous insurance funds in the field of primary care produced rigidity and further vetoes on the prospect of shifting the status quo.

Venue shopping proved detrimental to achieving policy change in 1992. The contextual idiosyncrasies ultimately hampered a shift in the policy trajectory towards public health. Institutional fluidity produced the expected policy paralysis. Policy entrepreneurs proved successful only in their assessment of timing, not of setting. Systemic conditions for change were favorable, but the necessary influence on policymakers was never achieved. Politicization, implementation gaps, and institutional fluidity rendered the rules of the game unpredictable and highly malleable. Seeking to navigate the *de jure* institutional context, policy entrepreneurs never reached the *de facto* locus of power. But where would that lie in such an inherently fluid system where public health policymaking was virtually non-existent? None of the options in the menu of venues in which entrepreneurs shopped in 1992 proved to be the answer.

Ultimately, New Democracy passed bill 2071/1992 because inertia was out of the question for the newly elected conservatives. "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). Despite the change in administration and ideology, the legislation grudgingly accepted much of the status quo. The bill merely re-legislated many of the unimplemented provisions of bill 1973/1983, most prominently the division of the country into Health Regions and the establishment of Regional Health Councils, and also enhanced politicization by introducing two new General Secretariats as mediators between the Central Council for Health and the MoH. Amidst increasing institutional fluidity and the politicization of public health, entrepreneurial strategies failed to merge the three streams while venue creation was not even attempted. Under the banner of reform, the end result was mostly more of the same.

Bill 3172/2003: Venue Creation and Policy Entrepreneurial Success

The Problem Stream

After 1992, momentum in the problem stream increased dramatically during the following decade, with indicators still highlighting Greece's abundant deficiencies in public health.

In contrast to the previous case, feedback emerged as a crucial mechanism in the problem stream during the lead-up to the 2003 reform. With systemic pathogenies persisting and policy

evaluation by national instruments remaining non-existent, "it was external expertise that delivered the first major policy feedback in 1994" (interview with infectious disease specialist and former MoH staffer). Under a PASOK administration – as the party returned to power in 1993 – the 10-year anniversary of both the Greek NHS and Greece's bid to join the European Single Market were viewed as milestones calling for the first comprehensive evaluation of the country's health policy trajectory. To this end, a Committee of Foreign Experts, chaired by Brian Abel-Smith, was formed by Health Minister Dimitris Kremastinos. "The Committee worked in close contact with national experts and visited health policy stakeholders and institutions around the country" to draft the 'Report on the Greek Health Services' (Abel-Smith et al., 1994) (interview with health policy expert and MoH advisor). The report's conclusions highlighted structural deficiencies in integrating and coordinating health services, abiding by implementation programming, addressing inequalities, assessing health needs, understanding epidemiological profiles, and promoting disease prevention. Among the notable recommendations was that of installing a holistic perspective to public health where virtually all aspects of policymaking should contribute towards the promotion and protection of the population's health (Abel-Smith et al., 1994).

In 2002 – and as problems remained unaddressed – feedback complemented the input of the Committee of Foreign Experts. Two mass-population surveys, supervised by the World Health Organization, were conducted by the National School of Public Health, an institution dedicated to research and practitioner training, operating under the auspices of the MoH. The reports uncovered alarmingly low levels of health service responsiveness and quality, as well as systemic social and economic inequalities among the population (Greek National School of Public Health, 2002).

In parallel, indicators continued to show major public health deficiencies. A study by the Medical School of Athens Centre for the Study of Health Services reported rises in deaths by malignant neoplasms and road accidents, a resurgence in the spread of infectious diseases, and an increase in unhealthy population habits – including smoking, drug use, and poor nutrition – between 1986 and 1996 (Tountas et al., 2009). Similar results were communicated by the National School of Public Health, which further underlined the constant rise in avoidable mortality between 1980 and 2003 (National School of Public Health, 2007). "Moreover, child obesity rates reached epidemic proportions by the turn of the 21st century" (interview with public health expert). A 2003 survey concluded that more than 40% of boys and more than 30% of girls in Greece were overweight or obese (Georgiadis & Nassis, 2007), while the country was ranked second highest in Europe for child obesity by the International Obesity Task Force during the same year (Jackson-Leach & Lobstein, 2006). As in the 1992 case, indicators showed that health services were unable to cope with an increasingly unhealthy Greek population.

Finally, focusing events made a difference. Greece's scheduled hosting of the 2004 Olympic Games saw increased attention paid to public health conditions. In 2002, the exporting of infected blood by the National Centre for Plasma Collection to the EU Red Cross Office prompted a public attorney investigation of safety standards (Kathimerini, 2002). In 2003, salmonella cases among members of the German team during their preparation in the Olympic Village generated doubts in the national and international press regarding Greece's public health preparedness (Hadjichristodoulou et al., 2006). Meanwhile, the outbreak of the SARS-COV-1 epidemic fuelled public debate on the country's capacity to manage the spread. As renowned epidemiologist Dimitris Trichopoulos categorically stressed at the time, "if we have [SARS] cases in Greece, the management of public health will be tested. There are emergency efforts

underway, but this could never cover up for the years and years of undermining public health services" (Foura, 2003). Focusing events, including the timing of the Olympic Games hosting, were instrumental in establishing a sense of urgency for public health reform.

In 2003, all three variables of the problem stream highlighted the fact that long-standing policy inertia had severely weakened the country's public health system and pointed out the urgent need for reform.

The Policy Stream

External feedback provided by the Committee of Foreign Experts proved equally important to the policy stream. From 1994 to 2003, policy entrepreneurs for public health refined the content of their pet proposals. Over time, a process of policy learning took place (Dunlop & Radaelli, 2022) within the primeval soup of ideas. Public health policy entrepreneurs in this period numbered 10 to 15 individuals. Most had been involved in Greek health policymaking since 1983. They were between 30 and 55 years old, had health-related degrees and policy experience as public managers in health organizations or primary care instruments, had acted as advisors during the shaping of pre-electoral party programs, and some were connected to the WHO and EU forums. Having failed in their efforts to promote public health services' development within the NHS, they saw the holistic perspective to health as a stimulus to broadening their focus.

As a result, the policy entrepreneurs for public health put forward the idea of an independent System of Public Health Services. This proposal was not part of a coordinated effort but rather the result of entrepreneurs independently disseminating similar policy alternatives to those put forward by senior party staff and the media. Entrepreneurs for public health argued that "effective public health policymaking could only be achieved through establishing mechanisms of communication and coordination for a set of services spanning policy fields – including prevention, primary care, secondary care, post-hospital care, hygiene, the environment, the economy, and social policy" (interview with public health expert and former member of reform design committees). Ensuring value acceptability, they proposed that such a system exceeded the NHS jurisdictionally. Promoting technical feasibility, they further posited that the new system "had strong institutional foundations and would only require the proportional development of its parts through adequate resources, meaningful policymaking powers, and established channels of interaction" (interview with primary care specialist and former member of reform design committees).

Competing with this broadened public health approach was the traditional medicine-centric idea that had long dominated the system. The highly integrated community of policy entrepreneurs within the NHS converged around the belief that "all problems in Greek health policy could be solved through adjustments to the system in place" (interview with former Minister of Health). Their proposed alternatives offered variations on incremental institutional change to make up for long-standing implementation gaps and also better financial management to restore sustainability. Overall, the scope of ideas was disassociated from radical change, as provisions such as unifying the independent insurance funds, curbing the disproportional investment in hospital care, and proceeding with administrative reforms to delimit the MoH's dominance were considered "red lines" in terms of value acceptability (interview with former MoH General Secretary).

By 2003, a solution had emerged within the policy stream, revolving around the establishment of an autonomous system of public health services. Policy entrepreneurs for public health,

after the failed efforts to advance such an idea through primary care services within the NHS, adapted it to maintain momentum. At the same time, a well-integrated coalition favoring the preservation of the status quo had been in place since the passing of bill 2071/1992. These proponents of the medicine-centric perspective had capitalized on the persistence of systemic pathogenies, had engaged in constant role-switching, and had established a regime of promoting highly softened policy proposals. The alternative of autonomy had softened up in the policy stream but this would not be an easy fight as those advocating the default option, the status quo, were powerful and well organized. It would ultimately come down to a good idea, paired with successful strategic action, to overcome the competition and produce policy change.

The Politics Stream

Without changes in institutional configurations in 1992, systemic structural pathogenies persisted in the Greek health policy sector. Leading up to 2003, institutional fluidity was manifested across the policymaking process. Powerful interest groups, such as hospital doctors, experts, and insurance fund representatives, "established consistent informal rapport with the leadership of both dominant parties", fostering *ad hoc* relations which undermined the efficacy of established institutions (interview with former health authorities' director). The establishment of General and Special Secretariats within the MoH evolved into a recurring mechanism to address policy needs and accommodate interests in a short-term "band-aid fashion" (interview with health economics expert and former MoH advisor). Institutional fluidity further increased after elections for Prefecture Authorities were introduced in 1994 (bill 2218/1994), producing instances where the central government would communicate only with partisan regional leaders on public health and hygiene matters. Meanwhile, the advisory instruments that were strengthened during instances of minor policy change – such as the jurisdictional placement of the National School of Public Health under the auspices of the MoH (bill 2194/1994) – witnessed a similar fate of being undermined to that of the Central Council for Health. Finally, regional instruments remained underdeveloped as Health Regions only began to take shape in 2001 (bill 2889/2001).

While institutional fluidity, centralization, and intense interest-group involvement persisted, the acceptance of the status quo by New Democracy in 1992 seemed to eliminate the prospects of ideologically motivated shifts in policy trajectory as the preferences of the two major parties appeared to align. As such, PASOK's return to power in 1993 failed to open a policy window; it was an instance of administrative turnover that promised no change. However, in 2000, the re-election of PASOK Prime Minister Kostas Simitis, with a campaign to modernize governance, reinvigorated hopes of structural change. Minister of Health Alekos Papadopoulos appeared willing to clash with the established power interests, advocating the unification of insurance funds in his early agenda. However, organized pushbacks led to the PASOK leadership withdrawing its backing. "The resignation of Minister Papadopoulos in 2002 over political disagreement ultimately generated greater momentum for policy change" (interview with public health expert and former member of reform design committees). His successor, Minister Konstantinos Stefanis, was appointed under pressure to deliver reform in the midst of a public health crisis and with the PASOK government agonizing over maintaining its credibility and delivering on its pre-electoral promise of modernization. Stefanis's declarations in the EU Council of Health Ministers during the Greek Presidency about "the pandemic not serving as a cause to exercise public health policy but as a reminder about the ever-present state responsibility for public health" signified a political desire for change (interview with former MoH staffer).

The political stream was ripe for reform and its urgency restricted the scope of the opposition.

Successful Strategizing and Policy Change in Public Health

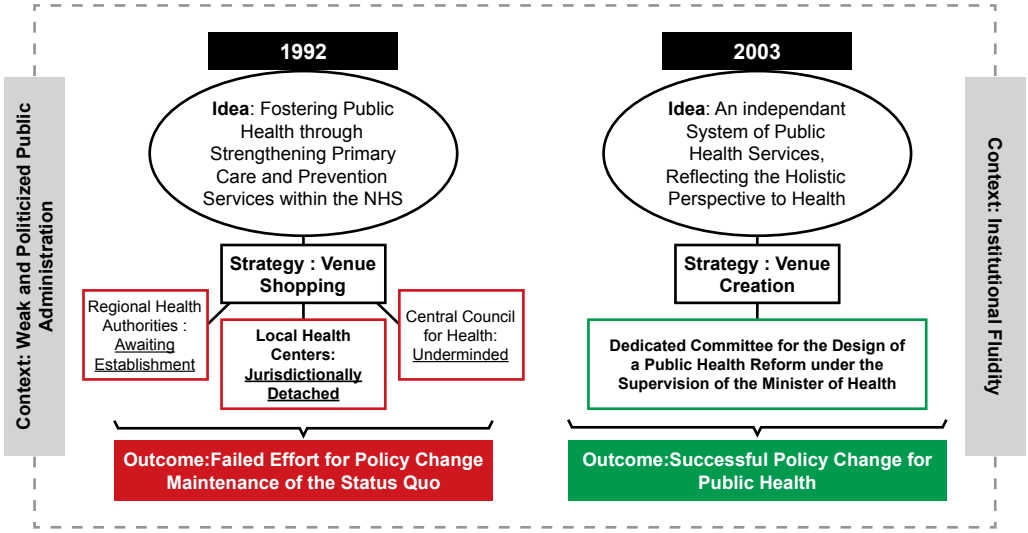
After 2000, policy entrepreneurs fundamentally changed their approach, aided by experience and feedback from the failed effort to achieve policy change in 1992. Parallel to introducing the idea of an Independent System of Public Health Services, they began establishing a distinct identity as public health experts and pursuing direct communication with policymakers. In 2001, the public health policy advocates – who, almost in their entirety, would serve as the architects of the 2003 reform – aligned themselves with Minister Alekos Papadopoulos. In the institutionally fluid Greek health policymaking setting, "this rapport occurred in an informal, direct fashion, grounded on common preferences" (interview with former director of Regional Health Authorities). Seeking to capitalize on the momentum of the political stream, the experts shaped the public health components of Papadopoulos's agenda and even "informally engaged in drafting a provisional public health bill" before the Minister's resignation halted progress (interview with public health expert and former member of reform design committees). Nevertheless, maintaining a clear strategic orientation, they were able to see their ideas through after Stefanis took the MoH helm.

With the window of opportunity opening in both the problem and the political streams – a public health crisis at the onset of hosting the Olympic Games and a new MoH leadership – policy entrepreneurs swiftly advocated the "establishment of a special committee to design the country's new health bill" (interview with former MoH health policy advisor). They stressed their distinct expertise and appealed to Prime Minister Simitis's governance modernization agenda through their long-argued policy plan for a new cross-sectoral system of public health services. Pursuing exclusively the creation of a new venue for reform concentrated and reinforced the image of collective expertise in the eyes of Minister Stefanis. With the setting-up of a dedicated public health reform design committee, policy entrepreneurs were able to insulate their advocacy from the long-established organized interests of the sector. Falling outside their jurisdiction and frame of ideas, neither the independent insurance funds nor hospital doctors were given space to try to preserve the status quo. Meanwhile, under conditions of administrative weakness, no other permanent institutional instrument could claim responsibility for undertaking policy design.

Long-term undermining and historic institutional fluidity "had eliminated any expectation for proposals to be driven through formal policymaking channels" (interview with public health expert and former member of reform design committees). Using effective strategizing, the fluidity of the policymaking process, and the absence of strong administrative instruments, turned weakness into strength. Unable to find an appropriate venue through which they could advance public health reform for nearly two decades, entrepreneurs successfully created one, setting the rules of the game to their liking. As a result, ideas swiftly turned into proposals and legislative provisions.

Following the committee's work, bill 3172/2003 was adopted by the Greek Parliament. The legislation defined public health policymaking as "the exercise of all aspects of public policy for the promotion and the protection of the population's health", introduced a System of Public Health Services spanning jurisdictions, and established that all services with responsibilities for public health were to provide input for the designing and updating of the National Strategy for Public Health. After two decades of structural deficiencies, Greek public health policy finally incorporated the holistic approach to health, instituting a progressive institutional framework. Radical policy change was the result of effective strategizing by policy entrepreneurs, centered around understanding contextual idiosyncrasies and identifying venue creation as the recipe for success.

Figure 1: Venue creation as the favorable strategic option for policy change in public health in Greece (1992 vs 2003)



Source: The Authors

Conclusion

What implications does venue creation raise for policy change? We have argued that, in settings with institutional fluidity and a weak and politicized public administration, policy entrepreneurs will be more successful in influencing policy change when they pursue the strategy of venue creation. Using the case of Greek public health reform, we showed that, over three decades, the same group of policy entrepreneurs in public health pursued policy change in two instances, with fundamentally different strategies in each. In a Greek health policy sector defined by institutional fluidity and a weak and politicized public administration, efforts to access and influence policymakers through formal institutional channels proved futile in 1992. Instead, and as these contextual idiosyncrasies persisted, the strategy of venue creation yielded dramatically different results in 2003, enabling policy entrepreneurs to facilitate policy change for public health through bill 3172/2003.

Our findings illuminate potentially insightful dynamics for the literature on policy entrepreneurs. Scholarship has drawn conclusions predicated on assumptions of institutional stability. Instead, we argue that successful strategizing for policy entrepreneurs may be highly contingent, moving away from agency in a vacuum and bringing back context (Petridou & Mintrom, 2021; Mintrom & Norman, 2009). Whereas networking and venue navigating, through shopping or shifting, may prove crucial in contexts with established policymaking processes, they can as easily cause wasteful use of the limited resources of policy entrepreneurs when the necessary institutional conditions are missing. Both institutional fluidity and weak public administration are crucial to our argument. The latter neutralizes many of the established strategic options identified in the literature by promoting centralization and by isolating policymakers from the policy community. Meanwhile, the former enables the creation of these temporary venues, with direct access to – and influence on – policymakers, a feat that would be impossible

in more established institutional contexts. In terms of both resource investment and policy change – reform design committees essentially operate at the highest level of decision-making and in isolation from competitors (Johannesson & Qvist, 2020) – venue creation emerges as the most favorable strategic option, as long as it can be pursued, and as long as policy entrepreneurs exhibit the acuity and experience needed to proceed with the strategic choice.

The conclusions have interesting implications for the MSF. Although the framework does not explicitly incorporate institutional variables, contextual idiosyncrasies lend themselves to operationalization within the politics stream. Especially when studying the politics stream through process tracing accounts using long-term horizons, it is the case that implementation gaps, the intra-sectoral undermining of policy instruments, and the formal and informal strengthening of specific interest groups, are all factors that shape both political determination and the relative impact of legislative or administrative turnover, organized activity, and the national mood during policy windows. Furthermore, recent refinements to the framework have suggested the presence of separate policy windows for agenda-setting and decision-making (Herweg, Huß & Zohlnhöfer, 2015). In institutionally fluid systems that enable venue creation, these temporary arenas seem to prompt both agenda and decision processes to take place simultaneously. Working directly under political leadership, policy entrepreneurs have unique access to direct feedback pertaining to both the prevailing political "winds" and to specific provisions that would hold up a bill in parliament. Bill 3172/2003, as has been the case with every health policy legislation in Greece's history, passed through parliament without much deliberation because debate had already occurred during the design stage. Venue-creating policy entrepreneurs thus appear to enjoy even greater prospects for manipulating policymakers.

Finally, we draw conclusions for Greek policymaking in health and other sectors. The identified institutional idiosyncrasies extend throughout the country's policymaking landscape. The impact on policy change is double-edged. On the one hand, a lack of policymaking mechanisms consistently delivers poor policy outcomes and allows powerful interests to profit disproportionately in zero-sum scenarios thanks to their levels of influence on governments. On the other hand, venue creation allows for radical change to occur, albeit in random isolated instances. While the credibility of any new policy is continuously being evaluated (Taylor, Zarb & Jeschke, 2021), ultimately – without potential for long-term planning and implementation programming – all change is likely to be temporally contained, creating a situation of constant reform but zero change.

Does this argument hold for other national settings sharing similar characteristics? Do other contextual factors also drive policy entrepreneurs to look past formal institutional venues? It is a research program with many benefits because it will not only confirm or amend the argument, but it will also shed light on the perennial and often unsuccessful quest for reforms in institutionally fluid and administratively politicized settings across different countries.

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