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Challenges and Adjustments of Healthcare and Labor Policies in Greece during the COVID-19 era: A Critical Assessment of the Key Social Policy Responses

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Abstract

The welfare state in Greece even before the outbreak of the global pandemic experienced multiple challenges and problems mainly as a result of its chronic structural, administrative, and financial problems which were further deteriorated by austerity measures. The pandemic that followed the ten-year economic crisis led to a new multifaceted crisis, adding further pressure on the National Health System as well as on the labor market, and precipitating the uptake of targeted measures and policies to support both the NHS with equipment, staff, and employment due to the imposition of national and local lockdowns. Confronted with such weaknesses, the establishment of a new welfare state would need to bear a higher degree of flexibility, inclusivity, and efficiency in order to live up to the increasing societal, health, and economic demands. In this sense, the aim of this paper is to explore the variations in health and labor policies (two key pillars of the welfare state) during the COVID-19 pandemic and assess whether there is a need for further interventions with regard to the social security and prosperity of citizens.

Keywords: Welfare state, pandemic, healthcare policy, labor policy

Introduction

Unlike most of the welfare states of Western and Northern Europe developed in the first two decades after World War II, the Greek one was created in the 1980s. For the first time in Greece's modern post-war history, equal access to social services was possible for the lower socio-economic groups through the development of the National Health System (NHS) and social security system that paved the way for universal access to healthcare and social protection. The central aim of these policies was to achieve a level of redistribution that would result in a reduction in economic and social inequalities. Nevertheless, the expansion of the public sector brought about widespread malfunctions (i.e., high public expenditure rates in old age pensions and low effectiveness in terms of old age poverty prevention, underdeveloped Primary Health Care, etc.) and favored the development of a "clientelistic corporatism" system which, in turn, failed to contribute to the formulation of empirically grounded policies. These were based on clientelistic dynamics that helped to structure an unequal system of distribution (Rapti, 2007: 52). Later on in the 1990s, the necessity of reconfiguring both the broader public sector and social services sought to reduce extensive expenditure and increase the efficiency of the provision of services. Despite the seeming efforts to reform the public sector and the welfare state (i.e., see Giannitsis' proposal for the social security system and long-standing attempts to reform the National Health System), reforms did not come to fruition due to a lack of political will and capacity to incur political costs (Bolton, Charalampopoulos, Skountridaki, 2019; Economou, 2010; Matsaganis, 2011; Sissouras, 2012).

During the recent economic crisis, the austerity doctrine implemented in several Eurozone countries treated the welfare state as the "critical patient" which reduced several of the key services provided (Karger, 2014; Kotroyannos et al., 2013; Papadopoulos & Roumpakis, 2012). In this regard, the Greek healthcare system was subject to staff reductions, such as the limited availability of beds (based on population) in intensive care units (ICUs) and the difficulty in modernizing its organizational structure (Mpouzika, Mpouzika, Papathanasoglou, 2018). At the same time, the decline in disposable income has rendered several patients unable to meet their own health needs (Tzagkarakis, Pappas, Kritas, 2020). Reductions have also occurred at the levels of social security, pension, and welfare, while internal devaluation policies have drastically reduced labor costs and rights (Guillén & Pavolini, 2015).

Consequently, it became evident that after the end of the ten-year financial crisis, the welfare state and its individual services underwent severe reductions (Sbarouni et al. 2020). That said, both the economic and the current health crisis highlighted the necessity of the welfare state to protect

citizens from social risks that are on the rise. Therefore, it should not be overlooked that at the international level the increasingly more complex and interdependent socioeconomic context poses further obstacles to a more direct and efficient response from the governments (Schwab & Malleret, 2021). Hence, the current health crisis of the COVID-19 pandemic underscores the fact that the respective public policies need to be more resourceful and targeted to tackle phenomena that were once considered rare. The methodological steps followed in this paper include the analysis of secondary quantitative data (descriptive statistics) collected from a range of international and national databases, such as Eurostat, OECD, World Health Organization (WHO), International Monetary Fund (IMF), World Bank, the Greek Institute of Labor and the Ministry of Economics. For the analysis of labor policies, we used data about the state of the economy (GDP) and examined the measures taken to mitigate the negative impact of lockdowns on the labor market. For example, for the analysis of the health policies and the condition of the NHS, relevant data was used to indicate the number of ICU units, the labor force in the NHS (nurses and doctors), the public and private (out of pocket) expenditures and the measures taken by the Greek government during the pandemic. The key goal is to analyze the condition of the labor market, NHS, and the measures taken pre- and post-pandemic and consider the system deficiencies in order to generate some broader policy recommendations.

Labor policies in Greece during the pandemic

After the end of an austerity decade, in the limited interval period between the exit from the fiscal adjustment programs (2018) and the outbreak of the pandemic (2020), the economic problems that afflicted social policy were still there. Indicatively, Greek public debt remained one of the highest in the EU at 200% of GDP in 2019 (OECD, 2021). Simultaneously, according to the World Bank (2021), there has been a gradual increase in GDP and a reduction in unemployment in the years 2018 and 2019, however, without adequately addressing labor insecurity which remained at markedly high levels (Papadakis, Drakaki, Saridaki, 2021).

On top of that, the COVID-19 pandemic was another challenge for Greek labor policies. While the restrictive measures during the first wave of the pandemic seemed to have been effective in reducing the spread of coronavirus and the death toll, they created more problems for the labor market and entrepreneurship, as long as employees and employers' activity, especially in the service sector, was suspended or transformed towards telework and e-commerce. As Aristodemou, Buchhass, and Claringbould (2021) argued, European countries with ineffective or problematic healthcare systems appeared to have implemented tighter containment measures during

the pandemic that are significantly associated with the occurrence of greater negative socio-economic impacts. While at first glance accessibility and efficiency of the healthcare system may not relate to the implementation of restrictive measures to deal with the spread of the coronavirus and their impact on the labor market and economy, it is nevertheless clear that all these problems highlight the urgent need to strengthen healthcare policies and improve employment on the grounds of interconnectedness and directness (Melidis & Tzagkarakis, 2021).

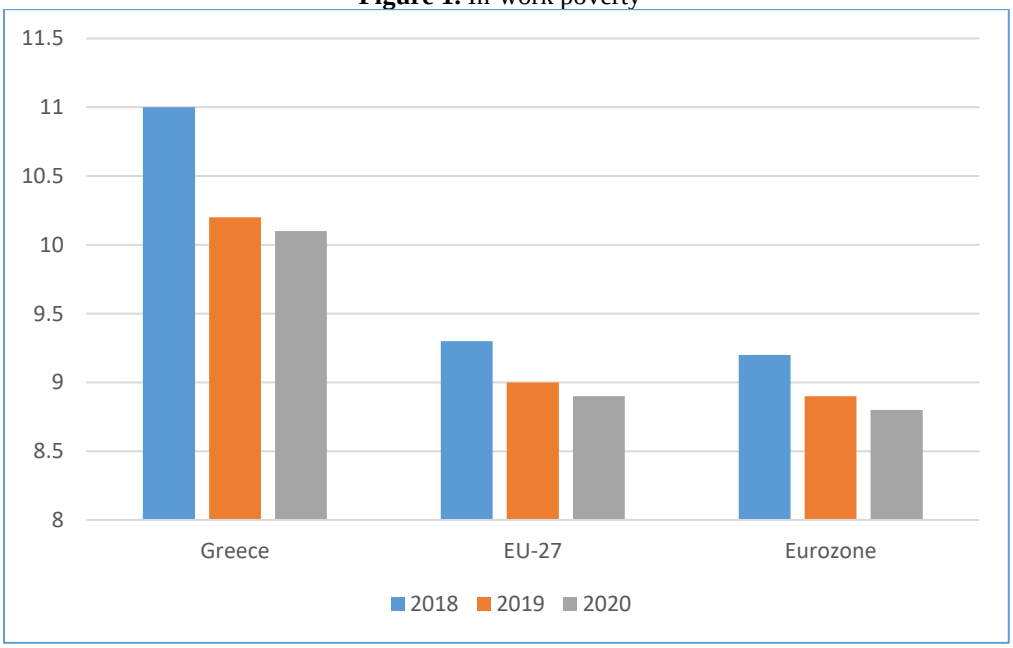
Particularly concerning was the strong impact of the pandemic on economic activity and employment in Greece. As the economy of the country relies heavily on services and tourism, the negative effects of the restrictions both in 2020 and 2021 (in the first and second lockdowns) were evident. Although there has been an upturn in employment rates at the end of 2021, Greece and Italy continued to be far away (65%) from the EU average (74%) in the last quarter of 2021 showing the lowest employment rates in the EU overall. It is worth noting that a key feature of the pressures on the labor market (as a result of the restrictive measures to contain the spread of the coronavirus) is the fact that the number of full-time employees working between 40 and 47 hours per week decreased by 33.3% in 2020 compared to 2019, while the number of those working less than 39 hours per week and those with more than 48 hours per week increased by 20% and 10% respectively (Greek Institute of Labor, 2021).

To address the negative effects of labor market constraints, policies amounting to 14% of GDP in 2020 and 7.5% of GDP in 2021 were developed by the Greek government, including, inter alia, financing to strengthen the healthcare system in terms of human resources and granting of tax breaks, subsidies and economic aid to employees, self-employees, and enterprises whose work and activities have been suspended (IMF, 2021). On 11 March 2020, the Greek government announced the first set of restrictive measures to contain the spread of the coronavirus (1st lockdown) worth €10 billion financed by national and European funds. As mentioned above, support for workers and businesses was seriously affected by the restrictions. For instance, government measures involved allowances for those who were suspended from work and facilities for parents of children under 15 years old who had to stay at home with them as all levels of education were interrupted and subsequently moved online (Moreira et al. 2020). Importantly, the Greek state has also undertaken the coverage of the social security contributions of private sector employees and self-employed. Another bunch of measures was applied to support the unemployed through an additional 400-euro allowance for the long-term unemployed, a two-month extension of unemployment benefits, and a 40% reduction in first-home rents for employees who were suspended from work (OECD, 2020). Although subsidized online training

programs were offered to self-employed professionals and scientists, these were heavily criticized for being poorly designed and implemented which were then replaced by a subsidy of 600 euros (Eurofound, 2020).

Furthermore, another program funded by the EU's SURE framework called SYN-ERGASIA allowed employers who underwent significant reductions in their economic activity to pay only part of employees' salaries while the rest was covered by the program. Additionally, this program included a special allowance for employees in businesses that suspended their activities. In effect, they were compensated for their social security contributions for the period they remained unemployed, while businesses and shop owners were exempted from paying taxes, rent, and other obligations. Evaluating both the SURE program and the overall labor support measures over the period of the pandemic in Greece, it becomes clear that the adoption of measures to mitigate the effects of the crisis was very important in terms of preventing an increase in unemployment (Betcherman et al, 2020). In this respect, Greece prior to and throughout the decade-long economic crisis had one of the highest rates of in-work poverty (Figure 1). This figure highlights the level of labor insecurity in the fragmented labor market in the areas characterized by temporary or part-time employment, flexibility, undeclared work, low wage levels, and informal rules-abuses (Ferrera, 2010). As shown in the chart below, despite the reduction in in-work poverty rates, Greece's percentages appear to be among the highest in the EU thus necessitating the uptake of additional measures to tackle this problem.

Figure 1. In-work poverty



Data compiled from Eurostat (2022).

Interestingly, Greece has had higher in-work poverty rates than the EU average over time despite a downward trend in recent years which, in a sense, follows the tendency at the EU level but does not reduce the existing gap between the former and the latter. Concomitantly, this is a strong indication that men and older workers are more likely to be at risk of in-work poverty. For example, groups such as workers with low educational attainment, the self-employed (which masks the case of implicit wage employment declared as self-employment), contract workers, and the partially employed have been reported to be at higher risk of in-work poverty in Greece over time. In light of the pandemic, this seems to be even more important as the main causes are linked to the increased in-work poverty rates and precariousness (Ziomas et al, 2019).

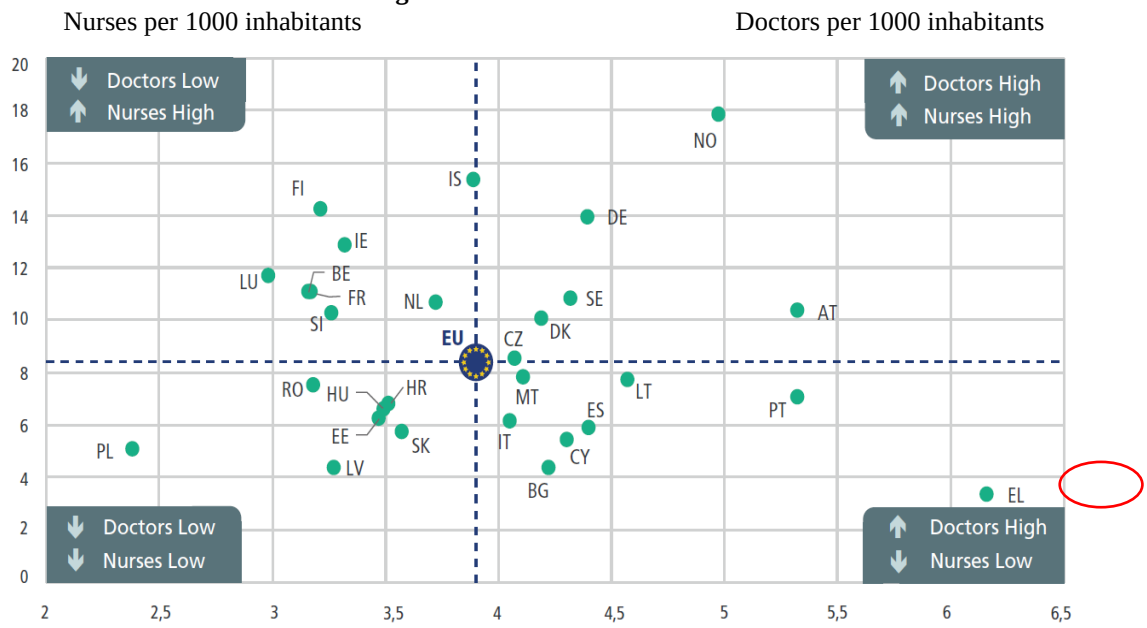
Healthcare policies in Greece during the pandemic. Highlighting persistent shortcomings and the need for public healthcare services

Undoubtedly, the COVID-19 pandemic brought healthcare systems to the center of attention as it highlighted the necessity of their strengthening to cope with the increasing healthcare needs arising from the successive pandemic waves. Broadly, Covid-19 revealed the shortcomings and long-standing problems of the Greek NHS which was even more exacerbated during the ten-year economic crisis (Economou, 2019). It should be noted that these problems, on the one hand, are deep-seated and structural dating from the establishment of the system and on the other hand, relate to the budgetary constraints imposed over the decade-long austerity period that reduced the accessibility and therefore the universality of the system during a period in which about ¼ of the country's GDP was lost (Tzagkarakis, Pappas, Kritas, 2020).

In a wider context, the Greek NHS covers only 61% of total healthcare needs, about 10 percentage points less than the OECD average, with the remaining share (39%) covered by private expenditure (OECD, 2019). It is understandable that the level of de-commodification of health needs is extremely low compared to all developed European countries. From this perspective, this situation exacerbates inequalities and creates coverage gaps, particularly for vulnerable socio-economic groups even prior to the pandemic (Melidis & Tzagkarakis, 2021). Simultaneously, just before the outbreak of the pandemic (2020), the healthcare workforce was reduced by 2,252 permanent employees compared to 2019 with the imbalances in terms of distribution and staffing levels being notable through an overabundance and unequal distribution of doctors and a significant shortage of nurses (Ministry of Interior, 2020). Despite the largely ad hoc recruitments during the pandemic (7,500 health workers), the continuous and further strengthening of the system is now an end in itself (OECD & World Health

Organization, 2021). According to data, Greece has 6.1 physicians and 3.3 nurses per 1000 inhabitants while the OECD average is 3.5 and 8.8 per 1000 inhabitants respectively (OECD, 2019). Despite the significant number of doctors, the way these are distributed across the country in tandem with the lack of general practitioners for primary healthcare underscores the lack of needs-based planning to achieve greater levels of efficiency.

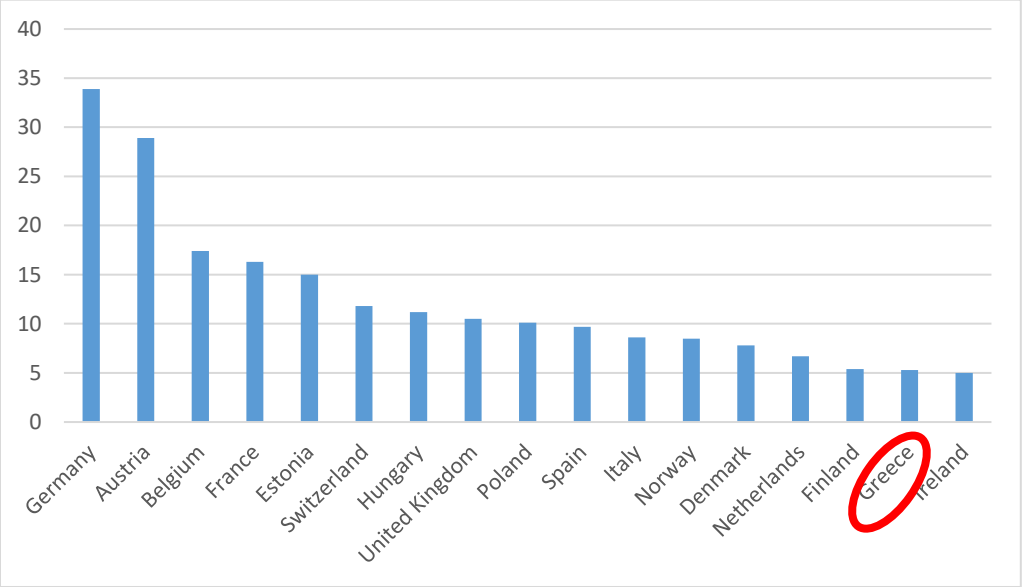
Figure 2. Nurses vs Doctors 2021



Source : Sagan, A. et al. (2021). Health systems resilience during COVID-19: Lessons for building back better. UK: World Health Organization – European Commission – European Observatory on Health Systems and Policies: 49.

In addition, the total number of qualified doctors as well as the number of doctors per specialty are not the outcome of any planning to meet the needs of the healthcare system. While countries with developed primary healthcare systems, such as Norway, Finland, and Germany, have an increased proportion of general practitioners, Greece in contrast presents a very low proportion with a particularly high percentage of doctors in specialties such as surgery, gynecology, and pathology while a significant gap in specialties such as geriatrics and rehabilitation remains (Tountas et al., 2020: 165-166). Another indication of Greece's poor record, according to the most recent data, is that it lags behind the European average in the number of intensive care beds per 100,000 population as ICUs were essential for the treatment of the most serious cases, in which Greece is reported to have only 5.3 beds per 100,000 population compared to 12.9 of the EU (Figure 3).

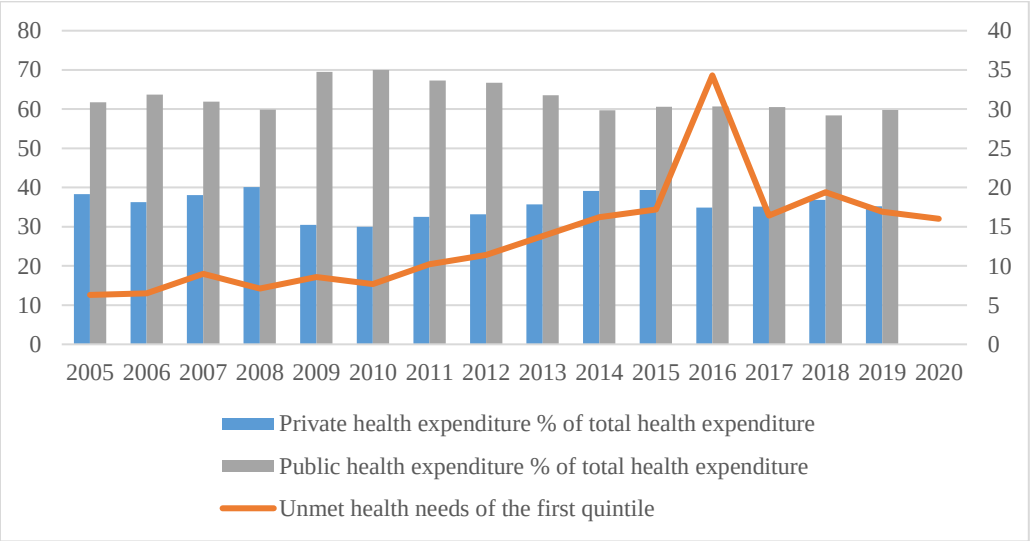
Figure 3. Intensive Care Unit (ICU) beds per 100.000 inhabitants in European countries



Source: Sagan, et al. (2021). *Health systems resilience during COVID-19: Lessons for building back better*. UK: World Health Organization – European Commission – European Observatory on Health Systems and Policies: 49.

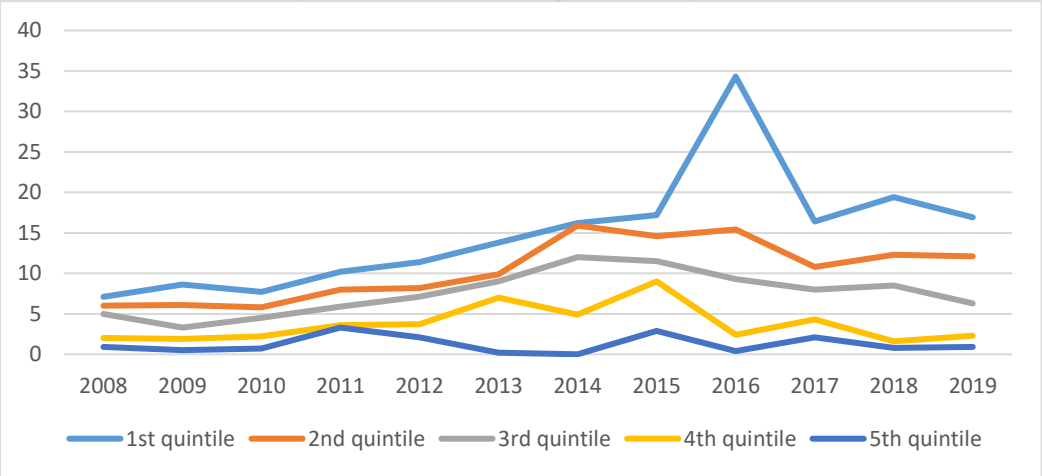
Even before the outbreak of the economic crisis, several studies identified that the Greek NHS was facing both organizational and financial issues which made it one of the most inefficient in the EU (Davaki & Mossialos, 2005; Economou, 2010; Tzagkarakis, Pappas, Kritas, 2020). Such problems included the failure to provide proper information to administrative services, lack of training and specialization of administrative staff, administrative centralization, distortions and inequalities in the allocation and performance of material and human resources, deficiencies in the diagnosis of needs, and consequent prioritization of interventions (Tzagkarakis, 2017). As a result of those, significant inequalities and access issues to healthcare services were caused which then became even more pronounced for the most vulnerable social groups that lack the capacity to meet their own healthcare needs (Karanikolos et al., 2013, Melidis and Tzagkarakis, 2021). As is clearly indicated in Figures 4 and 5, during the financial crisis public spending on health was decreased, while private spending and the unmet health needs for the lower economic strata (first and second quantiles) were seriously increased. Taking into account a number of studies, inequalities in access to healthcare services, better population health, and lower rates of unnecessary hospitalizations have been associated with public health expenditure. In other words, these indicate that increased expenditure along with organizational competence may enhance accessibility and system universality (Kringos et al., 2013; Xesfingi & Vozikis, 2016).

Figure 4. Public and private health expenditure vs unmet health needs of the first quintile in Greece



Data compiled from Eurostat (2022) & OECD (2022) datasets

Figure 5. Percentage of unmet health needs per income quintile in Greece due to their costs (1=lowest income, 5 =highest income)

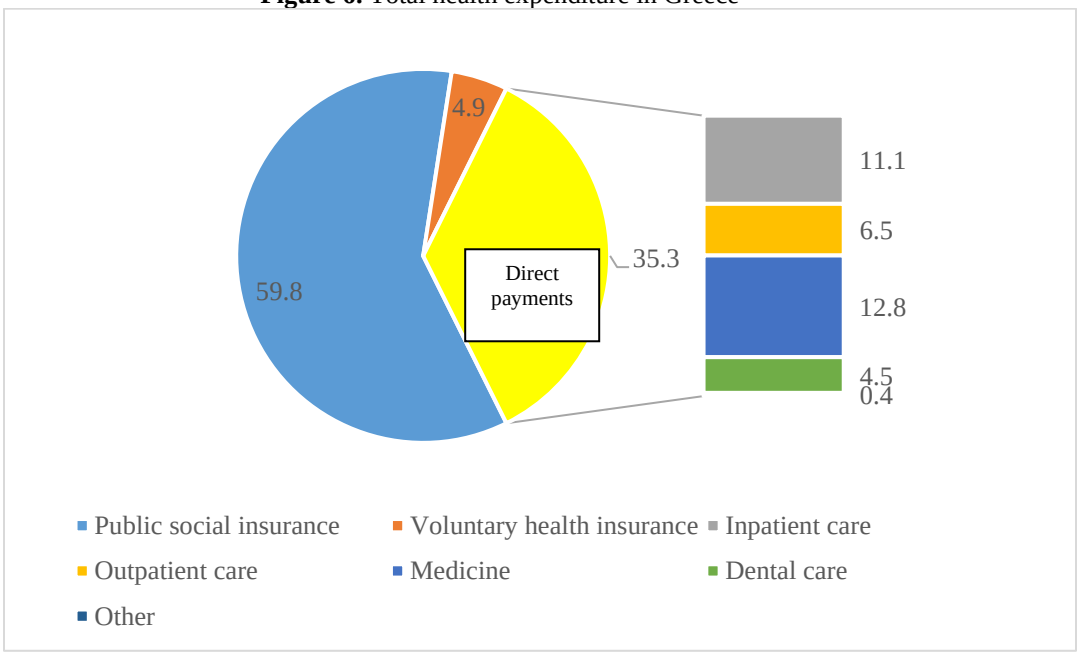


Data compiled from Eurostat datasets (2022)

Generally, public spending on healthcare appears to have declined during the economic crisis and up to 2019. In contrast, private health expenditure seems to have increased over the same period and remains to date at particularly high levels unlike the majority of EU Member States. Combined with the increasing inability to meet healthcare needs due to financial constraints for lower incomes, as shown in Figure 8, it becomes clear that there has been a widening of inequalities and a lack of capacity of

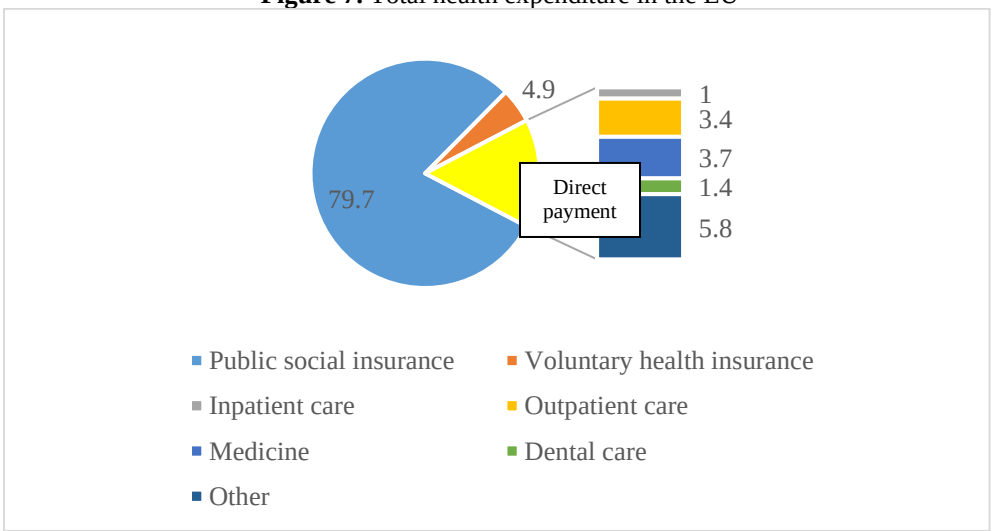
the healthcare system itself to adequately decommodify health needs. This in fact is evidenced when we look at the individual healthcare expenditure which is considerably higher than the EU average (35.3% compared to 15.3% respectively of total health expenditure) and contributes to the increase of inequalities and private healthcare costs.

Figure 6. Total health expenditure in Greece



Data compiled from OECD & World Health Organization datasets (2021).

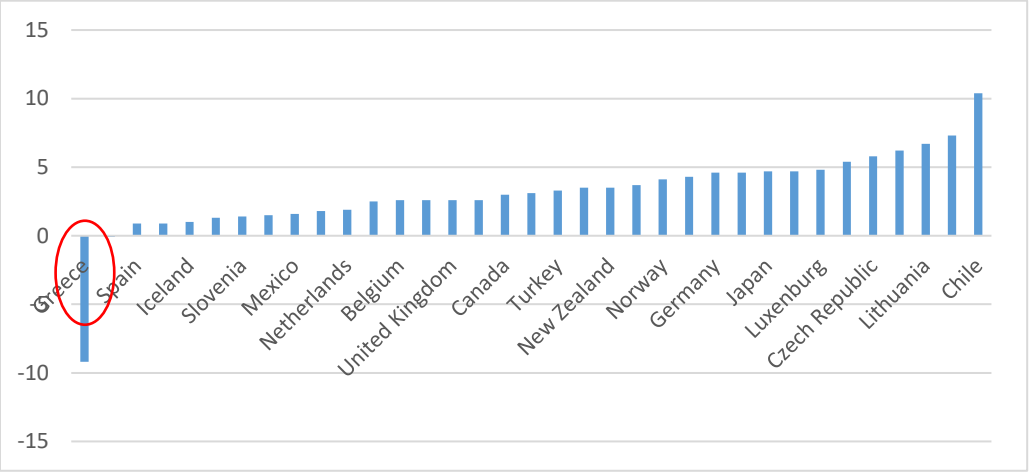
Figure 7. Total health expenditure in the EU



Data compiled from OECD & World Health Organization datasets (2021).

As figure 8 clearly indicates, the decrease in public spending on healthcare in Greece during the economic crisis was the largest among OECD countries. This manifests several weaknesses in the coverage of healthcare needs, especially for the most vulnerable citizens, while impacting the system's preparedness in cases of extreme events such as a pandemic.

Figure 8. Health expenditure percentage change 2009-2018



Data compiled from OECD datasets (2019).

From a critical point of view, the above-mentioned problems of the Greek NHS arguably act as obstacles to its preparedness for major health crises, especially in critical junctures such as a global pandemic. Although such a condition represents a huge challenge for any system in the field of relevant public policies, those systems characterized by higher levels of efficiency and coverage, such as the Norwegian and the German - hence preparedness – seem to be better off. Despite any temporal or operational variations, it is widely acknowledged that all EU Member States have taken restrictive measures to reduce infectivity. However, such measures were usually more drastic in states with less efficient health systems such as Greece where the containment measures, particularly during the first pandemic wave, were extensive and successful. It is telling that, had it not been for the strictness of these measures, the epidemiological results would have been much more negative and therefore the social impact much more severe because of the limited capacity of the system, either in terms of ICUs or, more generally, in terms of material and/or human resources as demonstrated in the graphs presented previously.

Although Greece seemed to have dealt effectively with the first wave of the pandemic, the strengthening of the healthcare system was rather limited than in most European countries considering that the shortages were already among the greatest as shown above. It should also be mentioned that

despite the limited capacity of Greek NHS, such as being understaffed, poorly structured-organized and lacking ICU beds, the restrictions imposed immediately and, consequently, the rapid adoption of surveillance guidelines (tracing, quarantine, information, social distancing, etc.) turned out to be a key point in containing the spread of the coronavirus. It also needs to be stated that the WHO's assessment of Greece's compliance with the healthcare criteria placed the country way far from the average of OECD and EU countries (OECD & World Health Organization, 2021). Although the number of beds available was limited prior to the pandemic (420 hospital beds in 2018 in the country), during the pandemic they were increased to 1,300 through the redeployment of hospital beds and the creation of new ones (OECD & World Health Organization, 2021). The increase in ICU beds is seen as a positive element that should be maintained and integrated into the overall strategy that considers the needs of the population and forms the conditions for the development of new ICUs accompanied by appropriate material equipment and staff. Against this backdrop, the digitalization of healthcare services through the introduction of new applications such as the MyHealth app and emvolio.gov.gr offered a great opportunity to further develop and modernize the procedures that facilitate citizens' access to healthcare services.

Nonetheless, it may be argued that in addition to restrictive measures and awareness-raising activities, Greece increased its spending on NHS support compared to the pre-pandemic era in 2020. However, these increases were below those of the majority of EU Member States (HSRM, 2020). Reasonably, the policy of restraint and subsequent reduction in health spending continued in the following pandemic waves. This was demonstrated in the 2021 budget with spending on hospitals and Primary Health Care (PHC) decreasing by 1.5%, while transfers for health benefits to the NHS reducing by 50% (Ministry of Finance, 2020). Only a small increase of €196 million was projected for 2022 for hospitals and PHC (Ministry of Finance, 2021). For instance, nearly about €1.5 billion is geared toward improving the resilience, accessibility, and sustainability of healthcare through the EU's Recovery and Resilience Mechanism (OECD & World Health Organization, 2021). In this regard, long-term policy planning is imperative. That said, the strengthening of the public healthcare system should be based on a broader strategy determined by the implementation of an empirically grounded assessment to effectively address the needs and shortcomings in healthcare services of each Greek regional unit.

Conclusions and recommendations

The new coronavirus (SARS-CoV2) has arguably brought to the fore the need for public policies to strengthen the NHS and tackle the problems in

the labor market generated by the lockdowns. In particular, the healthcare and employment sectors are two of the main areas that received significantly high pressures during the pandemic. For example, the contagiousness and morbidity of the virus in conjunction with the various adjustments and transformations that occurred in the labor market posed further challenges. Telework is now a form of employment that seems to be sustained and significantly expanded in the transition to a platform economy model. Without assuming that this change is a priori negative, the regulations on the part of the welfare state are important to protect employees, namely, precariousness. Greek labor market portrays some serious and high risks of job insecurity and in-work poverty, so further regulations in that direction would be important to ensure the right to disconnection from the computer regarding teleworking, shape the conditions for the protection of labor rights, insurance, working hours, sick leave, holidays, family allowances, etc. and reduce the shadow-entrepreneurship which often conceals precariousness. So, measures against precariousness and in-work poverty, such as social security contributions' compensation by the state for low-level employees without reductions in their salaries, may be considered in order to efficiently reduce the economic pressures that low-level incomes encounter as a result of high inflation rates.

At the level of healthcare policy, a new NHS needs to be better organized and structured. Treating the current pandemic as an exceptional event that could lead to a return to previous conditions would be a mistake. The focus of a broader strategy would be to increase and facilitate access to the system, particularly for the most vulnerable groups. Likewise, the adoption of an integrated PHC system would aid the likely prevention and health promotion while addressing mental and physical problems. Additionally, linking PHC with public healthcare and strengthening the role of the family doctor with corresponding incentives for general practitioners would offer the opportunity to enhance the quality of services and the general effectiveness of the system for the benefit of citizens (Wynn & Moore, 2012). To this point, the allocation and strengthening of healthcare financing should be grounded in needs assessment, long-term strategic planning, and proper material and human resource management with a view to improving access to healthcare for the wider population. Although the importance of a strong healthcare system and employment protection arrangements should not be downplayed, the pandemic can be seen as an accelerator of a much-needed overhaul of the existing NHS to live up to the needs of citizens and the standards of a 21st-century European welfare state.

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