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THE GREEK WELFARE STATE UNDER PERMANENT STRAIN: TRANSFORMATIONS, REFORMS AND PRESSURES

Summary

The Greek welfare state has faced multidimensional crises from the first period of its existence until now. From the traditional unstable democratic and institutional context to the financial crisis, which exacerbated social problems, and from the latter to the pandemic, which posed challenges for the immediate handling of the health needs as well as long term necessities for measures in order to address the economic shortcomings of the pandemic, the Greek welfare state has been in a permanent strain. This study aims to present the main historical as well as contemporary challenges of the Greek welfare state and to draw some conclusions about its role in the post-covid era as well as to emphasize the main directions in order to address old and new social problems, always with reference to relative empirical data.

Keywords: Greek welfare state, pandemic, crisis, social problems.

Introduction and historical perspectives of the Greek welfare state

According to several studies, the Greek welfare state is included in the Southern European welfare model as it shows some important common features and historical or institutional paths with the rest of the welfare states of this region. A quick look back at the history of the Greek state after liberation from the Ottoman Empire reveals the implementation of selective welfare policies that focused mainly on protecting those affected by the war for independence. The form of these policies is considered particularly incomplete because both the economic potential and the institutional capacity of the state were at an early stage. From 1836, the organization of the first mutual funds from specific labor unions begins, due to the limited state coverage of the pension and disability needs. The lack of a public insurance system increased the number of funds, the subsequent integration

of which into a common insurance system was a major problem (Stathopoulos, 2015). The delay in the establishment of an integrated and comprehensive insurance system is considered to be the result, *inter alia*, of the delay of industrialization and consequently, of the insufficient labor movement organization, which is the main pressure mechanism towards this direction. This is evident from the fact that, according to the available data, after the Second World War the economies of Southern European countries, among which the most typical example is Greece, relied to a much greater extent on the primary sector which was characterized by low levels of productivity, compared with the EU Member States average (Marinakou, 1998). For all these factors, especially during the first century of the Greek state, welfare in Greece was based mainly on private activity and charity (Stathopoulos, 2015) rather than comprehensive state intervention.

Nevertheless, it is a fact that from 1920s until the restoration of democracy in 1974, the country did not experience political, social and economic stability and as a consequence, the welfare state was not organized and expanded in a similar way as in Western Europe. The persistent problematic condition of the economy, political instability and lack of consensus, did not allow the structure of integrated social service systems that would ensure a rational as well as a socially just distribution and allocation of resources based on the public interest and not the promotion of individual privileges.

The restoration of democracy in 1974 opened a new perspective for Greece in terms of reaching economic, political and social stability. The stabilization of the political situation in the country was accompanied by the rapid development of an integrated and universal welfare state in the 1980s and an attempt to transform public social assistance into a right derived from the concept of social justice. It is well known that compared to other Western European countries, the effort to develop a comprehensive welfare state in Greece has been significantly delayed. It took place at a time when Western European welfare states were already in crisis and the world economy was in transition from the 1970s, after a long period of development and a more rational – in the common interest – institutionalization of welfare states. Thus, economic pressures, endogenous inadequacies and high inflation in the 1980s (Coutinho, 2012) led the southern European welfare states – and especially the Greek state – into crisis relatively quickly.

The distortions that were not resolved but were institutionalized during the period of the expansion of the welfare state in Greece, are those that made it ineffective, unbalanced and unjust, in the sense that it selectively favors some social groups and marginalizes others. This political culture, which did not incorporate dialogue and consensus-seeking efforts to resolve serious problems, was based both on the dependence of civil society and labor organizations on partisan interests (Ferrera, 2012) and on the centralization of public administration, the reckless expansion of the public sector and the development of a private economy based on family businesses and state support (Marinakou, 1998).

Structural problems and inefficiencies of the Greek welfare state

Several internal parameters, in conjunction with external pressures such as the economic crisis, played a crucial role towards the persistent crisis of the Greek welfare state. To this end, the basic characteristics of the Greek welfare state, which are also relatively

common for the other South European welfare states, are the following: (1) a highly fragmented and corporatist income maintenance system marked by internal polarization, whereby peaks of generosity (e.g. in pensions) were accompanied by gaps of social protection[1]; (2) the withdrawal from corporatist traditions in the field of health care and the establishment (at least partially) of universalistic National Health Services; (3) a low degree of state intervention on the welfare sphere and a highly collusive mix between public and non-public actors and institutions; and (4) the persistence of clientelism and the formation of elaborate patronage structures for the selective distribution of cash subsidies (Ferrera, 2012). To the above characteristics, (5) the resilience of reform-resistant practices when faced with external challenges/stimuli should also be reported (Lavdas et al., 2013). On the basis of these parameters, it is worth noting two important viewpoints that essentially summarize the condition of the welfare state in Greece. Firstly, Mulé (2016: 25) indicates that in Greece – as well as in the other South European countries – *"the welfare state is characterized by a mixture of universalistic and selective benefits and is based on fragmented, highly particularistic welfare policies"*. Secondly, Zambarloukou (2015: 653) on a more critical tone explains the reasons of failure noting that *"while the system as a whole was 'expensive, wasteful and socially exclusive', successive Greek governments failed to carry out substantial reforms, even though initiatives were periodically taken in this direction"*.

Ferrera (2012) claimed that unlike Western Europe, in which industrialization was further promoted and increased the need for the establishment of welfare state services, Southern European economies and especially Greece, remained agricultural and relatively underdeveloped, heavily reliant though on state support. Other reasons that explain this lag can be found in strong authoritarianism and the difficult transition to democracy as well as the extensive clientelism. In other words, Greece suffered politically and socio-economically as it lost the pace and trailed behind Western Europe in state modernization. It is supported by several scholars (Ferrera, 2012; Gallie & Paugman, 2000; Watson, 2008) that – in comparison with the continental, (Nordic and Western) welfare systems – the late modernization, industrialization, and democratization that characterized the Southern welfare states, in a sense, limited the space to resolve the existing problems and hindered the establishment of socially just and effective welfare institutions. Specifically, social vulnerability and inequality were quite extensive as a result of the establishment of an 'insiders--outsiders' system. As 'insiders' are the employees of the public and large private enterprises and 'outsiders' are the employees of small enterprises under flexible contracts. The 'insiders-outsiders cleavage' draws its origins from the labor market separation into three sectors namely, the core, the peripheral and the underground (Ferrera, 1996; 2012; Moreno, 2000). The core sector was characterized by employment stability and strong protection rules due to the realization of the 'male-breadwinner' system[2]. The peripheral includes

[1] The gaps of social protection include inequalities in social provision for different groups of employees, namely strong protection for public servants but inadequate protection for a significant part of private sector employees.

[2] The male breadwinner system is an ideal of the family in which men earn a significant wage and provide family protection while wives are concentrated on domestic labor and care (informal-unpaid) for family members. It has been important in most western European welfare regimes as an effort to underpin state policies towards gender relations and gender roles in paid employment and the family. It has also been commonly used as a conceptual tool for understanding differences between welfare regimes.

small enterprises, mainly in the services and construction sector, characterized by job instability, low protection, lower wages and extensive labor flexibility. Finally, the underground sector encompasses non-formal and informal workers[3] and a black economy followed by informality, instability and low wages.

The above described-situation inevitably raised job polarization[4], brought about widespread social vulnerability problems (high levels of poverty and social exclusion for the young people, NEETs, child, and old age poverty, gender pay gap etc.) and constructed a welfare state contingent on pensions and the 'male-breadwinner protection'. For some scholars such as Matsaganis (2013), this is a strong evidence of how the welfare system failed to address social problems, such as old-age poverty, excluding measures on childcare, safety nets and active labor programs for youth and other vulnerable social groups. It is noteworthy that the participation of women in the labor market was extremely low during the 1970s and only from the 1980s it started to grow but still remains comparably lower than the Western and Northern European countries (Eurostat, 2017). After the 1980s Greece experienced a raft of drastic changes. Agricultural (World Bank, 2017a) and industrial employment (World Bank, 2017b) declined, the services sector grew drastically (World Bank, 2017c), the feminization of the labor market increased (Eurostat, 2017) and simultaneously, the labor market flexibility rapidly augmented (Ferrera, 2012). These changes associated with the European and Eurozone membership aimed to address the competitiveness problems, the labor market inclusion and the welfare state reforms to encounter emerging social risks. Paradoxically, the relevant policies towards that goal failed to reduce the social vulnerability problems while the prospects of economic, social and welfare state development increased.

External dimensions: The impact of the financial crisis

Apart from the structural problems of the Greek welfare state, the contribution of the economic crisis between 2008 and 2018 seems determinant for rising social problems

[3] Although there is no commonly accepted definition for non-formal employment and various terminologies such as, flexible, or marginal employment (Leonard, 1998), the key distinctive element is the reduced (less than 8) working hours (ILO, 2015; Meulders, Plasman & Plasman, 1994). The notions of informal and flexible employment are often used to describe the same group of employment forms. At the same time, the non-formal or flexible form of employment is often distinguished from the informal in the sense that the term flexible or non--formal refers to a form of employment that is within the existing institutional context but lacks the features of the formal while the informal includes not just discrimination with formal but elements of institutional abuse (De Grip, Hoevenberg & Willems, 1997) or voluntary-personal activity. Therefore, non-formal employment includes (a) fixed-term employment, (b) part-time employment, (c) rotational employment, (d) subcontracting within a business, and (e) self-employment. On the other hand, informal forms of employment typically include: (a) child labor, (b) housekeeping, (c) unpaid family-owned employment, and (d) uninsured employment. Overtime, in the context of a non-formal employment, which is a common phenomenon, is part of the informal as it is not remunerated, indicating the ease of transition from the non-formal to the informal. This transition constitutes a clear procedure for the exploitation of the employee and contradicts the fundamental aim of promoting human's autonomy through paid work.

[4] The term "job polarization" refers to the labor market dualism and is used to describe the discrimination between individual groups regarding the access to work. Increasing dualism leads to social marginalization and the promotion of forms of work that maintain or inflate precariousness, that is, "underemployment" (Matza & Miller, 1976: 661).

and its inability to address them. Thus, the welfare states of the Eurozone periphery[5], in which Greece is categorized, were confronted with tight budgets and serious economic pressures (Celi et al., 2017; Dotti Sani & Magistro, 2016; Petmezidou & Guillén, 2014; Ryner, 2015). The exacerbation of the general and youth unemployment at high levels (mainly in Greece, Spain, Italy and to a lesser extend in Portugal) became a structural problem (such as the long-term unemployment, and a decline of prospects for reintegration into the labor market) that increased the risk of poverty, precarious employment (and in-work poverty), social marginalization and exclusion (see Tables 1 and 2 as well as Figure 1) as well as increased working hours even in the years before the crisis (Zawadzki, 2005) as well as during the economic recession (2008–2018) (OECD, 2016). The cyclical form of this problem essentially suggests that more funding for tackling rising problems are deemed necessary[6]. For instance, declining employment levels squeezes insurance and tax contributions. This means that it would be more difficult for the state to finance the social insurance system. As a result, these problems have become even more acute for the most vulnerable social groups, such as those confronted with an imminent risk of poverty, single-parent families, the NEETs, and children (Kotroyannos et al., 2015)[7].

Table 1. Unemployment percentages based on age, gender, education level and nativity, 2008–2018

	Greece		**Spain**		**Italy**		**Portugal**		**Eurozone**	
	2008	***2018***	***2008***	***2018***	***2008***	***2018***	***2008***	***2018***	***2008***	***2018***
Men (15–64)	5.2	15.5	10.1	13.8	5.6	10.0	6.9	6.9	6.9	8.0
Women (15–64)	11.6	24.4	12.9	17.1	8.5	11.9	9.3	7.6	8.4	8.7
Age 15–24	21.9	39.9	24.5	34.3	21.2	32.2	16.7	20.3	15.8	16.9
Age 25–49	7.7	19.8	10.3	14.1	6.4	11.1	7.3	6.2	6.9	8.2
Age 50–64	3.8	14.7	7.8	13.7	3.2	6.5	6.6	6.2	5.7	6.2

[5] The term Eurozone periphery is used here to describe the diversion between the countries which meet the convergence criteria both in economic and social terms, and the countries which are far behind meeting these goals. It is a geographical term but rather describes the convergence-divergence cleavage in the Eurozone and was used mainly after the Eurozone debt crisis by several scholars, such as Beck (2013), to criticize the structure and the economic policies implemented by the Eurozone and the core countries such as Germany.

[6] It should be noted that the increase in social funding may not necessarily solve social problems if the interventions are not effective and based on needs assessment. As Wódz, Faliszek & Trzeszkowska-Nowak (2018) indicate in social policy we tend to focus on financial benefits and redistribution but it is necessary to develop more individualized services available to citizens in a framework of universal access in order to increase effectiveness and efficiency. This demands public funds but also the re-organization and re-structure of the welfare system for example with the creation of comprehensive Primary Health Care with family doctors concentrated on the specific needs of their patients in the region they are working.

[7] According to OECD data, child poverty in Southern European countries (Spain, Greece, Italy, Portugal) is the highest among the countries of the Eurozone. See: https://www.oecd.org/els/CO_2_2_Child_Poverty.pdf

	Greece		Spain		Italy		Portugal		Eurozone	
	2008	*2018*	*2008*	*2018*	*2008*	*2018*	*2008*	*2018*	*2008*	*2018*
Education level: Primary	7.7	22.8	15.4	22.3	8.5	14.9	8.3	7.7	11.7	15.2
Education level: Secondary	8.9	21.9	10.5	15.5	6.1	10.2	7.8	8.3	6.9	7.5
Education level: Tertiary	6.5	14.3	6.4	9.0	4.6	6.1	6.9	12.7	4.3	5.1
Native	8.0	19.0	10.2	14.4	6.7	10.4	7.9	7.1	7.1	7.8
Non-native	6.8	26.9	17.5	21.9	8.5	14.1	10.9	11.4	13.2	13.0
Unemployment Total	7.9	19.5	11.3	15.4	6.8	10.8	8.0	7.3	7.6	8.3

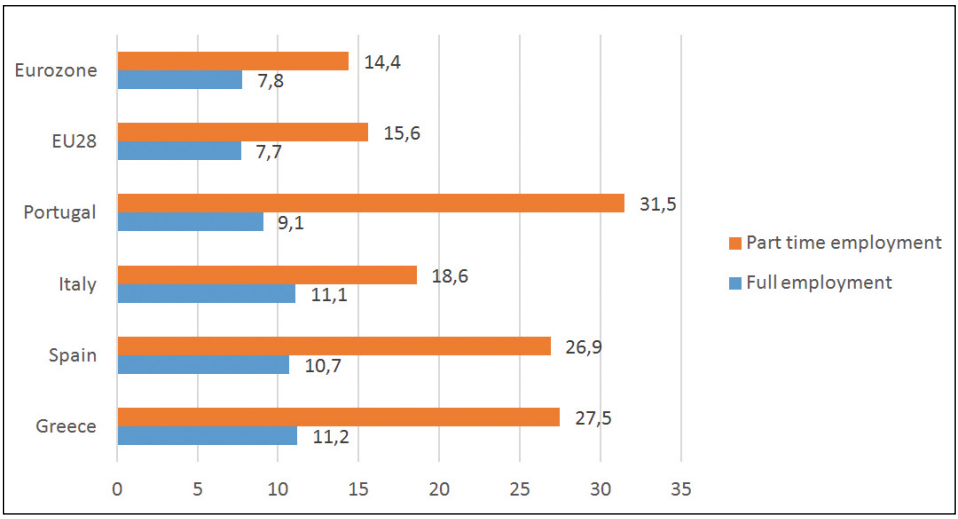
Source: Eurostat (2019), Available at: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=lfsa_urgan&lang=en and: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=lfsa_urgan&lang=en (Ανάκτηση: 4/13/2020).

Table 2. Danger of poverty and social exclusion by age group

Countries/ Age	Total	Up to 16	16–24	25–54	55–64	65–74	More than 75
2008							
Eurozone	21.6	23.3	26.5	19.6	24.7	18.2	22.1
Greece	28.1	27.8	34.3	25.6	32.1	23.8	34.0
Spain	23.8	29.6	26.0	20.7	23.0	22.9	29.7
Italy	25.5	28.0	31.6	23.6	26.2	23.7	25.2
Portugal	26.0	29.2	28.6	22.8	28.5	24.5	31.5
2018							
Eurozone	23.0	24.2	29.7	22.4	25.4	17.3	20.9
Greece	35.7	35.7	46.3	37.5	41.6	23.3	27.1
Spain	27.1	31.5	35.8	28.2	27.9	16.6	19.0
Italy	29.8	31.5	35.0	30.9	31.7	21.8	26.6
Portugal	24.0	23.0	30.1	21.7	30.0	19.1	25.9

Source: Eurostat (2019). Available at: https://ec.europa.eu/eurostat/databrowser/view/ilc_peps01n/default/table?lang=en (Accessed: 10/10/2019).

Figure 1. In-work poverty-2017



Source: Eurostat EU-SILC (2019). Available at: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=ilc_iw07&lang=en (Accessed: 10/25/2019).

The decline in citizens' consumption potential has different effects on the economic sustainability of individual socio-economic groups. For example, the middle socio-economic groups in Greece witnessed a serious negative shift in their living standards. Similarly, the change in consumer habits came as a response to the sharp increase in taxation that exhausted citizens' tax capacity (Bell & Blanchflower, 2015; Boot, Wilson & Wolf, 2015). At the same time, the slashing of wages exposed to poverty risk a large proportion of citizens that belong to the most vulnerable groups, such as immigrants and the youth, due to the inability of the social safety net to address the fallout from the recession (Laparra et al., 2012; Matsaganis, 2018). This trend depicts that the Greek case shows the highest levels of material deprivation[8] in the Eurozone and the highest increase amongst EU countries during the crisis (Eurostat, 2019a[9]). With the exception of Portugal, the other Southern European countries seem to be on track by keeping the same high levels as before the crisis (Eurostat, 2019a). It could be argued that the inability of the welfare state to provide adequate protection services in the fields of employment, social security, health, and education, increased uncertainty and social risks and put social cohesion in jeopardy.

With disposable income decreasing by 24.33% between 2008 and 2017 in Greece[10] and the welfare state facing the challenge of saving funds, the apparent social consequences

[8] Material deprivation is the measurable value of the inability of the welfare state to provide conditions to meet basic needs, let alone safeguarding social welfare, which is a subsequent step.

[9] https://ec.europa.eu/eurostat/statistics explained/index.php/Material_deprivation_statistics_-_early_results.

[10] For more details see: Eurostat (2019), Disposable Income, Available at: http://ec.europa.eu/eurostat/tgm/table.do?tab=table&language=en&pcode=tec00113 (Accessed: 12/8/2019).

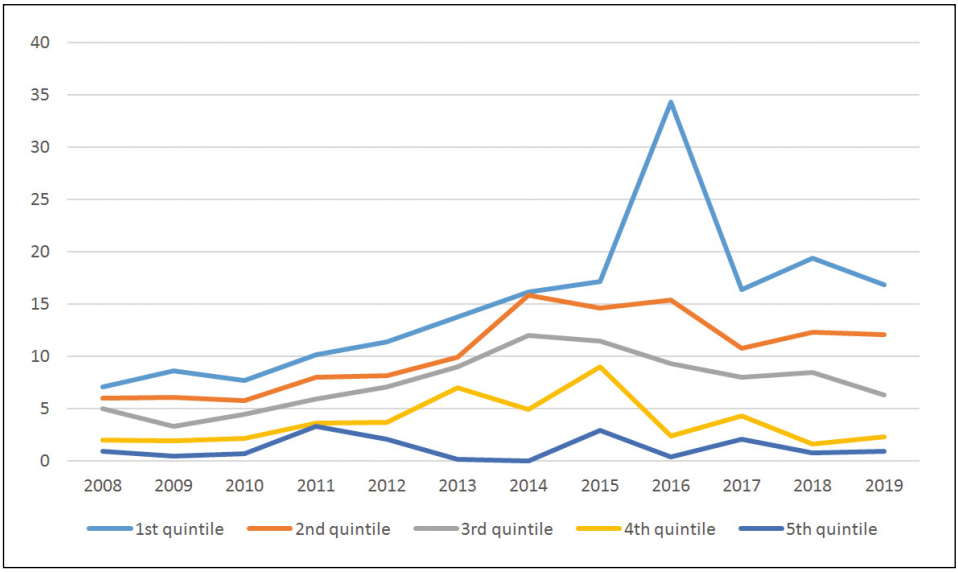
were an increase in poverty and inequality. Young people appeared to be one of the most vulnerable socio-economic groups both in Greece and the rest of the Southern European states. In the same vein, the collapse of the household incomes led to an increase in poverty. For example, recent data has demonstrated that Greece possessed the highest youth poverty rate in the EU in 2017. It is acknowledged that the youth and general poverty rates during the economic crisis sharply increased not only in Greece but also in Spain (Eurostat, 2019b[11]). Furthermore, the decline in government revenues caused by the financial crisis and the ensuing reduction in social contributions[12] constrained the funding opportunities essential to meet the rising health needs. Simultaneously, the growing demand for social benefits, such as unemployment benefits, put the public finances on strain (Venieris, 2013). Therefore, and under the exogenous pressure of Memoranda[13], countries such as Greece sought to curb state funding. A large number of studies has shown that budget constraints seriously affected health financing which, in turn, lowered the prospects of access to services as well as to medicines (see Figure 2) and the level of response to health needs (Kalafati, 2012; Karamanoli, 2012; Karatzanis et al., 2012; Kentikelenis et al., 2011; Tsiligianni, 2013; Tsiligianni et al., 2014; Vandoros et al., 2013; Zavras et al., 2016). Admittedly, these problems were more evident in the most vulnerable social groups. That being said, the access to health services has become more difficult in rural areas as the population majority is mainly elderly (Tsiligianni et al., 2014; Vandoros et al., 2013; Zavras et al., 2012). Some other studies (Musgrove, 1995; Stuckler et al., 2009) and relevant data (see Figure 2) presented that during the economic crisis the prospects of coping with health problems may decrease, especially for the lower socio-economic groups. This reasonably brings to the fore the discussion of affordability and adequate response. Meeting health needs for the middle and lower socio-economic strata became quite challenging as they seemed less able economically to respond while the cost markedly climbed up (Karanikolos et al., 2013). Moreover, there is the assumption that inequality is amplified between the economically prosperous and the rest, that is, the vast majority of citizens including the middle- and low-income groups. In doing so, it is shown that the state is moving away from the objectives of equal access to health services, without, however, meeting the health needs equitably and tackling risks successfully.

[11] https://ec.europa.eu/eurostat/statistics-explained/index.php?title=File:Share_of_young_people_(aged_16-29_years)_at_risk_of_poverty_or_social_exclusion,_2017_(%25)_YP18.png).

[12] By social contributions we refer to the employees' and employers' contributions as part of the decrease of income and employment levels that comprise a significant part of the health system.

[13] Memoranda of Understanding between the Greek government and the European Commission, the European Central Bank and the International Monetary Fund on a bailout in order to avoid the bankruptcy of the Greek state. In response, the Greek authorities had to comply with a set of extraordinarily detailed conditions on reforms.

Figure 2. Percentage of unmet health needs per income quintile in Greece due to their costs (1=lowest income, 5 =highest income)



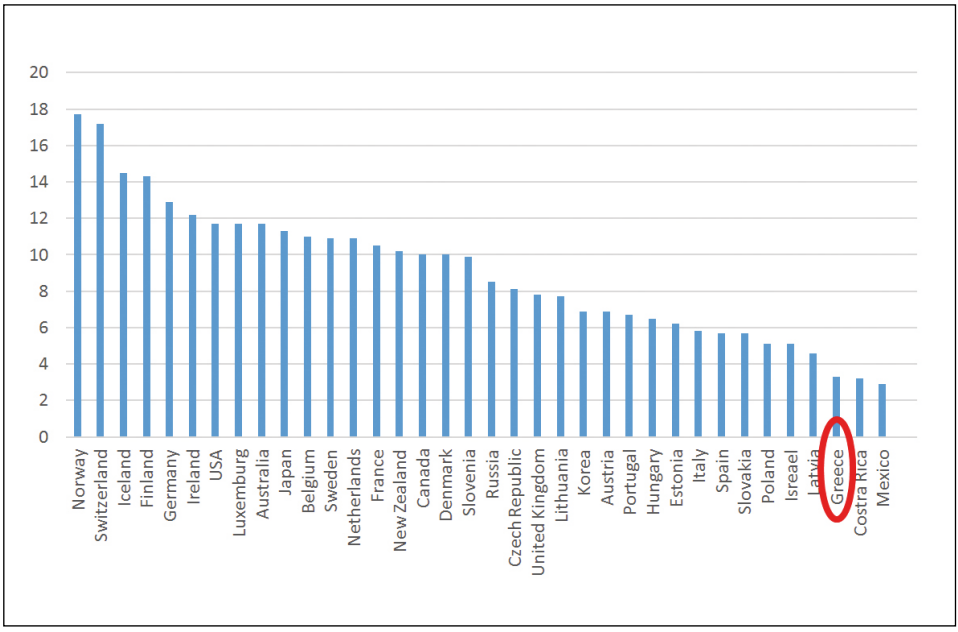
Source: Eurostat (2022) [hlth_silc_08] Available at: http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do (Accessed: 6/28/2022).

Despite the creation of the Greek NHS as a system of universal access to health care, the objectives of providing quality and integrated health services fall significantly short. The problems – among others – consist of the lack of an integrated and modern primary health care system, the lack of empirically based policy development, organizational problems in the allocation of material and human resources, the outflow of expenditure not related to actual needs, as well as underfunding, leading in essence to reduced levels of health de-commodification. For instance, it is a fact that, until the outbreak of the economic crisis, Greece showed the highest pharmaceutical expenditure per capita in the EU (Vandoros & Stargardt, 2013), largely as a result of over-prescription. The consequence of this trend was both financial pressures on social security funds that cover part of the costs of the insured and pressures on family budgets due to the insureds' share of the costs. One of the factors contributing to the outflow of expenditure in the health sector has for years been polypharmacy, as a result of over-prescription, the lack of an integrated, universal and technologically modern e-prescribing system, clientelism between doctors, pharmacists and pharmaceutical companies and the lack of information for citizens about the risks and side effects caused by the excessive use of medicines (Theodorou et al., 2009).

Specifically, the Greek public healthcare system covers only 61% of total health needs, about 10 percentage points less than the OECD average, with the remaining percentage (39%) covered by private expenditure (OECD, 2019). It is understandable that the level of health de-commodification is extremely low compared to all developed European countries,

which exacerbates inequalities and creates coverage gaps, particularly for the lower socio-economic groups, long before the pandemic. At the same time, before the outbreak of the pandemic, the health workforce was reduced by 2252 permanent employees compared to 2019 (Ministry of Interior, 2020) and the imbalances in terms of distribution and staffing levels are notable, as there is an overabundance of doctors (however inefficiently distributed) and a significant shortage of nurses. Despite the largely ad hoc recruitments made subsequently during the pandemic (7500 health workers), permanent strengthening of the system is a current necessity (OECD & World Health Organization, 2021). According to the OECD, Greece has 6.1 physicians per 1000 inhabitants while the OECD average is 3.5 and 3.3 nurses per 1000 inhabitants while the OECD average is 8.8 (OECD, 2019). However, despite the significant number of physicians, the way they are distributed across the country and the lack of general practitioners for primary health care system highlights the lack of needs assessment planning to achieve greater levels of efficiency (Sagan et al., 2021).

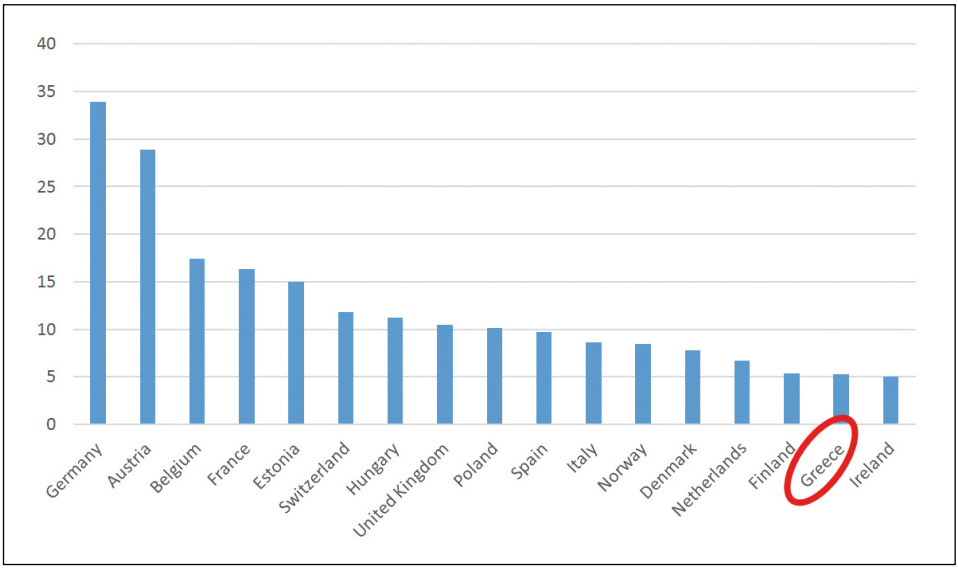
Figure 3. Nurses per 1000 inhabitants in OECD countries



Source: OECD (2019). *Health at a Glance*. Paris: OECD: 173.

Another very important indicator where Greece seems, according to the most recent data, to lag behind the European average is the number of intensive care beds per 100,000 inhabitants. This indicator was the subject of a public debate during the pandemic in Greece, as ICUs are essential for the treatment of the most serious cases. On this indicator Greece had only 5.3 beds per 100,000 population compared to 12.9 for the EU average of 14 based on the most recent data before the pandemic (Figure 4).

Figure 4. 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.

Clearly, the abovementioned shortcomings that the Greek National Health System (NHS) faces act as obstacles to its preparedness for major health crises, such as that of the new coronavirus. Although such an event represents a huge challenge for any system in the field of relevant public policies, those characterized by higher levels of efficiency and coverage – hence preparedness – are in a better position.

It should be mentioned though that in addition to restrictive measures and awareness-raising activities during the pandemic, Greece increased spending on NHS support due to the pandemic compared to the pre-pandemic era in 2020. However, the increases were far below those of the majority of EU Member States, already from the first pandemic wave (HSRM, 2020). This policy of restraint in public health spending continued in subsequent pandemic waves, as the 2021 national budget showed that spending for hospitals and Primary Health Care (PHC) decreased by 1.5%, transfers for health benefits to the NHS decreased by 50% (Ministry of Finance, 2020), while a small increase of EUR 196 million was projected for 2022 for hospitals and PHC (Ministry of Finance, 2021). Although EUR 1.5 billion was committed to improve the resilience, accessibility and sustainability of healthcare by the EU's Recovery and Resilience Mechanism (OECD & World Health Organization, 2021), unless a broader strategy is implemented to strengthen the public health system through permanent needs assessed interventions and policies within an empirically grounded policy formulation framework, these opportunities will be lost and the interventions in the midst of a pandemic will only become circumstantial.

The pandemic and beyond. Challenges for a sustainable welfare future

After the economic crisis – and before its consequences were slightly healed – a different but also multidimensional crisis occurred; the pandemic. What are the lessons learned by the COVID-19 pandemic about the role of the welfare state in Greece? While, especially in the first phase of the pandemic the Greek welfare state addressed relatively effectively the challenges posed, it is necessary to permanently strengthen the national health system by human resources (nursing, supportive and medical staff), by more ICUs, by supporting the Primary Health Care (PHC) framework and by increasing funding for research. By linking PHC with public health and strengthening the role of the family doctor with corresponding incentives for general practitioners, the possibility will be given to enhance the effectiveness of the system for the benefit of citizens. To this point, the need to strengthen health financing should be added, based on needs assessment per region and with strategic planning that aims to allocate material and human resources on the basis of needs and with a view to improving accessibility for the population and subsequently, reduce inequalities. All these measures would increase accessibility, efficiency, effectiveness as well as quality and are based on specific shortcomings that the Greek welfare state has been facing for decades (OECD, 2019).

At the time, Greece has the lowest rate of human resources in health and social work, the lowest rate of practicing nurses and the lowest rate of long term care beds among the European countries (OECD, 2019). These figures show that the welfare provision and health services were inefficient to cover the needs of the population and the pandemic has made the necessity for their amplification even more pressing. While some efforts have been made, permanent solutions based on needs assessment should be implemented in order to create a comprehensive framework of social welfare services that will increase citizens' quality of life.

Following the health crisis, an economic one is occurring and the welfare state should be ready to support the vulnerable and to bring about welfare for all. This is noteworthy as the pandemic highlights the need for a comprehensive welfare state that will serve as a mechanism that efficiently addresses the consequences of vast crises. While during the financial crisis the welfare state was hard hit, the health crisis and its tragic implications show the limits of private initiative and the scope of public intervention regarding social issues (Tzagkarakis, Pappas, Kritas, 2020). Even the universal access to vaccines and the free selection (either to have the vaccine or to choose among different kinds) was an achievement of the welfare state[14].

The challenge now for the welfare state is to find a way to preserve rights and reduce social inequality. Therefore, this state should re-create society. The welfare state must renew its consensus tools, the institutional framework, which still faces structural inefficiencies derived from its historical and institutional tradition, and its production mechanisms in order to maximize all its advantages and guarantee an increase in the quality of life. Therefore, issues such as the lack of human and material resources in the NHS, the problematic labor market security, the extensive informal economy and social inequality, should be

[14] The opposition to vaccination is a phenomenon of the post-modern era in which the freedom to choose while it is a right may also threaten the most important public good; public health. The welfare state should use mechanisms of information, health promotion and persuasion in order to enforce the right to public health.

severely confronted through an extensive public investment based on needs assessment. Thus, the welfare state should reduce the inequalities, especially in the peripheral and underground sector due to rotational employment, pseudo-entrepreneurship and non-formal employment which are highly increased due to the enforcement of teleworking (Nieuwenhuis & Yerkes, 2021) and also reduce the family-work life imbalance though the "right to disconnect" so that flexitime at work does not become "stiffentime". Moreover, strengthening the small and medium-sized businesses and creating incentives for new jobs, will increase labor opportunities and enhance social cohesion.

However, as it has been already shown, the Greek welfare system is in the midst of a constant crisis, unable to convincingly address the increasing social problems that avert people from enjoying fundamental social rights, such as health care, education, employment, and social protection. Thus, reforms are necessary in terms of achieving a comprehensive recalibration strategy and preventing further dismantling. Second, the economic crisis as an external parameter has decisively contributed to the increase of social problems. And this will continue after the pandemic unless interventions can be implemented. It is obvious that income inequality is connected to poverty and this could be associated with the extensive volatility of the labor market and unemployment. Third, certain social groups such as NEETs, seem to mostly suffer after 2010 (Kotroyannos et al., 2015), a variance which could be attributed to the economic prospects, (lack of) concerted action, and targeted policies in tackling youth unemployment (Papadakis et al., 2020). Fourth, there is a considerable divergence in meeting health needs between the high and low-income groups in Greece, even though the pandemic was handled relatively positively, especially in the first wave. Fifth, this persistent crisis (from institutional to economic-financial and now to health that also affects society and economy) arguably affected social fabric by exacerbating the already existing problems and systematically challenging the social cohesion. The surge of the socio-economic problems during the crisis reminds us of the need for more targeted policies and strengthening of the welfare system structures. However, what raises lots of concerns about post-pandemic Greece is the formation of some negative dynamics and trends in society. To put it bluntly, some problems for the socially vulnerable groups seem to persist or even worsen, thus revealing a fear for the welfare system's capacity and response to address social problems in the future.

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