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Centralization and Lockdown: The Greek Response

Nikolaos Zahariadis and Vassilis Karokis-Mavrikos

> *We are at war with an enemy who is invisible but not unbeatable.*
>
> (Prime Minister Kyriakos Mitsotakis, March 17, 2020)

> *I am more afraid of our own mistakes than of our enemies' designs.*
>
> (Pericles in Thucydides, *The Peloponesian War 1.144*)

When the COVID-19 pandemic hit the world in January 2020, Greece, like many other countries, was caught unaware and unprepared. Barely out of ten years of austerity and still in the middle of a devastating migrant crisis, the country was resource-poor and politically polarized. Nevertheless, because of its administrative policy style—low policy capacity and low inclusiveness—as well as the low trust that Greek citizens have toward public institutions, the country's response followed the hypothesized trajectory specified in Chapter 2: high centralization. However, deep problems emanating from the illusion of total success during the first wave of the crisis (February–May 2020) exposed institutional deficiencies and generated social discontent and political distrust, leading to centrifugal tendencies during the second wave (September 2020–January 2021). The country's response has subsequently shifted to a more regionally nuanced approach, changing the dynamics of crisis management and partially amending our original centralization hypothesis.

The chapter first describes Greece's policy capacity and trust and then explores how they shaped the national response. The analysis of the response strategy is informed by 20 interviews with Greek policymakers and academics conducted over two waves (July–August 2020 and December 2020–February 2021). The selection of respondents was based on relevant scientific expertise as well as experience in formal positions during the current or a previous pandemic. The interviews were semi-structured, guided by the analytical axes of the policy styles framework. The names and affiliations of all respondents are listed in the appendix. Comparing the insights

collected through the interviews between the two waves, we note the factors that pressed for a shift away from centralization. Still heavily centralized, national response has begun to acquire more centrifugal elements as the Greek government has shifted priorities to a more carefully calibrated public health-economy trade-off. We conclude with observations about our case and identify theoretical gaps in the argument.

An Administrative Policy Style in the Making

Greece has an administrative policy style. In terms of policy capacity, the country exhibits top-heavy concentration of powers, a hierarchical mode of decision-making and implementation, and a high degree of constant institutional change and jurisdictional ambiguity. Similar to other South European countries, it has a profoundly politicized bureaucracy, steeped in formalism and heavily influenced by political patronage (Sotiropoulos 2004). Reasons for these pathologies include historical legacy, partisanship, clientelism, nepotism, and widespread corruption in the transition to democracy (since the fall of the military dictatorship in 1974) as well as a culture of perennial reforms and implementation gaps.

Owing to its legacy in the Napoleonic tradition (Spanou 2008), the Greek administrative system has followed the path of heavy statism. Because the system proved economically very successful following World War II (Pagoulatos 2003), public organizations became deeply entrenched and centralized, functioning on the basis of formal rules and procedures and subjected to direct political control. The fall of the military dictatorship added new issues in terms of partisan politics, democratization, and state-society relations (e.g., Lyrintzis 1984). The arrival of the populist left in power in 1981 saw the dramatic expansion of state bureaucracy through increases in public employment in the name of democracy and modernity (Sotiropoulos 1996). Following the path of least resistance, the ruling Socialists (and their conservative successors) chose to add layers of more state bureaucrats rather than eliminate agencies which were no longer needed. The tendency was perpetuated and propagated by the introduction of temporary general and special secretariats in various ministries, usually abolished by the next administration in power, clogging the already crowded bureaucracy and producing implementation gaps (Makrydemetres 1999). The end result was a huge increase in patronage as a source and consequence of political power (Spanou 1996), clientelism and a labyrinth of agencies, and rules that were often in conflict with one another.

Institutional ambiguity, widened through jurisdictional overlap, produced endemic conflict. As Hajer (2003) reminds, the multiplicity of meanings embedded in ambiguity empowers public agencies to continually (re)interpret institutional opportunities and constraints. (Re)interpretation generates instability and political tension (Zahariadis 2016). In this environment, political patronage becomes the main vehicle to cement benefits and ensure survival. The high politicization that continues to characterize the Greek political system and public bureaucracy, including health care, has tended to overshadow the economic-cum-managerial dimension of operating hospitals, favoring political criteria of organizational and individual performance (Ballas and Tsoukas 2004). Modernizing hospital management "has been in the agenda for years, but staffing has been inconsistent and practices remain outdated" (interview with Emeritus Professor of Management Aris Sissouras).

Minimal Inclusiveness, Perennial Reforms, and Low Trust

What is more, laws have often been adopted by the legislature with minimal consultation with social actors (low inclusiveness). Despite legal obligations in years past to consult with affected social actors, usually meaning labor unions, successive governments have done so in politically expedient ways due to centralized powers. Consultation and inclusiveness were often attempted in form than in substance. Governments have used party-affiliated experts not to meaningfully inform but to legitimize decisions, usually for the benefit of a partisan network of actors in each policy sector (Kalyvas et al. 2012). Austerity and creditor demands since 2010 have strengthened political expediency and reduced inclusiveness (Ladi 2014). Laws are now passed with dizzying speed, hardly any inclusiveness of social actors, and under emergency procedures in the name of obligations to meet creditor targets. The situation is exemplified by the perennial state of reform that Greek bureaucracy finds itself. In addition to the flux encountered in the 1980s, major reforms to streamline administration have been attempted throughout the 1990s and 2000s including, most recently, capacity-building reforms encouraged by the bailout packages. With the exception of tax collection tools to help balance public books, reforms have mostly failed to take hold (Lampropoulou and Oikonomou 2018). Obstacles have included lack of preparation and cohesion, lack of political will, weak social support and input, and a general political environment that rewards most of the spoils to the electoral winners (Spanou and Sotiropoulos 2011). To this list, we may add suspicion by affected (health) professionals of a biased state; reforms are met with selective consent and dissent (Bolton et al. 2018). In this case,

trust in the system and in reforms evaporates. Perennial and unsuccessful reforms increase ambiguity, further feeding low capacity and trust and cementing the downward spiral.

Trust in Greek political institutions is generally low. The perceived lack of transparency, corruption, and widespread nepotism have made Greeks expect less from their government. As Norris (2011) argues, in countries where democratic performance fails, citizen expectations plummet and distrust increases. Successive European Social Surveys show that Greeks have less trust in their government and political institutions than most of their European allies. The rate of decline accelerated once the economic crisis hit, just like it did in other South European countries hit hard by the economic crisis (e.g., Torcal 2017). As Ervasti et al. (2019, 1222) categorically assert, the Greek "people have been repeatedly disappointed with the attempts of politicians of various persuasions to implement policies guiding the nation out of the crisis." By 2018, the country had been hit hard by perceptions of declining quality of governance, lack of accountability, and political transparency, all leading to confidence and trust levels in government and public health services hovering around an abysmal 16% and 42% relative to the OECD average of 42% and 70%, respectively (OECD 2019).

The Greek Health Care System

Such dysfunction and public sector pathologies have long manifested in the Greek health policy sector. Beginning with the establishment of the Greek National Health System (GNHS), in 1983, the sector has been defined by immense centralization, jurisdictional conflict, narrowness in policy outputs, and continuous formal and informal rapport between the government and a highly integrated policy community (Sissouras 2012). The sector has exhibited a clear orientation toward hospital care, encouraged by the hegemonic Ministry of Health (MoH) and the powerful doctor guild (Kyriopoulos and Telloglou 2019). Reform design has been delegated to a small community of health experts with close ties to the government (Petridou et al. 1999) who undertook an array of formal and informal positions and engaged in constant role switching. They undermined inclusiveness from within, legitimizing the institutional configurations in place and maintaining the prevailing balance of interests.

Efforts to introduce decentralized instruments, although legislated on multiple occasions, have largely proven futile during implementation (Athanasiadis et al. 2015). Professor Christos Zilidis categorically states:

> the regional pillars of the system never really functioned effectively and, despite provisions in the health bills of 2001, 2003 and 2005, power remained concentrated in the hands of central political and administrative instruments; specifically, the MoH and the Greek Center for Disease Control (CDC).

Moreover, as Professor Christos Lionis asserts:

> the integral parts of the Greek health services system – hospital, primary and social care – lack integration. Social care services are supervised by the Ministry of Labor, local public health is under the auspices of the Ministry of Interior and primary health care lies with the MoH.

The resultant jurisdictional ambiguity has exposed deficiencies in health monitoring capacity and the absence of updated vaccination and disease registries, inform Professors Dimopoulos and Tsouros. These are key elements of any strategy to effectively combat a pandemic. Missing clear division of labor, consistent cooperation across levels and sectors, and long-term coordination, Greek health care lacks administrative instruments, funding, and the legal infrastructure to adequately address issues at the regional and local levels. Research on public health systems and services and in public health law concludes that creating such instruments is pivotal to policy innovation, infrastructure development, and effective implementation (Burris et al. 2012).

The decade-long financial crisis (2010–2020) only made things worse. Hospitals were one of the main contributors to the ballooning public deficit, the other being the railroad company (Zahariadis 2013). Public funding was unavoidably slashed, supplies were cut back as part of the broader government initiative since 2015 to generate large primary budget surpluses, and staff was decimated in terms of numbers, salary, and morale (Bolton et al. 2018). The GNHS continued to be viewed as highly problematic, inefficient, and corrupt (Sissouras 2012). Following ten years of economic austerity and five years of a concurrent migration crisis, the GNHS found its budget cut by three-quarters in 2020 and the number of Intensive Care Unit (ICU) beds standing at a mere 560 beds (Psaropoulos 2020). To put it into context, this number represents 5.2 beds per 100,000 population (Greece's population in 2019 was 10.72 million according to data from Eurostat) as opposed to the OECD-22 average of 12 beds per 100,000 (OECD 2020).

The COVID-19 Response

A centralized top-down approach emerged as the only course of action for Greece against the COVID-19 threat, especially during the first wave. Despite belated pushback from businesses, some civilians, the Church, and political opposition parties, the Greek government used scientific advice and symbolic politics to legitimize a very stringent lockdown. The pandemic hit the country in two waves. The first lasted from late February to early May 2020. After hesitant measures designed to help the economy recover from the blow caused by the pandemic, the country experienced a second wave of cases and consequent deaths that was far worse than the first. We first track the Greek response during the first wave, then briefly discuss the summer interlude, and finally focus on the second wave from late September 2020 to January 2021.

Centralization and Success during the First Wave

Closely tracking Italy's predicament at the time, Greece realized that it could not afford an epidemic of a similar magnitude to neighboring Italy. "There was opposition [to a general lockdown], mainly from our unit on the economy, but it was quickly overcome, with the images that were starting to come from Italy definitely playing a part," stated Prime Minister Kyriakos Mitsotakis (interview on August 5, 2020). The country's deficiencies in resources and health services capacity precluded any prospect of managing large numbers of patients from the start. Systemic public sector dysfunction forced a proactive response, focusing on prevention, not treatment. "Our single immediate priority was protecting the GNHS from overloading by any means necessary. We shifted all of our attention on how to contain the spread of a threat we knew nothing about," stressed Deputy Minister of Health Vassilis Kontozamanis. "We wanted to make sure we would never reach a state where people would die because we would be incapable of offering care," admitted the Prime Minister.

Action was swift, turning weakness into strength. "Other countries, with much better hospital infrastructure and more ICU units per population, maintained an illusion that their systems would be able to cope, so they delayed [countermeasures]," informs Ioannis Tountas, head of Greece's Institute for Social and Preventive Medicine (in Labropoulou 2020). On February 23, 2020, the Prime Minister set up an 11-man National Committee for the Protection of Public Health against COVID-19, composed of the MoH's general secretaries and directors for public health services and emergencies, the presidents of the national agencies for public health, medicines, and emergency

services and four experts specializing in microbiology and infectious diseases. While the international community failed to settle on common guidelines, the Greek Prime Minister prepared to introduce strict measures.

> The international scientific community did not provide clear directions at the start. Let me remind you that the WHO has made quite a few U-Turns so far. It was late to declare a state of world pandemic, it did not advise on using masks in the beginning etc. I spent time educating myself on what this new threat was. I spoke directly with people on the frontlines – people offering care at ICUs – and realized quickly this is and can be ugly. And this led me to the quick personal decision to proceed with a lockdown.

In the low-trust, adversarial Greek polity, he knew that fingers would soon be pointed and blame games were sure to follow.

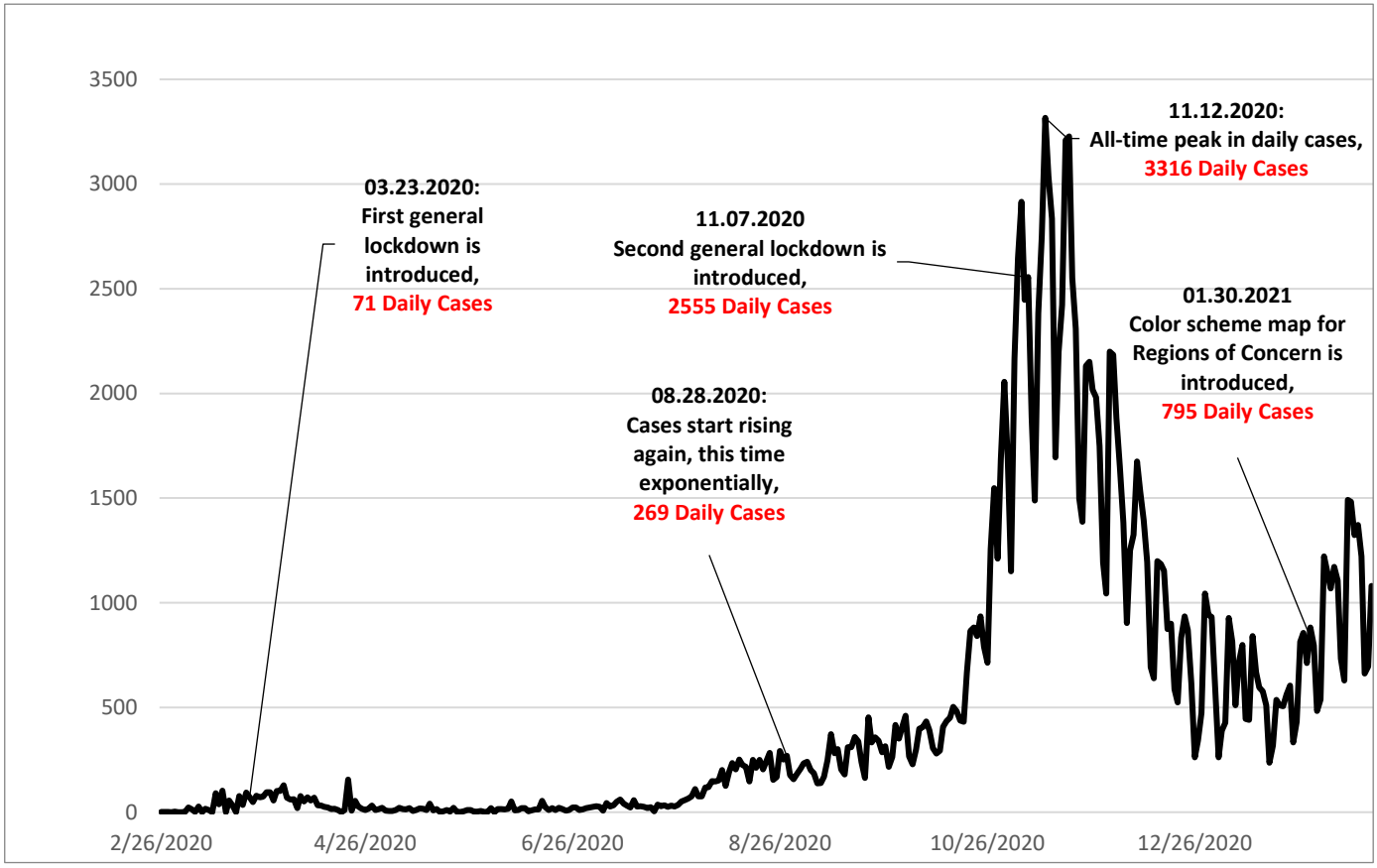

Figure 5.1: New Daily Confirmed Covid-19 Cases in Greece
Source: Our World in Data - Greece: Coronavirus Pandemic Country Profile (26.02.2020 – 16.02.2021)
Available Online at: https://ourworldindata.org/coronavirus/country/greece?country=~GRC

During the first wave (Figure 5.1) and consistent with our hypothesis, the government drafted a concentrated command-and-control plan with very stringent measures. On February 27, as a result of three confirmed cases, the government canceled carnival events throughout the country, leading to significant political pushback. Social disruption increased resistance from political opposition and individual voters. However, as the number of confirmed cases continued to climb, all educational institutions across the country were closed on March 10. A new Committee of 26 scientists "for the Response to Emergency Public Health Threats from Infectious Causes," which became known as the COVID-19 Specialists Committee, was created on March 11. On March 12, movie theaters, gyms, and courtrooms were closed. On March 13, with 190 confirmed cases and one death, malls, cafés, restaurants, beauty parlors, museums, and archaeological sites were ordered shut followed by beaches and ski resorts the next day, including banning flights to/from Italy. The most impactful measures came on March 23, when, following examples by other EU countries, the government banned all non-essential travel and imposed restriction of movement nationwide. Subject to heavy fines, citizens could leave their homes only with special permits and for specific reasons.

With no prospect of making structural changes to the process of policymaking during an emergency, decision-making and coordination were handled by a handful of politicians and bureaucrats, with the Prime Minister undertaking the leading role. As Mahoney and Thelen (2010) predict, Greeks engaged in some institutional change, especially in the form of layering or bricolage (addition or *ad hoc* recombination of capacity). But, unlike their argument, they did not need to overcome political friction. Three new instruments emerged as vital sources of input, prompting a higher-than-expected degree of inclusiveness, albeit in a clearly centralized mode. First, the National Public Health Organization (NPHO), founded by the preceding radical left–right (SYRIZA-Independent Greeks) government to replace the Greek CDC, acted on its mandate as "Greece's designated authority on infectious diseases and public health emergencies." It started issuing directives as early as of February 9, 2020, published a provisional Pandemic Response Plan, had some of its proposals acted upon immediately (e.g., setting up the national COVID-19 case registry hosted by the NPHO website), and undertook all digital communication with the public. Second, the COVID-19 Specialists Committee "met daily" since its establishment at the MoH and "saw most of its proposals accepted by the leadership" (interview with Panagiotis Gargalianos, member of the COVID-19 Specialists Committee). Blamed by many for its narrow composition—by Greek standards—the COVID-19 Specialists Committee did not have the "interdisciplinary and intersectoral character" of similar committees established during

the 2009 H1N1 pandemic or the 2002 Sars-Cov-1 epidemic (interview with Emeritus Professor Ioannis Kyriopoulos). Nevertheless, unlike its predecessors, it undertook a more meaningful role, serving as the central advisory body rather than the usual symbolic recognition mechanism as had been the case in the past. Third, the General Secretary of Civil Protection and Crisis Management, Nikos Hardalias, was upgraded to Deputy Minister, within the Ministry of Citizen Protection. Minister Hardalias notes that

> following the Prime Minister's decision in February [2020], Civil Protection undertook the central coordinating role in the fight against Covid-19. Additionally, in close cooperation with police units, fire departments, the coast guard, the MoH and the NPHO, it developed and carried out all contact tracing as well as data processing, in the new National Data Analysis Centre hosted in the new Civil Protection headquarters.

In line with the government's broader agenda of a more meritocratic and efficient state apparatus, efforts were made to increase inclusiveness and enhance administrative capacity from the start while maintaining concentration of powers at the highest level. "Acting early bought us time to prepare for what will come because the pandemic is far from over," stresses Deputy Minister Kontozamanis.

Coordination was exemplified by a consistent message delivered in daily briefings by the spokesperson of the MoH and member of the COVID-19 Specialists Committee, Dr. Sotirios Tsiodras, a professor of infectious diseases at the University of Athens. He was often accompanied by Minister Hardalias. This is a coup for the Greek civil service because it combines transparency and expertise. This did not go unnoticed neither by the public nor by the political opposition. "It gave legitimacy to the measures and support to the socially costly decisions. It was hard to refute through political debate a set of measures so strongly grounded on science" (Professor Zilidis). The scientific legitimation of the strict lockdown policies added to the "initial terror widely publicized in the media from deaths in Italy and Spain" (interview with Associate Professor Effie Simou) in achieving compliance. The government managed to induce higher trust, turning "the traditionally reactionary Greek public to an obedient one" (interview with Professor John Yfantopoulos). The Prime Minister categorically declares:

> I think we found a great balance between the fear and strictness that Nikos Hardalias inspired and the expertise and sweet voice that Sotiris Tsiodras brought. This was not explicitly planned from the start, but when we saw it was working, we heavily invested in it.

Decision-making seemed particularly responsive to feedback.

Frustration and Concern Grow Exponentially during the Summer Interlude

Greece's early response with horizontal measures of strict social distancing introduced through a centralized mode of policymaking catapulted the country to a success story and cultivated citizen trust in government (Petridou and Zahariadis 2021). The number of cases, and more importantly deaths, were kept to a minimum. Key social alliances were formed "in fronts that could threaten trust and compliance, such as with the Greek Orthodox Church," as Professor Zilidis informed. Public funds as well as considerable private donations increased the number of ICU beds to 1,017 in May 2020, close to the threshold of 1,200 that would put the country on par with the EU average of ICU beds per 100,000 people (Athens News Agency 2020). With the risk of a GNHS collapse significantly minimized and with less than 10 daily cases, lockdown measures started being lifted on May 4. The hospitality sector was allowed to resume operations on May 25, and international travel restarted on June 15, in an effort to deliver a much-needed boost to the economy through Greek tourism. Greece relies on tourism for a fifth of its income and a quarter of jobs, making it the single most important economic sector (Tugwell and Nikas 2020). Showing awareness of the long-term persistence of the COVID-19 threat, the government created the Governmental Committee of Coordination for the COVID-19 response at the end of June to collect information and propose or amend government programs under consideration during the pandemic.

Nevertheless, despite the seeming goodwill and increasing trust in government, preparedness for a second wave proved lackluster, and the country was soon plagued by policy capacity deficiencies. Three factors during the crucial summer months generated frustration and concern causing trust to plummet again. Declining levels of trust shaped the Greek response during the second wave of the pandemic (September 2020–January 2021). First, the trade-off between public health and economic objectives made prolonged lockdown measures very difficult to implement. The COVID-19 crisis came on the heels of a 10-year economic recession, devastating a fragile and hesitant economic recovery. Professor Kyriopoulos stressed this point: "The trade-off between public health and the

economy was very pertinent in the Greek case. Capitalizing on the early success and opening up following the example of other EU success stories was way too appealing for the government." In fact, in a public opinion poll in early June, more worried about their financial situation (32%) as opposed to those worrying about their health (23%)—42% were concerned about both (ekathimerini.com 2020). As a result, the number of cases began to rise (Figure 5.1). Whether cases were the result of infected tourists coming through land borders in Macedonia and Thrace, where initially no tests were administered in contrast to air travel, or of more tests, the fact is that the government lost a major tool in its successful response against COVID-19: contact-tracing. As the World Health Organization (WHO) makes abundantly clear, "contact tracing … is a key strategy for interrupting chains of transmission" (WHO 2021, 1). However, because it requires abundant manpower, sensitivity to local context, close engagement with communities, relevant and continuing training, and exhaustive investigation (WHO 2021, 2–4), effective contact-tracing is difficult to perform beyond a certain threshold of cases.

Second, the success generated by responses to the first wave created a false sense of security. Because the general lockdown was so effective, it was thought that the country's authorities could implement the same policy response with similarly successful results. But the centralized response meant that all regions were treated equally without regard to the nuances of local context. Precisely because regional health authorities were underdeveloped and understaffed, the country lost precious time in both monitoring and responding in a timely manner. In other words, centralization's success became its own weakness during the second wave (interview with Marios Themistokleous, General Secretary for Primary Health Care). The signs had been there since the first wave, but were masked underneath the nationwide mobility restrictions. "When spikes in cases would emerge in Northern Greece, the response was always to send NPHO personnel, or Tsiodras and Hardalias in a helicopter, to go check the situation" stresses Professor Zilidis. "During the daily briefings there were no qualitative indices and no information on the geographical spread of the cases. Local communities never understood whether the danger levels were increasing or falling in their area," suggests former Minister of Health Andreas Xanthos. And the Prime Minister adds: "I wish municipalities and administrative regions took greater initiative. Since that was rarely the case, I was forced to intervene." For as long as the only priority was containing the spread of the virus, problems with policy capacity lay dormant underneath the luster of self-congratulations.

Sustainable economic performance demanded learning to live with the virus and delaying a second nationwide lockdown as much as possible. Most of the summer was spent managing the rapid lift of all mobility restrictions.

People understood the need for the protection of public health, but as early as June 2020, 65% favored restrictions only in places experiencing spikes in cases and only 21% of those surveyed in a public opinion poll favored horizontal measures similar to those imposed in the spring of 2020 (ekathimerini.com 2020). Early attempts at regional lockdowns came with significant delay and little or no planning. On July 14, then Minister of Health, Vassilis Kikilias, spoke on national TV about the "Plan B of regional lockdowns." But the country did not acquire the monitoring and implementation capacity to take such regionally nuanced measures until November.

Third, the duration of the pandemic took a toll on trust and consequently compliance. New daily cases crept up during the summer, surpassing 200 on August 9 for the first time (Figure 5.1). The March lockdown had been introduced with less, although daily testing had increased since. On August 17, the Prime Minister announced lockdowns in areas with high numbers of cases, which included curfews, restrictions to gatherings, and mandatory mask-wearing. The August local lockdowns did not envision business closures. Tsiodras and Hardalias returned to television for bi-weekly briefings. "Now we need to kick the population's caution back up again, and we are bringing them back" stated the Prime Minister during our interview. However, despite bringing back the proven-worthy messengers, the message was no longer as powerful or even appropriate in some cases. Local lockdowns caused political and popular pushback, and with more relaxed measures than the ones employed during the first wave, they were very often breached. The lack of capacity at the local level meant that centrally taken decisions could not be effectively implemented. "If you do not take into account the diverse needs of the different population groups and do not deliver tailor-made messages involving local authorities, the communication strategy cannot be effective" stresses Christos Lionis sharing first-hand experience from mass non-compliance in Crete. The high trust in the government's successful response to the first wave began to erode. One study, conducted between March and August 2020, reported that levels of high trust resulting from initial successes by the Greek government and health authorities decreased by 31 and 21 percentage points, respectively, during that period (Kanellopoulou et al. 2020).

As the initial approach to local lockdowns seemed to be failing and while cases continued to rise, low monitoring capacity further delayed meaningful interventions. Nightclubs and bars were secretly breaking curfew in rural areas (Skai Online Newsroom 2020). Many nursing homes, "most being private institutions without proper quality and legal auditing," informs Professor Lionis, "lacked the capacity to stop the spread among the elderly." Despite great effort by Civil Protection to cooperate with local and regional authorities in containing the disease and implementing

measures, the government could never stay “a step ahead of the disease” (Prime Minister). Aware of institutional deficiencies, the government also knew that it could not engage in wholesale change during the crisis.

Chronic deficiencies in developing regional administrative capacity in public health rendered this feat impossible. Greece’s seven Health Regional Authorities are understaffed, uneven in size, and with unclear jurisdiction over public health matters, cooperating uncomfortably with the 13 Administrative Regions and the NPHO. Figure 5.2 provides a map showing the different administrative regions. “The Sixth Health Regional Authority is managed only by a chief administrator and two deputies and covers [an area of] nearly one-fourth of the country” (Minister Xanthos). “The Regional Public Health Labs – created in 2003 for disease monitoring – were never staffed and the one in Thessaloniki has remained locked up,” asserts Professor Zilidis. The head of Attica’s Administrative Region, in collaboration with the Union of Athens Doctors, voluntarily donated 10 mobile care units to government, to be used for testing in Attica in cooperation with the NPHO. While trying to improve the country’s monitoring capacity, these acts rendered the massive institutional gaps more visible at the same time. “The Attica Regional Authority, when activated, proved more effective than the NPHO in identifying needs and intervening” comments Professor Yfantopoulos. Regional instruments performed as well as they could but chronic understaffing and jurisdictional ambiguity did not optimize results. The policy context required upgrading of infrastructure, but the legal foundations, let alone administrative expertise and funding, were simply not there.

Highly centralized monitoring and tracing could not contain the rise in cases. Low capacity and trust prompted a centralized response, but when trust began to rise, low capacity produced centrifugal pressures. In the beginning of fall, daily cases increased exponentially (Figure 5.1). Committed to avoiding a second nationwide lockdown, the government opted to continue with regional measures, in combination with some nationwide tightening up. But during September 2020, trust levels in both the government and the scientific community deteriorated. Measures seemed to change daily, as did the recommendations of the COVID-19 Specialists Committee. Schools opened with mandatory mask-wearing on September 11, following long discussions on classroom size. A 12–5-am curfew was introduced for mini-markets following a record-high (at the time) 453 cases on September 21, according to data from the Johns Hopkins University. Professor Simou states categorically: “Decisions were viewed as contradictory and untimely by citizens.” Meanwhile, the blame shifting harmed politicians and experts alike. The second wave of the Dianeosis (2020) survey on COVID-19 showed “high trust on scientists” dropping from 85% to 65.6% and “high trust on the welfare state” dropping from 56.7% to 42% between April and September 2020.

Delaying a second lockdown and maintaining an open economy eventually forced treatment, not just prevention, to become a priority. Low policy capacity tested the GNHS, pressuring it to the verge of collapse. Primary care services in the country have been rudimentary and unembedded in the public culture. “Eighty percent of cases exhibit symptoms which can be dealt at the primary care level but only 15% of Greeks are registered to their dedicated family doctor,” claims Minister Xanthos. Home care for people unable to visit hospitals or in high danger of infection “is non-existent,” added Professor Kyriopoulos. At the end of the day, the chronic problems of the health sector made matters worse. “An integrated system of healthcare services was never achieved in Greece,” said Professor Sissouras, forcing all patients to hospital care. During October, daily cases started surpassing 2,000, while daily ICU patients moved past 100. The designated COVID-19 hospitals established during the first wave—predominantly in urban centers—reached capacity limits while hospitals in rural areas faced a lack of equipment and specially trained personnel. The GNHS’s durability was questioned daily. It became clear that the country lacked the structural foundations to handle a nationally open economy with only regional measures in place. Neither ensuring compliance nor monitoring and tracing cases, let alone treatment, were feasible.

General Measures and Regional Lockdowns during the Second Wave

Political pushback and plummeting trust led to the worst of both worlds: rising cases and failing measures. During the national holiday weekend of October 26–28, no further restrictions were imposed although celebrations were canceled. The holiday is a double celebration for the city of Thessaloniki, the capital of the Province of Macedonia, where most cases were traced during the fall (Figure 5.2). As the Minister of Development Adonis Georgiadis stated on Skai TV (January 5, 2021): “Not imposing stricter restrictions on Thessaloniki was the biggest mistake we made. The Covid-19 Specialists Committee made recommendations for a lockdown, but we wanted to show respect to the Orthodox Church.” Daily cases jumped by more than 1,000 in the following week, continuously reaching new record numbers. “We (the Committee) were blamed for failing to contain the epidemic in Northern Greece. If you have three cities acting as super-spreaders it only takes a day or two for a whole region to come under siege,” underlines Professor Gargalianos. The delay had reached the breaking point. On November 3, 2020, the government announced a lockdown in Northern Greece, and on November 7, 2020, a general lockdown was introduced across the country. The centralized mode of response that proved so effective in the spring returned “with a vengeance” in

late fall. Swift, centrally made decisions and public health priorities over the economy prevented the catastrophe that Greece's neighbors had faced in the course of the pandemic.

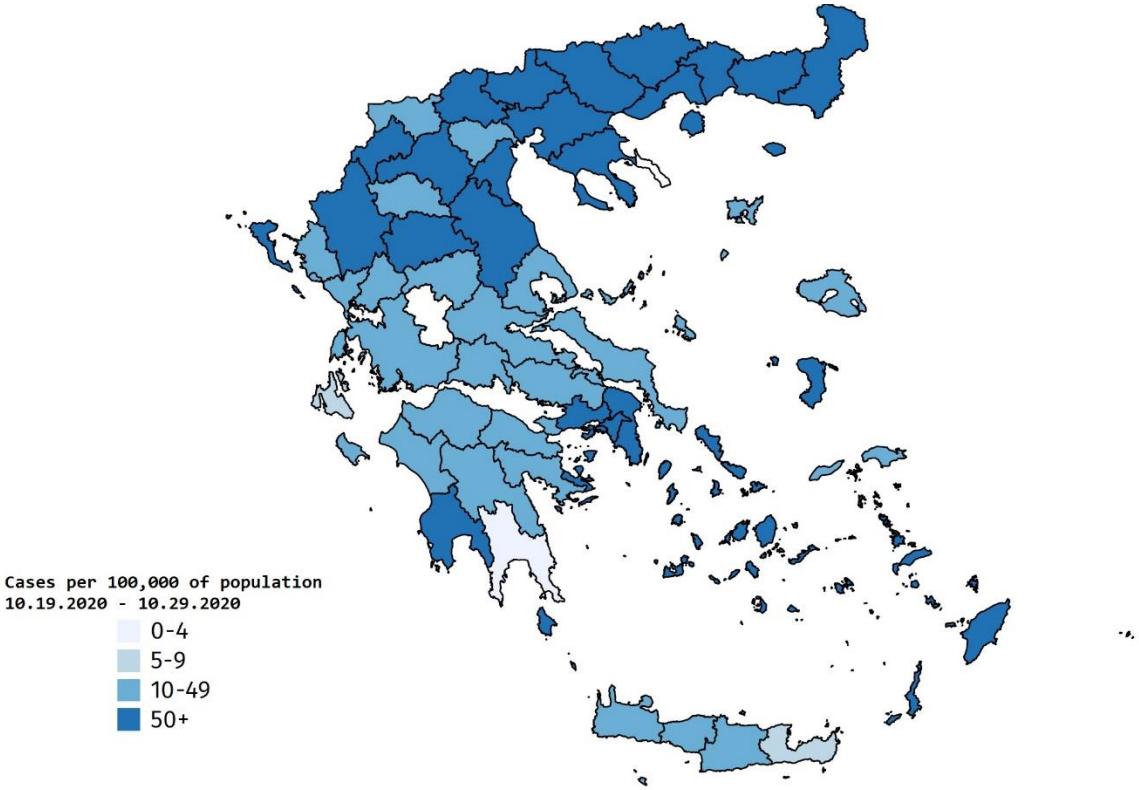

Figure 5.2: Cases per 100,000 of population, Greece, 10.19.2020 – 10.29.2020.
Source: EODY

The task of maintaining "normal" life without complete lockdown demanded a more centrifugal response—that is, with higher trust. Because Greece structurally lacks the institutions for higher administrative capacity—and little was done to build it because of lackluster preparedness during the summer and insurmountable problems in making deep structural changes during the crisis—it could not achieve the needed response flexibility. Maintaining a centralized response, because again, this is what the country could do, created problems mainly driven by low trust (in compliance), low administrative capacity (in treatment and monitoring), and low inclusiveness (in monitoring, communication, and enforcement regarding local measures). When things reached the breaking point in November, a couple of quick decisions managed to get the situation back on track (for the most part). But, when the aim shifted to also addressing economic problems, the centralized response was slow, rigid, overwhelmed, and ultimately ineffective. The government did not act in time, made costly mistakes, lost the public's trust, and finally brought the

GNHS back to the brink. Only during and after the second nationwide lockdown did things begin to change, and a more appropriate, regionally nuanced—centrifugal in this book's terms—response has hesitantly begun to be implemented.

To mitigate the public health toll and economic cost that were by now decimating voter goodwill, the national government finally mustered the resources to create better regional monitoring capacity. An initiative by Professor of Chemistry Nikos Thomaidis to test waste water for COVID tracing—identifying viral loads at the regional and local levels three–four days before symptoms are expressed in the population—was enthusiastically adopted by the government, providing a costless solution to the lackluster regional monitoring capacity. With an effective tool for regional intervention in hand, the government introduced a color scheme map on January 30, 2021 to designate Regions of Concern, making them subject to significant mobility restrictions. There are three levels of measure stringency:

- Horizontal measures in the entire country such as mandatory use of masks in all public areas inside and outside, restrictions of movement within regions and prohibition of movement across regions, prohibition of private congregations, and others.
- Measures in specific areas under scrutiny, that is, areas where COVID-19 cases are on the rise, such as a curfew from 9 pm to 5 am, one person per 25 square meters in retail stores, and others.
- Measures in high-risk regions—that is, areas where the number of cases exceeds a threshold level—such as a curfew from 6 pm to 5 am, church service with up to nine individuals present, and click away service, that is, pre-ordering goods and picking up only by appointment (GSCP 2021).

More recent examples of centrifugal response tendencies involve the government's plan to achieve vaccination coverage of at least 70% of the population by actively engaging local primary care facilities (historically underutilized services for vaccination), pharmacists, and regional mobile units (interviews with General Secretary Marios Themistokleous and Pharmacist Evie Papathanasiou). As the past summer's experience demonstrates, decentralized response and inclusiveness of social actors require timely and meticulous planning.

It is evident that monitoring capacity, and to a lesser extent the message, is devolving to a more regional approach that is targeted and specific to the particular local context. Institutional capacity has been built but mostly *ad hoc* through bricolage and some layering (Mahoney and Thelen 2010). The message has also had to change from almost

exclusively safeguarding public health to a more balanced health-economy calibration. While a centralized response formed the essence of the Greek response to the first wave of the pandemic, the crisis that ensued has prompted more centrifugal tendencies during the second wave.

Conclusion

In this chapter, we have argued that policy style interacted with political trust to shape the Greek response to the crisis created by the COVID-19 pandemic. We showed that when the pandemic hit the country in February 2020, Greece exhibited an administrative style coupled with low trust in government and other relevant public institutions. Focusing on measures taken during the response phase, that is, reaction to the pandemic, we have confirmed our hypothesis. However, we have also uncovered a certain dynamism driven by feedback from earlier response measures. While we anticipated a more-or-less "fixed," that is, centralized response, we also uncovered centrifugal tendencies during the second wave. Command and coordination remained firmly in central–national hands throughout the two waves. But the message changed as the trade-off between public health and economic performance became more visible, and politically pressing, while there were attempts at more regionally nuanced outcomes. To be sure, centralization is still the norm—after all, policy styles cast a long shadow onto the future—but trust and the direction of response appear to wax and wane, further buttressing our argument for an interactive effect of style and trust on national crisis response. Figure 5.3 summarizes the findings.

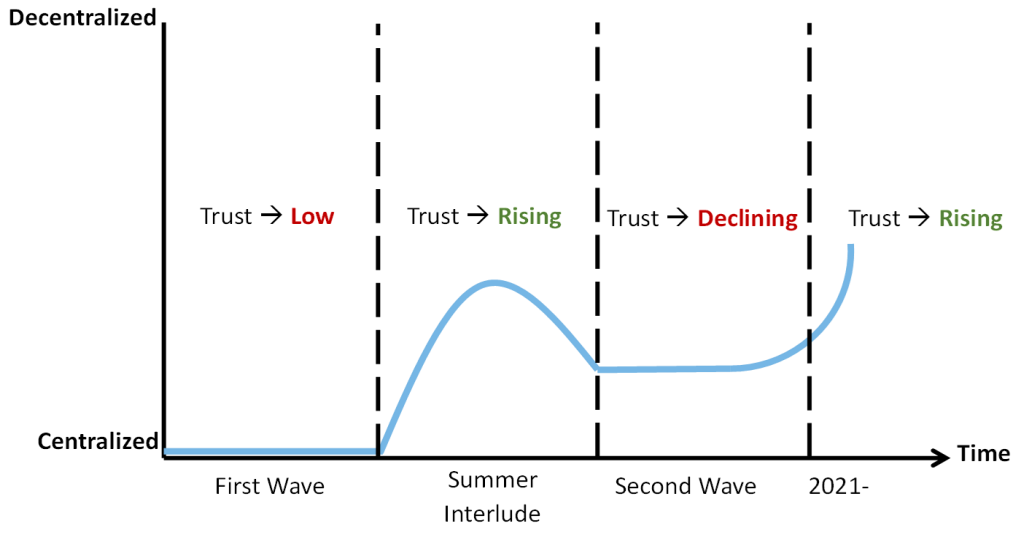

Figure 5.3: Policy Style and Trust during the Greek Response to the Covid-19 Pandemic

As predicted, Greece initially adopted a highly centralized response. Low administrative capacity interacting with low trust prompted a coordinated and clear response. Action was swift largely driven by weakness. Ten years of austerity and a gargantuan migrant crisis left health care understaffed and severely underfunded. Precisely because the Greek leadership knew that capacity in the health care sector was too low to withstand high numbers of cases, it decided to focus on prevention. Weakness turned to strength. The success of the first wave hid structural capacity deficiencies that were highlighted during the interlude. Affecting trust levels (Cairney and Wellstead 2020), they shaped the centrifugal response during the second wave. A change in aims as well as lapses in monitoring, staffing, and more importantly, poor regional infrastructure created huge problems that could not be overcome. Institutional inertia created friction that generated political tension in addition to centrifugal tendencies.

While the argument appears to explain the actual response quite well, it leaves important questions unanswered. Why was the response so well coordinated and implemented in a country better known recently for chaos and paralysis? Is it because "Greece has shown a tendency to create alarm reflexes during crises, exhibiting much more effective management than in normal times" (Professor Kyriopoulos)? Or is the answer found in political leadership (Rhodes and 't Hart 2014)? Our analysis cannot but commend the current leadership for insight and forethought, at least relative to past governments' performance, as stressed by most of our interviewees. Whatever the answer, these are interesting questions that await further research.

Three theoretical implications should be emphasized. First, the argument has to incorporate the notion of feedback (e.g., Béland 2010; Mettler and Sorelle 2018). The Greek response was shaped by interactions of policy style and trust, but changes in trust (and to a lesser degree capacity) altered the effects over time. Positive and negative effects were felt within a very short period of time, leading to contradictory pathways: the need to change course but still experience the same results (Daugbjerg and Kay 2020). And all that without much capacity or trust to do it. The argument on policy styles needs to conceptualize feedback.

Second, confirming the literature's expectations (e.g., Lavazza and Farina 2020), experts played a significant but secondary role. The response was shaped by experts, but decisions were fundamentally political. Experts framed, communicated, and legitimated the message of essentially political decisions: whether, where, and when to implement a lockdown, compliance issues, and the like. The key command-and-coordination unit was Civil Protection, which is located within the Ministry of Citizen Protection, that is, the police. It further buttresses our

argument regarding the essence of administrative style: crisis response focuses attention and resources on units with administrative, not substantive expertise.

Third, the findings partially support Mahoney and Thelen's (2010) institutional change argument but also extend it. Compliance is not just a variable affecting institutional change, and therefore policy capacity, but also crisis management. While they hypothesize gradual institutional change, we find more abrupt changes under crisis conditions. The changes observed in Greece fit Mahoney and Thelen's institutional outcomes: bricolage, that is, mostly *ad hoc* recombination and expansion of capacity, and layering, that is, the addition of capacity to address new purposes. Amending their argument, the changes were affected by policy context but not by political friction, that is, overcoming veto players. This makes sense as crisis conditions temporarily mute opposition. The mechanism linking compliance to change is trust. Policy styles cast long shadows into public policymaking under extraordinary conditions. Interacting with political trust, both variables affect compliance rates, which, in turn, open power-distributional opportunities to bring changes that affect policy style and trust. Such interactive loops over iterations in a short period of time go a long way toward explaining the Greek response to the crisis caused by the COVID-19 pandemic.

Figure 5.1 New Daily Confirmed COVID-19 Cases in Greece.

Figure 5.2 Regional Map of COVID-19 Cases per 100,000 of Population in Greece (October 19, 2020–October 29, 2020).

Figure 5.3 Greece's Response as a Function of Administrative Style and Fluctuating Political Trust.

Appendix

Interviewee Name	Description	Date
Kyriakos Mitsotakis	Prime Minister of Greece (2019–)	August 5, 2020
Vassilis Kontozamanis	Deputy Minister of Health (2019–) President of the National Organization for Medicines (2008–2009)	August 5, 2020

Ioannis Kyriopoulos	Emeritus Professor of Health Economics—National School of Public Health, Athens Member of the 2009 Pandemic Response Committee as Dean of the National School of Public Health	July 27, 2020 and January 27, 2021
Effie Simou	Associate Professor of Mass Media and Health Communication, Department of Public Health Policy—University of West Attica Coordinator and author of the "National Action Plan for Public Health 2008–2012" (Ministry of Health)	August 3, 2020
Christos Zilidis	Professor of Social Medicine and Epidemiology, University of Thessaly Leading Member of the Design Committee for Greece's first Public Health Law (2003)	July 28, 2020 and December 15, 2020
Aris Sissouras	Emeritus Professor of Management, University of Patras Leading Member of the Committee for the Design of the Greek NHS (1981–1982)	July 26, 2020
Ioannis Tountas	Professor of Social and Preventive Medicine, National and Kapodistrian University of Athens Greece's National Representative for Health at the OECD (2009)	July 29, 2020 and December 18, 2020
Christos Lionis	Professor of General Practice and Primary Health Care, University of Crete Deputy General Director of the Regional Health and Welfare system of Crete (2001–2004)	August 1, 2020
Meletios-Athanasios Dimopoulos	Professor of Haematology/Oncology, National and Kapodistrian University of Athens	August 18, 2020 and January 28, 2021

	Rector of the National and Kapodistrian University of Athens (2015-)	
Agis Tsouros	Emeritus Professor of Epidemiology and Public Health—University College London Former Director of the Division of Policy and Governance for Health and Wellbeing, WHO, Regional Office for Europe	August 7, 2020
Nikos Hardalias	Deputy Minister for Civil Protection and Crisis Management (2019–)	February 5, 2021
Panagiotis Gargalianos	Pathologist, Infectious Disease Specialist, Athens Medical Center President of the Hellenic Society of Infectious Disease Specialists and Member of the COVID-19 Specialists Committee	January 23, 2021
Marios Themistokleous	General Secretary for Primary Health Care, Ministry of Health (2019–)	February 3, 2021
John Yfantopoulos	Professor of Health Economics and Social Policy, National and Kapodistrian University of Athens President of the National Council for Public Health (2014–2016)	January 21, 2021
Andreas Xanthos	Minister of Health (2015–2019)	January 27, 2020
Evie Papathanasiou	Pharmacist General Coordinator of Eastern and Northern Attica Party Staff Registry (New Democracy)	January 21, 2021

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