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Healthcare Provision for Marginalized Populations

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Abstract

Social vulnerability is a concept defined by physical, social, economic and environmental factors, which, together with individual or social characteristics such as poverty, ethnicity, marginalisation, etc., increase the negative impact of a potential risk. Disadvantaged population groups are usually structured by such characteristics and as a result experience inequalities that affect their rights. In this light, a fundamental human right that is under attack is that of health and, by extension, access to health care. Public health systems play an important role in mitigating or exacerbating this social inequality. With health inequalities being a real and present danger that needs to be addressed, ways of reducing this phenomenon have been identified, but they must be strengthened, with the necessary contribution from state mechanisms.

Aim: The aim of this research project is to document and highlight the inequalities faced by disadvantaged population groups in accessing healthcare, with an emphasis on social vulnerability. In addition, ways of eliminating social inequalities in healthcare are proposed.

Method and materials: The methodology followed for the development of this thesis is a literature review of scientific journals, textbooks, books, and the internet, with the aim of providing the most accurate depiction of the phenomenon of medical tourism based on real-world data.

Keywords: Social Vulnerability; Disadvantaged Population Groups; Healthcare Provision

1. Introduction

Social vulnerability is shaped by the characteristics of individuals or groups and by the conditions that affect their ability to anticipate, cope with, resist, and recover from the impacts of hazards. According to the United Nations Development Programme (UNDP), vulnerability is defined as “a human condition or process resulting from physical, social, economic, and environmental factors, which determine the likelihood and scale of damage from the impact of a given hazard”. More specifically, social vulnerability is determined by a range of interrelated factors—physical, social, economic, and environmental—that heighten a community’s susceptibility to harm. Social characteristics and circumstances such as poverty, occupation, caste, ethnicity, exclusion, marginalization, and inequalities in the distribution of material resources within a society or community further exacerbate vulnerability

Within this framework, access to healthcare emerges as a fundamental human right that is often at risk of being violated. Health inequalities generally refer to disparities in the quality of healthcare—particularly in terms of access, treatment options, preventive services, and health outcomes—among groups experiencing social disadvantage. Historically and across cultures, access to healthcare services has been recognized as a fundamental human right. The conceptual weight of this right reflects critical principles and societal values. Undeniably, health is a core component of human dignity.

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Every individual deserves the opportunity to experience physical and mental well-being without suffering needlessly from preventable illnesses or injuries. The inability to access healthcare undermines basic human dignity and can lead to the marginalization and disempowerment of individuals.

Moreover, ensuring universal access to healthcare promotes social justice and equity, helping to reduce disparities in health outcomes across communities regardless of socioeconomic status, gender, ethnicity, or geographic location. Health is also a key driver of human development. A healthy population is more likely to access education, participate in the economy, and contribute meaningfully to society—thereby supporting social and economic progress. In contrast, poor health can trap individuals and communities in cycles of poverty and disadvantage, increasing long-term healthcare costs and hindering societal advancement.

State healthcare systems play a pivotal role in either mitigating or exacerbating health inequalities within a society. The structure, accessibility, and quality of healthcare services provided by the state can significantly influence disparities in health outcomes across different population groups. Governments that prioritize equitable access, high-quality care, and robust public health interventions have the potential to substantially reduce health inequalities.

Conversely, healthcare systems that fail to address the needs of the most vulnerable—whether due to inadequate funding, poor infrastructure, or inequitable policies—can deepen existing health disparities. Such systemic shortcomings often lead to poorer health outcomes among disadvantaged populations, further entrenching social and health inequities. The aim of the present study is to highlight the health inequalities faced by disadvantaged population groups, while also discussing specific strategies and approaches through which these adverse conditions can be reduced—and ultimately eliminated. This paper is based on a literature review, with data collection and manuscript preparation carried out between November 2024 and February 2025.

2. Material and method/Methodology

The methodology followed for the development of this thesis is a literature review of scientific journals, textbooks, books, and the internet, with the aim of providing the most accurate depiction of the phenomenon of medical tourism based on real-world data.

3. Results and findings

According to the World Health Organization (WHO), health is defined as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity”. This definition emerged in the context of the rise of Western medicine, which began to take shape in the 19th century and continued into the early 20th century. Western medicine traditionally adopted a reductionist view of health, focusing primarily on the absence of illness and defined largely through physical and biological parameters.

Throughout the 20th century, the WHO’s definition of health gained global influence and played a critical role in shaping national healthcare systems, pushing countries to move beyond traditional, purely biomedical boundaries in their conceptualization of public health.

From a more theoretical and contemporary perspective, the formulation of scientifically robust definitions of health requires careful consideration of context. Not all potential definitions are equally applicable within the clinical or scientific domain. For instance, if health is constructed based on ethical frameworks dominant in the middle and upper classes of Western societies, individuals from different socioeconomic or ethnic backgrounds may be unfairly evaluated through a lens of cultural bias, resulting in the devaluation of their personal health experiences.

Moreover, defining health as a fixed “state” has also drawn criticism in recent years. Scholars argue that such a static conception neglects key dynamic elements that are crucial in understanding clinical realities and the lived experiences of patients.

Indeed, the concept of health extends far beyond the mere absence of disease or disability, or even physical parameters alone. It can be understood as a capacity to be healthy—a continuous, dynamic process that is potentially attainable for all individuals under all circumstances. This conceptualization of health embraces both distress and well-being, while consciously avoiding the risk of becoming utopian or unattainable in practical terms.

New and more sustainable definitions of health may be emerging—ones that frame health as the ability to confront and manage one's own adversities as well as to maintain conditions conducive to well-being. In more functional terms, health may be interpreted as the capacity to respond to environmental events with appropriate emotional, cognitive, and behavioral reactions, while avoiding undesirable responses.

This evolving approach transcends both individualistic perspectives and models grounded solely in social determinants of health. It instead incorporates both individual and social variables, placing emphasis on personal responses to environmental stimuli. Additionally, while this view is somewhat rooted in the cultural values of Western societies, particularly in its focus on individual resilience and self-management, it remains largely independent of explicit moral or normative positions.

It is a well-established fact that healthcare as a human right is not a novel concept, but one that has been recognized and institutionalized in various forms across the globe. Today, most developed nations offer universal healthcare systems to their citizens. The following is a brief historical overview of how healthcare came to be understood and accepted as a universal human right.

The modern Western conception of “rights” can be traced back to the Enlightenment era. Under the European feudal system, individuals were subject to the will of their superiors, whose power was derived from monarchs—who, in turn, claimed divine authority. With the collapse of this system, the idea emerged that rights could be safeguarded through a social arrangement, which political philosophers such as John Locke and Jean-Jacques Rousseau described as a “social contract.” Locke, in particular, rejected the notion of individuals as mere subjects and instead viewed them as citizens whose inherent rights demanded respect—even from rulers. The social contract thus empowered the people and justified rebellion if rulers failed to uphold human rights.

Later, Thomas Jefferson incorporated these principles into the U.S. Declaration of Independence, further advancing the notion of inalienable rights. Throughout the 19th century, egalitarian political movements promoted the universalization of this thinking. The labor movement, especially in the late 19th and early 20th centuries, extended Locke's argument by asserting that rights are earned through participation in the creation of value. Just as an artist has ownership over their work, workers and citizens contributing to the development of products or governance structures were seen as holding a stake in those systems.

The Second World War marked a turning point in the global understanding and protection of human rights. The Universal Declaration of Human Rights (UDHR), adopted by the United Nations in 1948 (with eight abstentions and no opposing votes), begins with the affirmation that:

“The recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world” .

In the postwar period, the international community recognized the urgent need to define and protect the rights of individuals. The Constitution of the World Health Organization (WHO), adopted in 1946, expanded this framework by declaring:

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (WHO, 1946).

This notion was further codified in international law with the adoption of the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1976. Article 12 of the ICESCR states:

“The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (UN, 1976).

These rights include bodily autonomy and reproductive freedom, as well as freedom from torture or non-consensual medical experimentation. The ICESCR places a duty upon states to ensure access to key determinants of health, such as clean water, sanitation, food, nutrition, and housing, along with a comprehensive healthcare system that is affordable, accessible, and non-discriminatory.

Most recently, in 2015, the United Nations reaffirmed these principles through the adoption of the Sustainable Development Goals (SDGs). Among these is the commitment to: «Achieve universal health coverage, including financial

risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all” (UN, 2015).

The pages of medical journals reveal a long-standing and well-established tradition of defending human rights, dating back to the time of Thomas Wakley, who founded *The Lancet* in 1820 (Kandela, 1998). One notable expression of this tradition occurred in 1999, when the *British Medical Journal* (BMJ) hosted a forum to facilitate dialogue between advocates and critics of the human right to health.

During this discussion, the Tavistock Group, a private think tank with interests in health systems ethics, presented a draft framework of ethical principles affirming the right to health as a core human entitlement (Smith et al., 1999). This draft aimed to serve as a starting point for broad, interdisciplinary discussion among professionals across the medical and healthcare fields, ultimately seeking consensus on the nature and scope of the right to health.

A key principle underpinning the Tavistock Group's proposal was the idea that, although the individual is the rights-holder, the provision of healthcare services in response to that right must be understood within a community-based context. Accordingly, as a fundamental human right, the right to health cannot be bought or sold on the open market like other commodities, nor can it be constrained by a person's ability to pay.

Instead, the Group emphasized that governments bear the responsibility to fund medical education, training, and research, to invest sustainably in supporting healthcare professionals, and to ensure that knowledge is freely shared, irrespective of institutional affiliations or proprietary claims. These obligations reflect the collective and systemic nature of realizing the right to health in practice.

In contrast, arguments opposing the recognition of health as a human right have primarily focused on contesting both the definition and scope of human rights and healthcare itself. Initially, critics of the Tavistock Group's proposal argued that, while civil and political rights are now broadly accepted as fundamental human rights, “there is little rational or utilitarian basis for treating healthcare in the same way” (Barlow, 1999: 321).

Furthermore, even if general agreement could be reached regarding health as a human right, opponents questioned who bears the obligation to provide the necessary resources to fulfill this claim—even for the provision of basic care.

Critics also stressed that any attempt to define healthcare as a right must account for a wide range of social, economic, organizational, scientific, and technical issues and relationships before a comprehensive consensus on the scope of the right can be achieved. Additionally, they argued that even if such definitional barriers were overcome, critical decisions would still need to be made concerning availability and access, as demand would likely outpace supply. As Loeffler pointed out, resource scarcity would inevitably lead to hard choices. Thus, as Barlow remarked,

“it is difficult to see how any provision of services could be construed as a human right, when satisfying such a demand imposes undue burdens on others.”

Nonetheless, while discussions about health as a human right often emphasize that good health can be achieved within social frameworks—ones that attend to poverty, education, housing, economic globalization, and other social determinants—this observation is frequently used to undermine the priority given to health itself. According to some commentators, however, the human rights movement offers a compelling response to such claims by articulating the “conditions for human well-being” that serve as an analytical framework for directly addressing the social harms that undermine health—a framework that proves more effective than traditional approaches. This approach seeks to unify public health and human rights as a single, mutually reinforcing agenda, which is believed to strengthen claims for certain social rights, including the right to health.

Prior to World War I, there was no public healthcare provision in Greece, apart from military hospitals. Although a few philanthropic hospitals operated in the major urban centers, organized public health services were virtually nonexistent. Several efforts were made over time to establish a state-run healthcare system, but it was not until 1983 that the National Health System (NHS) (*Ethniko Systima Ygeias* – ESY) was formally established through Law 1397/83.

The preamble to this law proclaimed health as a “social good” and declared that safeguarding the health of the nation was the exclusive responsibility of the state, explicitly rejecting healthcare commodification. Consequently, the establishment, expansion, and specialization of private hospitals and clinics were prohibited, as was private practice by physicians employed within the NHS.

Furthermore, the law made clear that all citizens were entitled to equal rights to high-quality healthcare (Ballas). In terms of financing, the Greek NHS adopted a hybrid model, drawing from both social insurance funds (Bismarck-type system) and general taxation (Beveridge-type system).

The National Health System (NHS) of Greece is organized into seven (7) Regional Health Authorities, which are numerically designated as follows:

- 1st RHA – Attica
- 2nd RHA – Piraeus and the Aegean
- 3rd RHA – Macedonia
- 4th RHA – Macedonia and Thrace
- 5th RHA – Thessaly and Central Greece
- 6th RHA – Peloponnese, Ionian Islands, Epirus, and Western Greece
- 7th RHA – Crete

Each RHA oversees the administration of three levels of healthcare services:

Primary care, which includes Health Centers, Regional Clinics, Specialized Regional Clinics, Local Clinics, as well as other structures such as Diagnostic Laboratories, Polyclinics, Child Mental Health Centers, Specialized Care Units, and Preventive Medicine services;

Secondary care and Tertiary care, which primarily involves hospitals responsible for inpatient care.

Law 3527/2007 currently defines the mission and role of the Regional Health Authorities (YPIE), which includes the following provisions:

- The planning, coordination, supervision, and control within the boundaries of each Regional Health Authority over the operation of all Health and Social Solidarity Service Providers. These Service Providers include:
 - Hospitals, Health Centers, and Social Care Units
 - Mental Health and Addiction Centers

Other public law legal entities and private law legal entities of the public sector that operate in the fields of health and social solidarity and are supervised by the Minister of Health and Social Solidarity.

- The submission of proposals and recommendations to the Minister of Health and Social Solidarity aimed at the more comprehensive and efficient provision of health and social solidarity services to the population within their region.
- The monitoring of the implementation, by the administrations of the supervised Health and Social Solidarity Service Providers, of policies established by the Ministry of Health and Social Solidarity (YYKA).

Essentially, the establishment of the RHAs represents the materialization of long-standing efforts to create a flexible and stable National Health System (E.S.Y.), capable of responding promptly, timely, and effectively to the needs of the residents of Greece.

According to the relevant legislation, the institution of regional reorganization through the operation of the RHAs as an executive body automatically establishes a two-way relationship with all healthcare units under their responsibility. The RHAs develop developmental plans for healthcare units and shape the overall regional development strategy.

The strategic development by the RHAs, in collaboration with hospital units, constitutes a set of planned actions. In this way, the strategy of each decentralized healthcare service unit becomes a functional part of the broader regional planning. Due to its character and purpose, each RHA is called upon to implement the “general” national health policy within the “specific” healthcare region (2nd RHA official website).

At the organizational level, the Greek healthcare system incorporates elements from both the public and private sectors. The National Health System (EΣY) is financed through the state budget, via direct and indirect tax revenues as well as social insurance contributions. It provides emergency pre-hospital care, primary/transfer care, and inpatient hospital care through rural clinics, health centers, and public hospitals. Physicians working in public hospitals and health centers

are full-time employees who are prohibited from running private practices, and they receive a salary funded by public resources.

Historically, social insurance funds have always played a crucial role in the coverage, financing, and provision of healthcare services. Until 2010, there existed a large number of social insurance funds. Consequently, there was a variety of systems, differences in contribution rates, coverage, benefits, and terms of benefit provision, which resulted in inequalities in access to and financing of health services .

Thus, in 2011, a significant restructuring of the healthcare system took place, resulting in the consolidation of all social insurance funds and ultimately the creation of EOPYY (National Organization for Healthcare Services Provision). The ultimate goal of this move was to develop a single entity acting as the purchaser of medicines and health services for the insured, thereby increasing its bargaining power with suppliers, which indeed occurred.

Between 2011 and 2014, EOPYY gradually transformed into a unified health insurance fund, solidifying its role as the sole purchaser of health services. During the transitional arrangements, those who were members of insurance funds before 2011 continued to pay the health contribution rates defined by their respective funds, while citizens who entered health social insurance from 2011 onwards became direct members of EOPYY and paid a standardized contribution rate. Contributions were collected by the individual insurance funds and then transferred to EOPYY.

Since 2017, this function has been assumed by a single organization, the Unified Social Security Fund (EFKA), which is responsible for collecting all health and pension contributions.

Social vulnerability is a relatively recent concept that gained prominence in the early 2000s and is studied across various disciplines. It refers to the susceptibility of individuals or groups to risks and stresses from social and environmental factors, as well as their capacity to cope with and recover from adverse effects. This vulnerability is influenced by social interactions, culture, institutions, and economic status.

Certain populations—such as children, youth, women, migrants, refugees, and low-skilled workers—are especially vulnerable to both traditional and emerging social risks. These risks stem from changes like precarious employment, poverty, family challenges, and discrimination. Social vulnerability extends beyond income poverty, encompassing factors like housing, employment stability, family structure, and social exclusion.

The causes of increased social vulnerability include globalization, technological advances reducing labor dependence, and large-scale population movements. Addressing social vulnerability is crucial for modern societies, requiring inclusive policies and integration efforts supported by national laws and international agreements to promote equal opportunities and social cohesion.

In Greece, institutionally, vulnerable social groups, at-risk groups, or high-risk groups are defined as those population groups that have limited or no access to social and public goods and face difficulties or are unable in many aspects and various fields to achieve a good quality of life (e.g., housing, employment, adequate income, education, medical care, social security, etc.). These mainly include homeless people, unemployed/long-term unemployed individuals, people with disabilities (PWD), patients (with serious pathological problems, mental illnesses), ex-prisoners, users and former users of addictive substances, HIV-positive individuals, people from religious or cultural minorities, Roma/Gypsies, single-parent families, juvenile offenders, abused women, victims of trafficking, refugees, migrants, repatriates, and those affected by natural disasters and catastrophes (fire victims, earthquake victims, flood victims) (Balourdos et al., 2014).

According to Law 4019/2011 (Government Gazette 216 A'), on Social Economy and Social Entrepreneurship, Article 1, paragraph 4, vulnerable population groups were defined as follows:

- "Vulnerable Population Groups," generally, refer to social population groups whose participation in social and economic life is hindered, either due to social and economic problems or physical or mental disorders, or due to unforeseen events that affect the smooth functioning of the local or broader regional economy.
- Vulnerable Population Groups are divided into two categories:
Vulnerable Population Groups and ii) Special Population Groups.
- "Vulnerable Population Groups" are those groups whose integration into social and economic life is obstructed due to physical and mental causes. These include individuals especially with disabilities, mental health problems or intellectual disabilities, and persons dependent on or recovering from substance addiction.

- "Special Population Groups" are those population groups that are at a disadvantage regarding smooth integration into the labor market due to economic, social, and cultural causes. These include particularly unemployed youth, unemployed over 50 years old, unemployed women, heads of single-parent families, illiterate persons, long-term unemployed, residents of remote mountainous and island regions, former or current prisoners, juvenile offenders, persons with linguistic or cultural particularities, and migrants.

However, the need to align the legal framework with rapid social developments soon led to the modification of the definition. According to Article 2, paragraph 8 of Law 4430/2016, the current recognized definitions are as follows: "Vulnerable" are defined as those population groups whose integration into social and economic life is hindered by physical and mental causes or due to delinquent behavior.

These include:

- Persons with disabilities of any kind (physical, mental, intellectual, sensory),
- Persons with substance dependence problems or recovering individuals,
- Minors with delinquent behavior, prisoners, and ex-prisoners.

"Special" are defined as those population groups that are in a disadvantaged position regarding smooth integration into the labor market due to economic, social, and cultural causes. These include:

- Victims of domestic violence,
- Victims of illegal trafficking and human trafficking,
- Homeless persons,
- Persons living in poverty,
- Economic migrants,
- Refugees and asylum seekers, as long as the asylum request examination is pending,
- Heads of single-parent families,
- Persons with cultural particularities,
- Long-term unemployed persons aged up to 25 years and over 50 years.

In summary, with Article 35, paragraph 1 of Law 4430/2016 (Government Gazette A' 205/31.10.2016), among others, Article 1, paragraph 4 of Law 4019/2011 (Government Gazette A' 216/30.09.2011), which defined "Vulnerable Population Groups" and distinguished between "vulnerable" (Article 1, paragraph 4(a) of Law 4019/2011) and "special" (Article 1, paragraph 4(b) of Law 4019/2011) groups, was repealed. Article 2, paragraph 8 of Law 4430/2016 newly defines the "vulnerable" and "special" population groups. Comparing the previous with the new regulation, it appears that the new law maintains the distinction between "vulnerable" and "special" population groups, but no longer presents them as subcategories of a broader category, as was the case with the "Vulnerable Population Groups" in the previous law.

Health inequalities represent one of the most pressing social challenges worldwide, manifesting as persistent and unjust disparities in health outcomes and access to healthcare services among different population groups. These disparities are deeply rooted in the social determinants of health, including socioeconomic status, education level, ethnicity, occupation, and living conditions, which collectively influence an individual's ability to attain the highest possible standard of health.

Vulnerable populations—such as migrants, refugees, ethnic minorities (notably the Roma community), and uninsured individuals—experience disproportionate barriers when seeking medical care. These obstacles may be multifaceted, encompassing language and communication difficulties, cultural misunderstandings, systemic discrimination or prejudice within healthcare institutions, bureaucratic complexity, and fear related to immigration status or financial constraints. Such barriers not only hinder timely access to preventive and curative services but also contribute to worsening health outcomes and deepen social exclusion.

The causes of health inequalities can be analyzed at three interconnected levels. First, the patient level involves the individual's socio-cultural background, health beliefs, literacy, and behaviors, which influence their interaction with healthcare services and adherence to treatment. Second, the healthcare provider level includes attitudes, cultural competency, and potential biases of medical professionals, which may affect the quality and appropriateness of care delivered. Third, the healthcare system level refers to structural and organizational factors such as the availability of services, resource allocation, insurance policies, and legal frameworks that determine eligibility and access.

Addressing these complex issues demands a comprehensive, multidimensional approach. Policies must be inclusive, culturally sensitive, and target the root causes of inequality by incorporating social determinants into healthcare planning. This includes training healthcare providers to develop cultural competence, improving language support services, and reducing bureaucratic hurdles. Primary care and general practitioners are pivotal actors in this framework, serving as the first point of contact and offering continuous, community-based care that can identify and respond to diverse patient needs.

In the Greek context, the prolonged economic crisis significantly exacerbated health disparities by increasing poverty rates and limiting access to the National Health System, especially for uninsured and marginalized groups. This led to the emergence of Social Clinics, volunteer-driven, non-profit healthcare centers offering free medical and social services to those excluded from public healthcare. Social Clinics not only provide essential primary care, medication, and social support but also serve as spaces for social solidarity and advocacy, drawing attention to the health rights of vulnerable populations.

Overall, reducing health inequalities requires a coordinated effort involving policymakers, healthcare professionals, social organizations, and the broader society. This involves implementing targeted policies, strengthening social protection mechanisms, promoting education and awareness, and fostering a healthcare culture grounded in equity and respect for diversity. Such comprehensive strategies are essential to ensure equal access to quality healthcare services, improve public health outcomes, and enhance social cohesion.

4. Conclusion

This literature review aims to analyze the functioning of the Greek Health System, with a special focus on Vulnerable Social Groups (VSGs) and their relationship with the public health system within the existing institutional and legal framework. It highlights the significant barriers VSGs face in accessing healthcare services, which may stem from the patients themselves, healthcare providers, or the healthcare system as a whole.

Additionally, the review addresses broader social inequalities, particularly in education, which is considered a fundamental human right and a central factor for social justice and development. It emphasizes the necessity of equal access to education regardless of social discrimination such as gender, language, religion, nationality, socioeconomic status, or sexual orientation.

The concept of socially disadvantaged groups refers to populations that, due to low socioeconomic status or other characteristics, encounter obstacles in benefiting from social services like education. UNESCO defines disadvantaged groups as those who, due to economic status, gender, ethnicity, or political conditions (e.g., refugees), have reduced chances of social and economic integration.

The review also explores the relationship between social inequalities and climate change, highlighting a vicious cycle: existing inequalities make vulnerable groups disproportionately exposed and sensitive to the impacts of climate change, while their capacity to recover from disasters is diminished, thus exacerbating social disparities. Examples include the increased vulnerability of poorer populations to floods or the difficulties faced by women and the elderly under extreme climate conditions. Moreover, the health and nutritional problems faced by indigenous peoples and minorities due to climate change are also discussed.

Finally, the review underscores that vulnerable social groups—such as minorities, women, children, the elderly, and people with disabilities—often experience multifaceted inequalities that exclude them from essential resources and services. Discrimination further intensifies barriers to social, economic, and political inclusion, while the lack of supportive systems and prevailing prejudices increase their susceptibility to exploitation and social marginalization. Addressing these inequalities is critical to promoting social justice and equality.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

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